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A new Italian Government: radical changes for the Italian NHS?

Giovanni Fattore

Introduction

Last May, Silvio Berlusconi won the Italian general election and returned to power after 5 years. The victory of his centre-right coalition, and in particular of his party, *Forza Italia*, has given him and his allies a strong majority in both houses. The coalition consists of four parties representing different political views and ideas about the devolution of the Italian state. Berlusconi's party had a superior performance in southern and northern regions, and appears well behind its leader. The second party, *Alleanza Nazionale*, lost votes compared to previous elections. It has strong roots in the south and in the public sector. Despite garnering less than 5% of the vote, the *Lega Nord*, a radical party calling for strong autonomy for northern regions, appears an important component of the coalition. It is now responsible for a special 'Ministry' for devolution (held by its leader, Umberto Bossi) as well as the Departments of Welfare and Justice. The fourth member of the coalition, the moderate catholic party, does not appear to wield much power and appears particularly interested in specific issues like financial support to private schools, rigid rules concerning medical reproduction and, to certain extent, abortion.

In some critical ministries the new government has balanced the numerous coalition politicians with a few independent well-respected experts. Particularly appreciated, both at national and international level, was the appointment of Renato Ruggero, the previous President of the World Trade Organisation, as Foreign Affairs Minister. The Ministry of Health was placed in the hands of Dr Girolamo Sirchia, a well-known haematologist from Milan. He has previously held political office in a local council and is the creator of the 'North Italian Transplant', the organisation responsible for the management of organ transplant activities in northern Italy. He has spent most of his professional life in a public teaching hospital in Milan, and has been already very active in promoting organisational changes in the NHS.

The Ministry of Health under new stewardship

In the early 1990s Dr Sirchia promoted a 'Charter' calling for less bureaucracy and more doctor involvement in management and, in 1996, he supported the so-called 'NERA model' where competition is promoted both in provision and insurance. In his first interviews as Minister he has shown caution. To date, he has mainly stressed three major points. First, that the institutional arrangements of public hospitals should be changed, opening governance to private entities; preferably non-profit foundations. Second, he has clearly defended the 'Lombardy Model'; the health care model implemented by the Lombardy region, the largest and the most affluent in the country. Taking advantage of the opportunities provided by 1992–93 legislation that promoted

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market elements and the regionalisation of the NHS, the Lombardy region established a clear separation between hospital organisations (running both out-patient specialist and mental health services) and health authorities (running the rest of the services, including primary care through the general practitioner's network). In addition, it greatly opens the NHS quasi-market to private (non-profit and commercial) providers through enlarging patients' freedom of choice and payments based on fee-for service. As a result, the commercial acute care (private) sector in this region increased its market share by 50 per cent in three years (from 12 per cent to 19 per cent), while in the same period, funding to public hospitals remained constant in nominal terms. The third point Dr Sirchia has emphasised concerns dual practice, where he announced new rules to soften regulation (see below).

Whether these first announcements by the minister and Ministry will be significant in terms of understanding future Italian health policy is difficult to say. Currently, they simply appear to be in keeping with the content of the (winning) political manifesto that was presented to voters. Overall, therefore, in reading the generic messages behind these announcements, they seem to suggest more continuity than change. Nevertheless, the future of the Italian health care system (not only the NHS) is likely to be strongly affected by some critical issues that the new government will face; although probably not before the end of 2002 or so.

Future issues

Financial crisis

Although Italy's public health care spending as a percentage of GDP is relatively low, health care is often regarded as a major determinant of excessive public spending. While observers note that the main problem of Italian spending is related to financial transfers to families (mainly pensions), short-term action nevertheless tends to focus on health care financing because it is easier to manage. At the same time, it appears increasingly difficult to run the NHS under pressure to increase quantity and quality of services in such a situation of financial stress. The challenge of dealing with difficult financial issues appears critical. These issues have been exacerbated by recent increases in public spending which are attributable to the complete elimination of co-payments on pharmaceuticals (since January), and a new national agreement on the reimbursement of NHS employees. Thus, what the new government may be willing to do is very difficult to predict. While substantial increases in public central funding is unlikely, other serious options have not yet been explored.

Regional Devolution

Since the inception of the NHS, the regions have always had a prominent role, and this role was strongly reinforced during the reforms of 1992–1993. In keeping with this, the new government has promised voters further steps to develop the Italian state into a federal state based on the subsidiarity concept (leave power and competence to the lowest possible level of government). Northern regions, more affluent and more interested in playing stronger roles, have called for more autonomy, especially in the areas of health, security and education. Health care is an area in which a strong model of devolution can be implemented. This is also coherent with the idea of 'Region Building' – that regional governments design and implement regional policies to manage their own resources and, consequently, become more visible to regional voters.

Regional devolution may help to exploit regional energies and strengthen incentives for improvement. But in the medium-term it can also accelerate the process of fragmentation of the NHS, and may touch on solidarity principles. Present legislation requires a substantial transfer of resources among regions in order to assure similar adjusted per capita spending. However, ensuring this inter-regional solidarity under the conditions of further fiscal devolution appears somewhat problematic. Differing choices and preferences are likely to emerge within the ruling coalition, with compromises between different political parties and regional instances. In fact, while some northern regions have been very aggressive in recent months, southern regions are becoming cautious.

Public-private mix

About 30-35 per cent of total health care expenditure is not covered by public funding. Private spending is only marginally intermediated by insurance agencies (although the health insurance market is growing), and focuses mainly on specialist outpatient care (to avoid waiting lists), de-listed drugs, dental care and rehabilitation. The high rates of increase in private spending show pressure from the demand side that is not presently matched by the public sector. Interest groups and factions of the parties which make up the ruling coalition are exerting pressure to support private spending through a more effective promotion of private insurance and, possibly, through an opt-out scheme where citizens receive a voucher to spend in the private insurance market. The introduction of an opt-out scheme, already suggested in some official regional documents, may become the central issue of the health policy debate over the coming years.

The public-private mix is also a vital question as far as the provision of services is concerned. The Italian NHS has always spent a substantial part of its resources to reimburse services delivered by the private sector (both non-profit and commercial). It can be expected that the government will be willing to further expand the role of private providers. In addition, a few experts and politicians support the idea of transforming some of the hospitals into new private entities (charities, private corporations under government control, etc.). It is important to stress that such action is possible only where hospital and specialist outpatient care is already managed by NHS trusts, as it appears unlikely that the private sector will be attracted by other NHS activities currently in the hands of the health authorities (prevention, primary care, mental health, etc.). In this respect, the Lombardy model presented above would ease the development of the private sector within the NHS framework.

Dual practice

The regulation of dual practice was at the heart of the 1999 reform but was only partially implemented. It is unlikely that the new government will proceed with this complicated piece of legislation, especially as it was not strongly supported by the previous government. Putting it simply, the new rules on dual practice have made a distinction between two categories of NHS medical doctors: those who opt to work only under the NHS framework, and those who are allowed to persue private practice independently. The first group is allowed to enter private practice. But only under the regulation and supervision of their NHS organisations can they attain top management positions in the NHS and enjoy better economic conditions. The second class would have limited access to clinical management positions (i.e. director of a clinical department) but would be completely free to practice privately outside NHS working hours. Legislation has forced doctors to make a definitive choice in this regard, and about 80 per cent of doctors have opted for the first solution. However, resistance to this regulation has been fierce, especially from certain medical specialities (eye medicine, anaesthesiology, and a few surgical specialities) and from most of the doctors with university posts. Present legislation will surely be modified, as already announced by the new minister.

Final remark

Health policy is not on the government's agenda for the 'first 100 days'. Nevertheless, it will be a hot issue in the coming months when the issues presented above will be addressed. Political confrontation is likely and promises to be rather vibrant. In order for the government to be able to address these issues properly, it will require more mature technical guidance with careful analysis of the present situation, along with detailed studies of future options and a sound knowledge of international experience.

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The changing public-private mix in health care

Ray Robinson

Reforms in European health care systems are leading a number of countries to reassess the public-private mix in the finance and provision of health services. There are a number of pressures leading to this reassessment. In several Eastern European countries, the desire to move away from monolithic state-run systems is a powerful driver. In Western Europe, attempts to shift a greater burden onto the private sector are often associated with a desire to contain or reduce public expenditures. On the finance side, however, the role played by the private sector is still marginal in most countries. As Mossialos and Thomson[1] have shown, for example, voluntary or private health insurance is mostly a supplement to tax-funded or social insurance based funding, and no major changes appear likely in this regard.

On the supply-side the situation is rather different. General trends in economic policy during the 1990s emphasised the scope for applying incentive structures drawn from the private sector to the public sector. Privatisation programmes, new public management and the introduction of quasi-markets into the public sector were all examples of this trend. Of course, many Western European countries have a long-standing tradition of pluralism in the supply of health care with private, voluntary and public sector organisations working alongside (or in competition with) each other.

In some countries though, a near to public sector monopoly has dominated provision. The United Kingdom National Health Service (NHS) is a vivid example of close to public sector monopoly in provision that has persisted despite considerable changes elsewhere in the economic and social environment. But some recent initiatives suggest that this might be about to change.

The UK experience

As part of the 1991 internal market reforms, the government initially indicated that district health authorities and GP fundholders – as purchasers of health care – would be free to purchase services from both public and private sector providers. In fact, the development of pluralism in the supply of clinical services to the NHS during the period 1991–97 was very limited. Most purchasing and providing took place between public sector organisations.

With the election of a Labour government in 1997 – with a commitment to the abolition of the internal market – the prospects for more public finance-private provision looked remote. Somewhat surprisingly, however, the incoming government embraced the so called 'private finance initiative' (PFI) – whereby private finance is used through partnership arrangements with the public sector in building NHS hospitals – more enthusiastically than the previous Conservative government. PFI is currently expected to account for 22 per cent of NHS capital expenditure by 2003/04.[2]

Developments in relation to the private provision of publicly funded clinical services are of potentially even more significance. In October 2000, the Secretary of State for Health signed a concordat with the Independent Healthcare Association, which set out the parameters for a completely new partnership approach between the NHS and private and voluntary providers of health care.[3] The concordat is based on

the premise that there should be no organisational or ideological barriers to the delivery of high quality health care free at the point of delivery.

Official interest in drawing on private sector capacity for NHS patients has undoubtedly been stimulated by the need for the NHS to have access to additional capacity in order to deal with winter peaks in demand. Shortages of NHS hospital beds have led to some severe difficulties in recent winters. Moreover, media coverage converts these difficulties into high-profile events with considerable political impact. However, the concordat envisages moving beyond short-term crisis management towards longer-term public-private partnerships. One area where this type of cooperation is envisaged is in the area of intermediate care.

Public-private partnerships in intermediate care

Intermediate care covers a range of services designed to promote independence among patients by: avoiding unnecessary hospital admissions; avoiding unnecessarily long lengths of hospital stay; promoting effective rehabilitation programmes; and planning new services in non-acute hospital environments. Intermediate care policy is seen as particularly important in the case of increasing numbers of elderly people who are often admitted to acute hospitals, and/or remain there unnecessarily, because of a lack of appropriate community or home-based facilities. As such, the government has allocated £900 million over the period until 2003/04 for its development.[4]

One model of intermediate care specifically identified by the government for service development is residential rehabilitation. This is defined as a short-term programme of therapy for people who are stable medically, but who need a period of rehabilitation to permit them to regain the necessary functioning and confidence to return safely to their homes. Residential rehabilitation may be 'step down', following a stay in an acute hospital, or 'step up', following a referral from a general practitioner for a person who would otherwise require hospital admission. One of the main UK independent providers of health care – BUPA – already offers a range of step up and step down facilities to the NHS, and is in discussion with departmental officials about how to extend this role.

Prospects for the future

Debate concerning the future of public-private partnerships in the UK was given considerable impetus in June 2001 with the publication of a report, *Building Better Partnerships*,[5] by the influential left-of-centre think-tank, the Institute for Public Policy Research (IPPR). The report sets out a rigorous agenda for the development of policy in this area. It starts with a clear assertion of principles; namely, a reassertion of the case for publicly-funded, universal services provided free at the point of use; a clear distinction between the funding and the provision of services; open-mindedness about partnerships between the public, private and voluntary sectors; and clarity about how to assess the appropriateness of public-private partnerships based on the criteria of social equity, responsiveness, efficiency, quality and accountability.

It then sets out what may be gained from policies that pursue the partnership approach in line with these principles. These include improved service quality through greater diversity and contestability; a focus on outcomes rather than how services are produced; access to private sector management skills and expertise; and the engagement of citizen groups in service monitoring and governance arrangements. In the absence of existing evidence on the performance of many public-private partnerships, the Commission favours an evidence-based approach using piloting and the evaluation of different models of partnership.

The publication of the IPPR report was a timely contribution to policy debate in this evolving area. Unlike much simplistic, ideological debate on the subject, it offered a systematic analysis of policy options and put forward its own proposals following a careful statement of the principles on which these were based.

But the impact of the report was not based solely on the quality of its analysis. It was also based on the fact that such an 'open-minded' approach was coming from a left-of-centre organisation with considerable influence in government circles. This does not mean, however, that the proposals are uncontested. Public sector trade unions – including those representing many NHS workers – have been outspoken in their opposition to greater private sector involvement in the public sector. At the time of writing, conflict between a government wishing to expand public-private partnerships and trade unions opposed to them is a real possibility. But, according to an increasing number of commentators, this is a trend that is likely to gather pace in the UK and elsewhere.[6]

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Health care policy in Greece: a new (and promising) reform

Lycurgus L Liaropoulos

As Greece joins the European Monetary Union (EMU) she can boast many accomplishments, especially on the economic front. The health sector on the contrary, lacking a coherent public health policy, lags behind in terms of quality, effectiveness, equity, and efficiency. Although health is constitutionally the responsibility of the government, the health sector is highly privatised and, despite certain favourable health indicators, public satisfaction is low and total expenditure high relative to the quantity and quality of services offered to many segments of the population. In order to reverse this negative picture, a major health reform is under way which promises to change the situation dramatically by the year 2006.

A brief history

After the fall of the dictatorial regime in 1974, social policy and especially health became a major political issue. A number of legislative measures were taken until the 1983 health reforms established a National Health Services (NHS) based on a social insurance (Bismarck) model with a strong element of government control and publicly-provided services. After fifteen years of mostly unsuccessful efforts, Greece is on the verge of yet another reform, planned to take effect in the six-year period 2001–2006.

The 1983 reform established a national health system with full-time exclusive employment for hospital doctors and a network of rural health centres. It was a response to public demand for change in the delivery of health services, a universal right to health services, and a more just geographical distribution of resources. The reform, which was never fully implemented, coincided with the establishment of national health systems in other Mediterranean countries and with health reform in Europe in the early 1980s, but was not equally successful.

Despite the measures taken in the last fifteen years, health care in Greece today shows serious problems. These are with respect to the financing and delivery of health services through the many social security funds; large geographical inequalities in the distribution of resources and services; problems in infrastructure development in the public hospital sector; and an ineffective over-centralised control mechanism by the Ministry of Health and other government departments and services. Provider reimbursement systems promote induced demand, and under-the-table private payments are a large part of total health expenditure. As a result – although reliable expenditure data do not exist – it is estimated that Greece spends almost 9 per cent of GDP on a 'product' of dubious quality and low public acceptability.[1]

The main provisions of the current health reform

This situation clearly had to change, and the system made more accountable, providing better quality of service at a lower cost. The health reforms introduced at the end of 2000 include many of the elements found in health systems throughout the EU. It retains the basic aims of universal coverage and equity in the distribution of services, but it also has efficiency and quality of services among its main objectives. An additional guiding principle is the 'de-commercialisation of health', reaffirming state responsibility for adequate health services provision, equitable distribution of health services and coverage of all health needs for all citizens, irrespective of age, sex, or ability to pay.

The main thrusts of the health reform are:

(a) decentralisation with regional development of health planning, control, and services provision by 17 Regional Health Systems (RHS);

(b) the separation of purchasing from the provision of services – by replacing the plethora of public health insurance funds by one main fund where all financial resources are concentrated and major purchasing decisions made;

(c) the development of primary health care through a network of health centres and the institution of the 'personal' doctor concept; and

(d) improvements in the quality and cost-effectiveness of health services through improved management of public hospitals, and the creation of the National Health Institute with a number of specialised agencies involved in research and policy development in areas such as health technology assessment (HTA), economic evaluation, and quality of care.

Health reforms are being implemented through various policy measures, the most important of which so far is Law 2889/2001. This established the 17 regional health systems, and set in motion the reorganisation of hospital management structures. The law abolishes the board of directors and its president-manager, and replaces them with a professional hospital manager signed on for a five-year term. No less important is the attempt to redefine the role played by academic doctors in public hospitals.

In some respects, with the health reforms of 2001–2006, Greece is trying to catch up with the health reforms in other European countries over the last two decades. It involves adopting many of the principles and policy objectives now prevailing in Europe and learning from some of the mistakes. For the first time there is a clear line separating the public from the private sectors, while quality, effectiveness and efficiency become explicit policy goals.

In my view, the main obstacles to the new health reform are no longer the traditional problems of financial

resources or political timidity, which have characterised other attempts in the past. Financing of health care, according to the Organisation for Economic Co-operation and Development is currently at 8.6 per cent of GDP in Greece, and despite measurement problems and the inclusion of high private payments, one may safely say that the money 'is there', but is simply not spent wisely. At the same time, the political will for major and radical change also seems to be strong. But, contrary to what has happened in the past, there also seems to be a very determined effort to include evidence-based knowledge in the drafting of health reform.

These two elements make one hopeful that substantial improvements in health care management in Greece may be expected. A major obstacle may be in the shortage of trained technical and managerial personnel to staff the many new top and middle-level posts, especially in view of the requirements posed by the regional organisation of the health system.

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Insights from Portugal's experience with waiting lists

Monica Oliveira

Since 1979, Portugal has had a national health system (NHS) with universal coverage and nearly free access at the point of use. The NHS is mainly financed via the state budget, and it owns the great majority of hospitals. Over the last decade the system has been moving towards a public contract model, with a generic purchaser-provider split. This has included the creation of contracting agencies (since 1997),[1] and there has been an increasing recognition of the role of the private sector (both for profit and not for profit). As in other countries, equity is the primary objective of health care policy, while other objectives include efficiency, quality, accountability and devolution of power.

Unfortunately, however, the system does not perform particularly well in regard of these objectives.[2] Specifically, a public-private mix in production (uneven supply between public and private), finance (high levels of out-of-pocket payments) and coverage (double to triple coverage of risks due to occupational coverage) has resulted in a perverse system of incentives. This mix has had two main consequences for the public hospital sector. First, it has contributed to high variability in public hospital costs, productivity and geographic supply, together with a lack of cost control and accountability. Second, a conflict of interest arises from doctors working simultaneously in the public and private sectors, the result of which has been low motivation in their work on the public side. Furthermore, it has encouraged a transfer of patients to the private sector. In turn, this has lead to inefficiencies in public hospital provision, such as low bed occupancy rates, under-utilisation of equipment and significant waiting lists in the public system. Waiting lists for specialist visits and surgical interventions in the public sector have resulted in dissatisfaction with the public side (while enhancing the attractiveness of the private[3]) as well as inequities in access, and have been the source of much media attention.

The waiting lists programme

In 1999, the Socialist government initiated a programme to address the question of waiting lists for surgeries, the *Programa de Promoção do Acesso* (Programme of Access Promotion, PPA). This was as an attempt to follow similar endeavour in other EU countries, though it was in large part driven by media pressure and attention. The main objective of the PPA was to increase public hospital performance by decreasing waiting lists and increasing output, through the use of temporary supplementary payments for health care services.[4] The programme was intended to address under-utilisation of capacity in public hospitals via an increase in surgical activity during afternoon and weekend hours (when doctors tend to work in private clinics), and to decrease inequalities in access. Supplementary payments were based on adjusted Diagnosis-Related Groups (DRG) prices,[5] and financing of the PPA had an extra funding source; namely, finance under a specific flow from the public health care budget.

The PPA was elaborated at the national level, targeted a set of pathologies with unacceptable clinical times (above a certain threshold), and was designed for the voluntary participation of public hospitals. The onus was placed on public hospitals to propose a plan for reducing waiting lists in the defined pathologies, and to bind themselves to this by signing a contract with regional health authorities (RHAs). Rewards (and penalties) were announced for the hospitals that accomplished the contractually-agreed levels (or did not respect the contract). The RHAs were also allowed to contract out some production to the private (for profit) and social sectors (not-for-profit) under the use of protocols and conventions, and with a similar payment system.

Impact

The programme's results for 2000 were announced by the Ministry of Health as a success and received considerable media coverage.

– Sixty-four public hospitals adhered to the scheme (around two-thirds of total public hospitals);

– around 17 000 surgeries were performed in public hospitals – against the 26 000 planned (a 65% realisation rate);
– the RHAs have made good and wide-ranging use of contracts with both the private and social sectors (though quantitative information is not available);
– activity under the PPA programme, for 2000, returned a financial flow of EUR 45 million (PTE 9 billion), representing less than 1% of the public health budget for 2000 (excluding oncology);
– awards were given to 16 public hospitals, resulting in an additional flow of EUR 2.5 million (PTE 450 million) – awards were computed as a function of the number of surgeries and of the realisation rate; and
– no penalties were imposed to hospitals with low realisation rates.

Nonetheless, many controversies arose. Technical difficulties were found with the Ministry of Health's figures, and differing results were in fact announced by other agencies. This demonstrates a lack of validation and updating of current waiting lists (lists were not 'cleaned' by checking for and removing repeated names, deaths, etc), communication problems between the ministry and hospitals, and a lack of homogeneity in the criteria for defining waiting lists. Moreover, some additional questions were raised in the press; particularly whether some hospitals were using waiting lists in external consultations as an instrument for manipulating waiting list numbers, and whether some hospitals were including some surgeries that should be classified as normal activity in the waiting lists (there was no control of, nor information on, hospitals' current activity). Hospitals that chose not to participate in the PPA programme have claimed that the financial incentives were insufficient for them to participate. Further, the discussion has lacked clarity as results for the hospital level were not published, and the system of rewards and penalties was not defined on an *a priori* basis.

Some insights

The PPA programme should be seen as an experiment. For the first time, there was public debate on some sort of performance indicators – some lessons should be taken away.

First, the PPA results provide further evidence that the low levels of hospital utilisation are a result of perverse incentives and managerial problems at the hospital level. Hospital doctors have shown a willingness to increase their work in the public sector as a response to changes in their financial incentives, and hospital administrations have been responsive to the objective of decreasing waiting lists. Second, results have revealed managerial and informational problems as the main reasons for deviations from the contracted production. There were inaccuracies in predicting capacity and in scheduling surgeries. Third, the social and private sectors had a key role in overcoming short-term problems in the public sector. Still, it is not clear whether the RHAs have made efforts to enforce the use of public hospitals' spare capacity before turning to the other sectors, nor if the private and social sectors were able to offer the PPA programme better (lower) prices than the ones fixed by legislation. Fourth, the design of the PPA policy suffered from several flaws. As it was not applied to external consultations, biases in the comparability of surgical waiting lists and times resulted. Because hospital funding is mainly retrospective and there is no control on normal production, there might have been incentives in some hospitals to transfer normal surgeries to the PPA scheme. And, as the PPA did not demand information to make clear the relationship between hospitals' extra-hours activity and the PPA programme, some perverse incentives might have occurred. Finally, the PPA represented a quick solution that has failed to address the structural problems of the system.

Nevertheless, the PPA was a positive experience in many aspects. Though there are doubts as to the reliability of the information, waiting lists seem to have decreased slightly between 2000 and 2001 (resulting in equity gains). As well, the PPA initiative imposed pressure on hospitals to re-define their strategies, improve their planning and to better analyse their mix of resources (i.e. achievement of efficiency gains). Discussions about waiting lists as performance indicators have increased the public awareness of the problems with the system, and might also have had some effect on improving accountability and transparency (although the issues raised in the public debate seem to have been influenced by the arguments of hospitals that did not perform well or that did not participate in the PPA).

It seems, therefore, justifiable (and, indeed, necessary) to progress quickly towards the design of a framework for publishing performance indicators (following initiatives from other countries such as the Netherlands which has called on hospitals to publish waiting times), as changes in the information setting are still to be explored in Portugal. As well, better use of financial tools to motivate doctors' productivity in the public sector should also be pursued.

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Readers may be interested in the following new publication:

Communism, Health and Lifestyle
The Paradox of Mortality Transition in Albania, 1950-1990

By Arjan Gjonça
Lecturer in Population Studies and Health in the Department of Social Policy and Research Associate, LSE Health & Social Care, London School of Economics and Political Science

This study takes a systematic look at the incredible rise in the life expectancy of the population of Albania. Through a careful analysis of newly available archive documents and statistics, Gjonça examines the social, economic, and political factors behind the success of improving life expectancy at birth from 51 to 71 years in a relatively short period of time and despite extreme poverty and strict isolationist governmental policies.

The research, based on data obtained primarily from the Albanian State Archives, which opened in 1994, attempts to explain why the Albanian pattern of mortality, with very high infant and child mortality and very low adult mortality, is so different from that of other East European countries with similar social and economic conditions. Using many tables, figures, and other data to illustrate the trends, the author concludes that lifestyle factors, and to a lesser extent government policies directed at health care, are the most likely determinants of Albania's successful mortality transition.

In his attempt to shed new light on the phenomena of Albania's remarkable success in shifting patterns of mortality, the author compares the changes with those experienced by other similar countries in an effort to determine whether the Albanian success was part of an overall improvement among countries that have 'good health at low cost' or if the Albanian way is a novel route to low mortality in developing countries. To support his conclusion that Albania's success largely depended on lifestyle, he carefully examines the changes in disease and infection, dietary patterns and lifestyle, education and urbanisation, fertility levels, and regional differences. By providing a brief but detailed background of the country itself, and its policies and programs to promote lower mortality, Gjonça offers readers an interesting portrait of the transitions that have taken place in this poorest of countries.

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