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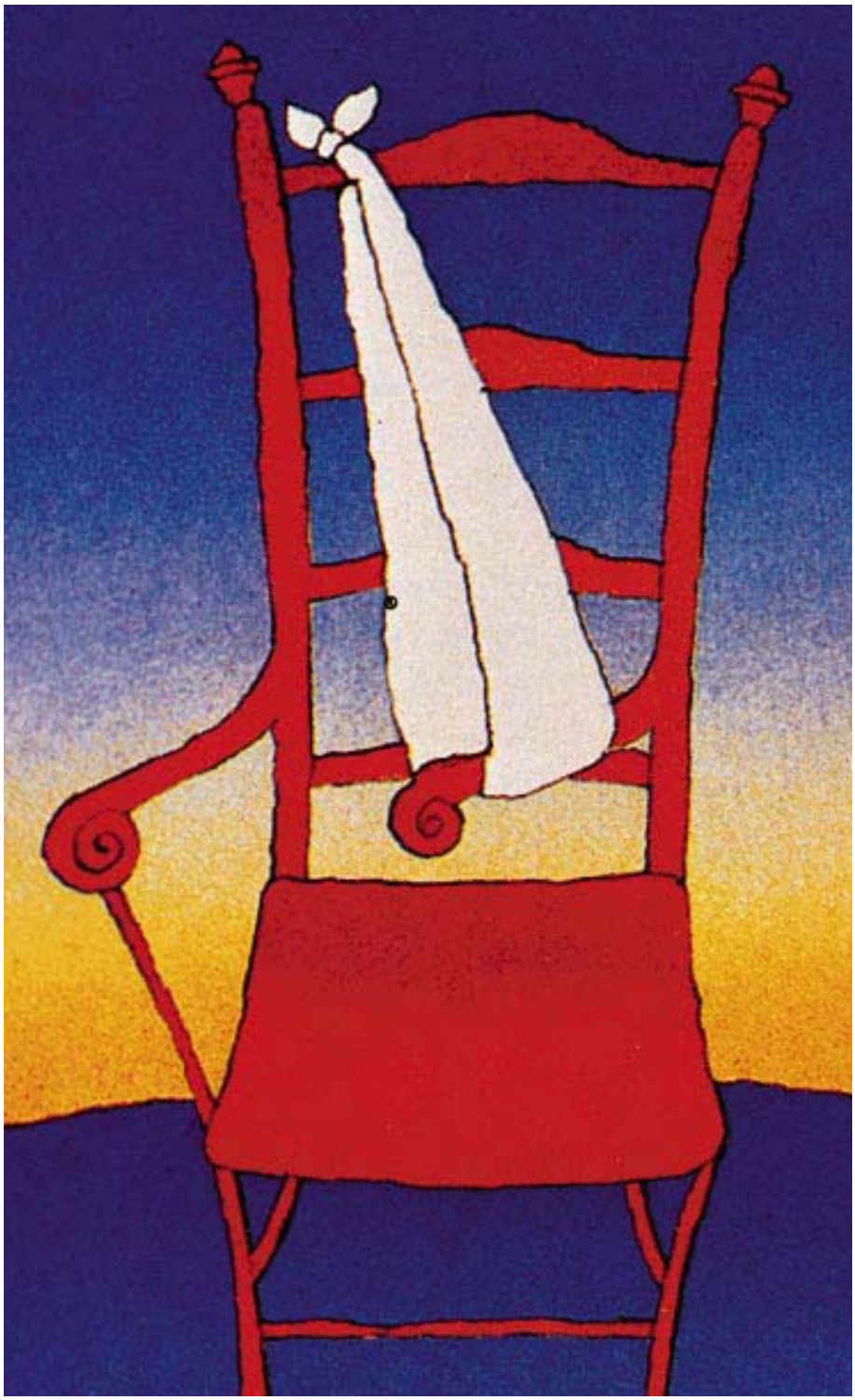

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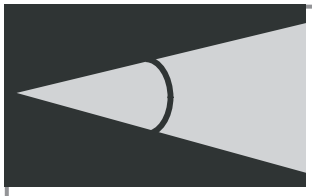

European Observatory on Health Care Systems

Summer School

Hospitals in a Changing Europe

Dubrovnik

27 August – 1 September 2000

The Observatory Summer School 2000 is organised by the European Observatory on Health Care Systems together with the Andrija Štampar School of Public Health in Zagreb with the support of the Health Development Agency (HDA) in England and the Open Society Institute. This year's course will focus on the hospital sector and on questions related to the impact of new technologies and the demands for hospital sector reform. In collaboration with the HDA the school will also include a number of sessions on public health and health promotion.

Building on the success of three advanced training summer schools (1997–1999), the 2000 course will offer practical and interactive teaching by a faculty of internationally renowned experts. This one-week intensive course aims to utilise experience from across Europe and to provide technical guidance and advice for strategic planning and development in the hospital sector. The school applies a training model that is based upon principles of interactive learning and combines lectures and presentations from leading experts in the field of health care and research workshops based on discussion and participatory teaching. Through practical examples and real-life case studies the course will allow participants to develop a systematic understanding of the key questions raised by the demand for hospital sector reform in different environments.

The course has been designed for participants from all professional areas of health care: national and international policy-makers, planners, hospital managers and senior personnel in the pharmaceutical and health insurance industries will all find the School a valuable learning opportunity. The summer school welcomes participants from throughout the European Region but is particularly keen to target participants from central and eastern Europe and the former Soviet States. The Observatory will be able to offer a limited number of bursaries to cover participation fees and accommodation. A Certificate of Achievement will be awarded to all participants who complete the School successfully and fully participate in all seminars.

The School will focus on the process of transition and the challenges facing the central and eastern European countries and the newly independent states. The analysis and comparison of national experiences will offer the participants a thorough understanding of the different organisational, financing and quality issues associated with provision of health care in hospitals and will provide the analytical and empirical background for making an impact in the development and implementation of national reform strategies in this sector.

Drawing on the expertise of the Observatory's partner organisations, the faculty will include health care specialists from the London School of Economics and Political Science, the London School of Hygiene and Tropical Medicine, the World Bank and the World Health Organization Regional Office for Europe as well as visiting speakers from the Observatory's extensive network in the field of health care.

Sessions will examine issues such as:

- Changing hospital patterns across Europe
- Introducing hospital information systems
- Are bigger hospitals better? Outcomes and costs
- Paying the hospital
- Pressures for change: impact of new technologies
- Health promoting hospitals
- Investing in health: the contribution of health care and the wider determinants of health
- Information needs: how to use epidemiology for promoting health

The School offers a social programme including a guided tour of the old city of Dubrovnik. The Hotel Croatia, Cavtat [www.hoteli-croatia.hr] will host the Summer School in a beautiful setting within easy reach of the city of Dubrovnik.

For more information about the Observatory Summer School 2000 send your details to:
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EDITORIAL

Health care reform in transitional Europe: from regional to country-specific analysis

For many of the so-called 'transition' countries of Central and Eastern Europe (CEE) and the Central Asia Republics (CAR), the onset of the new millennium heralds a time of increasing hope and optimism. The Czech Republic, Estonia, Hungary, Poland, and Slovenia are all well on their way to European Union (EU) membership; and a second group of countries, led by Romania and Slovakia are envisaged to have fulfilled the requirements of the *acquis communitaire* within the next ten years. That these countries have had some success on the path of structural and economic reform does not, however, tell the whole story. These are but several countries within a region comprising some twenty-five plus. And while all have faced similar shifts and challenges since the fall of communism and their respective attainment of independence, because of country-specific circumstances, they do not all share the same future.

Inter-regional economic disparities remain amongst and between CEE and CAR countries. GDP per capita, employment rates, average wages, budget deficits, all vary drastically between states. Thus economic restructuring programmes, including funding packages from donor organisations, can and do vary dramatically in the region. Language, ideological and cultural differences are also as distinct as anywhere else in the world, underlying the need for increased cooperation and understanding between countries. The pace of reform and the timing of independence vary between countries, and protracted conflict in many states has inflicted a heavy social and economic toll. Such disparities serve as a stark reminder of the danger in making generalisations over the region(s) in its entirety. As regards health matters, the danger of generalisation is especially worrisome, and the widespread optimism many analysts express for the on-going health care reform process should perhaps be slightly more guarded.

While the CEE and CAR countries do face many similar challenges in the health sector – the most striking of which may be adjusting to a withdrawal of the ideological premise of free and universal health care under the Soviet system – this is not to say that all requirements will necessarily be the same. National circumstances differ. Major health indicators such as life expectancy at birth, life years lost by disease, and childhood mortality all reflect specific national contexts. The need to take these differences into account is borne out in the different national approaches adopted vis-à-vis the specifics involved in reforming depleted health care systems, particularly as pertains to a shortage of funding and the need to establish new financing mechanisms.

Bearing this need to avoid sweeping regional generalisations in mind, this, the second Special Issue of *eurohealth* on health topics germane to the CEE and CAR countries, aims to build on the success of last year's inaugural publication. This year's version is more country and issue-specific, and engages more of a local perspective. In this vein, the editorial team is particularly pleased to be able to publish a set of one-to-one interviews with the Ministers of Health of Albania, the Federation of Bosnia and Herzegovina, and Georgia, and the State Secretary of Kyrgyzstan. These opinion pieces not only offer a personal insight into the policy-makers' perspective on health care reform in the various countries, but also provide grounds for comparative assessment between them. For undertaking these interviews on behalf of *eurohealth*, we are very grateful to Jan Bultman, Tamar Gotsadze, Virginia Jackson and Besim Nuri, all of the World Bank.

In addition to the interviews, this year's publication hosts a variety of topics and views. Several articles are concerned with improving either or both health care quality and access in particular countries: Albania (Edlira & Arjan Gjonça), Georgia (Rifat Atun et al.) and Hungary (James Kahan & László Gulácsi). Important issues such as unofficial payments for health care, health care privatisation, and user fees are covered in concise articles by Tim Ensor, Richard Scheffler & Franci Duitch, and Kamil Melikov & Ramiz Alekperov respectively. That not enough attention has been paid to mental health in the CEE and CAR countries is a point made by Ajit Shah, and the degree to which they lag behind their western counterparts in this area is brought home by Robert van Voren & Harvey Whiteford. Another area which has hitherto been neglected is the relationship between health and marriage in the transition countries, and an article by Peggy Watson reveals some thought-provoking findings. These are just some of the issues raised in this Special Issue, and their diversity serves to underline just how risky generalisations regarding health and health care in Central and Eastern Europe and Central Asia can be.

So while the need for committed and on-going action to promote health care reform – from both within and external to the region – remains as high as ever, the focus now becomes more country-specific. On behalf of the editorial team, we hope this year's Special Issue goes some way to generating debate on these issues.

Govin Permanand & Elias Mossialos

Envisioning health care quality in Hungary*

" both decentralisation and re-centralisation have failed as strategies for controlling escalating cost and improving quality and equity of health care."

James Kahan

László Gulácsi

Hungary, as a middle-income Central European country, is well on its way to accession into the European Union (EU). By most measures, it compares favourably with its neighbours in terms of health care: it has a cadre of well-trained health care providers, a relatively well-developed technological infrastructure and a long tradition of fostering innovation. Yet, the attitude in Hungary is one of frustration because of perceived slow or even retrograde movement in the direction of a more economically sound, high quality, accessible health care system.

Since the transition towards a market-oriented economy, Hungary has seen many attempts to improve its health care system. These changes have involved decentralisation and re-centralisation of the Health Insurance Fund Administration and the Social Insurance Fund Administration, and the only characteristic they share is their inability to deliver high-quality, cost-contained health care. Under the socialist regime, health and social services were financed by general funds and centrally administered. In 1993, these funds were separated into decentralised independent units, administered by self-governing bodies whose membership was selected by the trade unions.

By 1998, this organisational structure came to be viewed as a failure and was scrapped in favour of a special state secretariat under the direct control of the Prime Minister's office. Just recently, this structure has in turn been discarded, and the Health and Social Insurance Fund is now being administered by the Treasury. Thus, both decentralisation and re-centralisation have failed as strategies for controlling escalating cost and improving quality and equity of health care.

In spite of these sincere and repeated efforts, the desired changes are slow in arriving. In this short article, we will look at one aspect of poor quality care—overuse of services—as an example of some of the troublesome aspects of the health care situation in Hungary.

In a country facing strong economic pressures while trying to raise the level of quality in health care delivery, one would expect there to be significant underuse of services. As Hungary attempts to achieve the economic stability required under the *acquis communitaire* for membership of the EU, budgetary constraints have a particularly high impact on the capability to provide necessary services. However, and possibly even surprisingly, Hungary also experiences a large amount of overuse of services. Some examples make the point:

- A recent estimate from the National Health Insurance Fund showed that there were obstetric departments where more than half of the women have Caesarean section deliveries.[1]
- Pharmaceuticals expenditures far exceed budgetary planning. The total planned pharmaceutical budget for 1999 was HUF 123 billion. The expenditure rate through June 1999 was 15 per cent over plan, and the entire sum was projected to be spent by the end of September.[2] More generally, deficits in the health budget are increasing yearly.[3,4]
- Males over 20–25 years of age are invited to be screened for prostate specific antigen (PSA) once a year, in spite of considerable evidence questioning the effectiveness of such screening for much older, more susceptible populations.[5,6,7] The actual extent of overuse that results is not known because there is no database registering outpatient care such as compliance with the invitation.

Causes of overuse

The major causes (and eventually cures) of overuse may be divided into three categories, which we term here information, incentive and change agency. Inadequate information, conflicting incentives and the lack of effective change agents all combine to create an environment where overuse continues. Attending to each of those elements is necessary in order to diminish overuse. Care providers must be informed about

* We wish to thank Adam Oliver, Office of Health Economics, London for valuable comments on an earlier draft of this article.

whether or not their services are inefficient, they must be motivated to change their practices to a higher standard of care, and there must be agents capable of facilitating that change. In present-day Hungary, all three categories are problematic.

Information. The health information situation in Hungary might be characterised as too sparse. Major health information collection efforts, such as the Hungarian contribution to the World Health Organization (WHO) database initiatives, are focussed more on descriptive epidemiology instead of clinical practice. Although information on evidence-based medicine and assessments of health technology are not unknown in Hungary, dissemination has not been as extensive as would be desired; it is difficult to access information for use in resource allocation. Finally, what information is disseminated, is largely presented in an undirected format and programmes to present information in terms of care provider behaviours are absent. Thus, it is hardly surprising that information dissemination has not helped.[8,9]

Incentives. Although the nominal incentive system in Hungary, including capitated payment for primary care providers and a Diagnosis Related Group (DRG) system for hospital reimbursement, might be thought to encourage the avoidance of overuse, the *de facto* system contains few controls for overuse of services.

A scenario that has frequently occurred in Hungary illustrates the problem. A patient, perhaps overstressed from work, comes to his primary care physician for treatment. As is the custom, he hands the doctor an envelope before the treatment session. The doctor, in turn, prescribes a week of sick leave and therapy (covered by the national insurance) at one of the 'sanatoria' distributed throughout the scenic parts of the Hungarian countryside. The sanatorium is happy to obtain the fee for a week of treatment, and in addition, sees to it that the patient is well-provided with separately chargeable prescription pharmaceuticals and other care.

Formally, physicians are paid salaries; on a capitation basis for primary care and on a salaried basis for the hospital-based secondary care providers. However, in parallel to official payments, there is a well-established system of 'tips,' or under-the-table payments to physicians for the provision of services. (This system began under the earlier socialist regime, and was tolerated by the authorities as a 'temporary' measure to encourage wider access to treatment. However, as with many temporary measures, it has become institutionalised.) So, although the tips are technically illegal and not reported as taxable income, they are a major economic force driving the personal side of physician decision-making. The percentage of physician income that comes from these tips is unknown and probably unknowable; estimates range from ten per cent to ninety per cent of income. Precisely because the informal driving system is outside the boundaries of law, the de jure payment system is dominated by the actual perverse economic incentives encouraging overuse of physician services.[10,11,12]

Institutional services are similarly not driven towards efficient use of services because of the opportunities for 'gaming the system.' Beyond the expected 'DRG creep' of diagnosing patients to receive the highest reimbursement possible, there are other means used to increase institutional incomes. Thus, it is said that in obstetric units, "there is no labour without complications."[13] Many procedures take place 'after working hours' and, therefore, generate extra payments. Hospitals and sanatoria are happy to fill beds to capacity by admitting referrals that might be of dubious origin.

Change agents. The third piece of the triangle are the agents to facilitate change. Any health care reform programme needs identified and capable change agents in order to succeed, but various characteristics of the Hungarian situation shackle the potential ability of any of any potential agent. Because so much of the incentive system is informal, formal levers for change from above are not possible. As we discussed earlier, the continuing reinvention of the national health care system has been ineffective for the past decade, and nobody is optimistic that the next round will be any more successful. With the ability of the national government to intervene being absent, one might turn to more local levels, but the counties and regions of Hungary are not empowered to act. Finally, one might turn to self-policing of care providers through the legitimacy and peer influence of speciality societies, but in Hungary, these societies function more as protectionist trade unions rather than centres for the sharing of knowledge and experience.[14]

Change from below is equally problematic. Primary care is characterised by solo practices, and the lack of interaction among the providers means that agreement is difficult to create; in such an environment, the use of group management or peer agreement to develop evidence-based guidelines is not a promising strategy.[15] In Hungary, primary care is reactive and curative orientated, with little interest on the part of the providers in professional ordination; especially with regard to public health issues.

Towards cures for overuse

Where economic levers for policy change are absent or ineffective, other levers must be sought. In the case of Hungary, the basis for these levers may be found in the strengths of the health care system, including the high level of skills and interest in innovation. In instances where each aspect of the information, incentive and change agency triangle are contributors to a problem, solutions must be sought that involve each of the legs. In outline form, we here propose a vision for change – though admittedly, the devil is in the details, and full implementation of this or any other vision requires deeper analysis.

The core of our vision is the use of information and empowerment to create change agents who can affect the incentive structure. This requires each of the major potential change agents in the system – national government, regional government and speciality societies – to have its own

authority and responsibility.

Central government. The role of the central government is to determine the total health care budget and to allocate it to regions, based on population and need. The need may be in part based upon the descriptive epidemiological databases currently under construction, but should also be based upon health technology assessment. Here, Hungary may benefit from research done in other countries.

The central government may use evidence from health technology assessment to further refine DRGs to not only specify payments for care, but also to set broad-based limits on what services will be available for local choice. The reason why this measure belongs at the level of the central government is that it will be the basis for quality assurance standards which will be required of all members of the system. Once an impetus for change has been achieved, the central government can move towards the sorts of health technology assessment dissemination media similar to the United Kingdom's National Institute for Clinical Excellence (NICE). But a Hungarian NICE as a first step might be premature and risk losing credibility and future effectiveness.

Regional government. Regional governments more or less take on the role of resource allocators. At this level, the costs of hospitals and the determination of drug formularies may be made, but must be based upon evidence in response to local needs. County administrators can do this by setting up coordination groups among the chiefs of the different regional speciality societies. Allocations of these resources will serve to reduce the incentives to game the system, and rewards for quality care can begin to be realised.

Speciality societies. The speciality societies are the bottom leg of the triangle. They will be responsible for determining appropriate care that will be used by the central government and regional government in formulating the resource allocation decisions. The quality assurance part of the central government function will serve to keep the speciality societies focused on evidence-based decisions rather than on guild-preservation ones.

How might this look in practice? Nation-wide groups of specialists will meet to determine the prioritisation of their practices. These prioritisations will be evidence-based and presented in the form of goals for care. At the regional level, within the resource allocations of regional administrations, the local practice communities will develop clinical practice guidelines. The resource allocations will not be volume restraints, but rather, in a German fashion, payment ceilings by category. In this way, the group of specialists in the county police themselves and overcome the social dilemma of each person trying to use as many procedures as possible.

Conclusion

The excessive use of health care, driven or facilitated by the physicians and provider units, is a problem in Hungary. The main reasons for this excessive use are a lack of information, inappropriate incentives, and absence of agencies of control. We have presented a tentative outline towards addressing this problem, within which the central and local governments and the medical societies are empowered to act as control agents. The structure of this outline, however, relies upon the determination of some fundamental policy objectives and the establishment of infrastructure to facilitate the agencies of control to carry out these objectives. Further development of the specifics presented here in outline form here – followed by a plan to implement the changes suggested – are needed to assist Hungary and countries in similar circumstances in achieving high quality health care delivery with the economic context of the *acquis communitaire*.

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Health care privatisation in the Czech Republic: Ten years of reform

Richard Scheffler

Franci Duitch

"There is little doubt that the privatisation of medical practice, combined with an open-ended fee-for-service point system of reimbursement, has had a profound impact on the Czech health care system."

After a decade of reform efforts in the health care sector, the Czech Republic has experienced both successes and failures in its transition from a Soviet-imposed system of public financing and provision of care under a centralised command-and-control structure, to a decentralised, market-driven system of compulsory health insurance and fee-for-service reimbursement.

On the positive side, Czech health care reform has brought increased access to new medical technology, updated medical protocols and guidelines, and higher quality of care, all of which have translated to greater clinical efficacy, as indicated by the dramatic improvements in population health status measures such as male and female life expectancy, rate of infant mortality, and rate of premature death from cardiovascular disease.[1,2] Reform has also elevated the voice and stature of consumers with respect to choice of providers and treatments. On the negative side, inefficiencies and misallocation of resources wrought in part from poor management practices and excess capacity in physicians and hospital beds – all legacies of the Soviet model – continue to plague the Czech health care system.[3,4,5,6,7] These old problems, coupled with reform-based disincentives to control the volume and costs of services, have rendered the system vulnerable to rapid inflation. In this article, we provide a thumbnail sketch of the core elements of the reforms and the underpinning national policies as initiated in 1989, the major outcomes of these efforts to date, and the key challenges that lie ahead for Czech policymakers as they develop and implement further midcourse corrections in the financing and delivery of health care.

Core elements of Czech health care reform

The reforms were designed to achieve solidarity, decentralisation, and privatisation through three major elements: (i) mandatory health insurance for all citizens, financed by a national health insurance fund to which the government and, via a payroll tax, workers and employers contribute; (ii) creation and promotion of competition among non-profit, employment-based health insurance plans in the private sector; and (iii) movement of physicians and other health care workers into private practice and the transfer of some hospitals to decentralised private control.[5] Under the reform plan, workers contribute 4.5 per cent of gross wages, employers contribute 9.0 per cent of gross wages, and the self-employed pay the full tax of 13.5 per cent of annual income, to the national health insurance fund. The government pays for the elderly, children, military personnel, and the unemployed.

The motivation for the privatisation of the Czech health care system was to transfer the centralised power of

Note: Richard M. Scheffler was a Fulbright Scholar at Charles University, Prague, Czech Republic, in 1993.

the state-run health system to private individuals and institutions. This motivation was the same one that was driving the privatisation of the Czech economy overall. What is, however, noteworthy is that a key part of the social support system – health care – was in fact privatised so rapidly and without a clear idea of the role of the private sector.[3,6,7]

Health care was ripe for privatisation, in part because it was in a state of excess supply. By international standards the Czech Republic has a dramatically high level of physicians and facilities. There are over 50 per cent more physicians and hospital beds per capita than the United States, which is also in a situation of oversupply. This oversupply, coupled with the Marxist philosophy of surplus value, meant that physician wages were quite low: on average, 6,000 korunas (approximately, US $180) a month, a figure only slightly higher than the overall average wage.

The motivation among physicians, as well as dentists, for the privatisation of practice was that of higher incomes and clinical autonomy. They would no longer have to be state employees but rather would be able to practice independently and receive fees from the government-run health insurance system or from patients directly. Over 95 per cent of Czech physicians are now in private practice. As the reform plan was originally conceived and implemented, providers were paid solely on a fee-for-service point system for services covered by the health insurance system. This point system is similar to the relative value scale used in the United States, Germany, and Canada. In theory, it is based loosely on the cost of providing a service. Costs include professional time, supplies, and capital equipment. In reality, however, the point value in Czech health care was somewhat arbitrary and subject to political influence. The value of the billing point was then subject to budgetary limits. The funds available to the insurance companies were divided by the total points billed for by providers to calculate the value of each point (a zero-sum game). Point values were subject to changes in the volume of service points billed for. The value of a point was about 0.5 koruna (approximately 34 korunas to US$1).

Privatisation of facilities involved a different motivation. At the outset of reform, the Czech government understood that it had an oversupplied, inefficient system. Moreover, much of the system was in disrepair and badly in need of capital. Thus, the motivation was to move these facilities out of the government's budget. However, here the conceptualisation of privatisation was not as clear. Many of the hospitals were public goods. Some were teaching hospitals that trained physicians and other health professionals, and many were involved in clinical and biomedical research. These public functions were not fit for privatisation, hence these hospitals were taken off the list. They would not be privatised, though they could become involved in private joint investments with the private sector.

By the end of 1991, 56 facilities out of a total of 199 (in-patient and outpatient) were privatised, representing about 28 per cent of the facilities and 9,389 beds. This, out of a total of 80,321 beds, constitutes just under 12 per cent of the beds. Some hospitals were given to charities at token prices, while others were sold, usually at less than the book value of the facilities. Hospitals near spas that were attractive to foreign visitors were easily privatised. Others, in rural communities, were simply transferred to local authorities upon request. Various routes of privatisation for facilities were much debated, but the actual process pursued by the government lacked clear, established guidelines or principles. As a result, the privatisation process was undercut.

The third element of privatisation was implemented in the government-run insurance sector, beginning in 1991. Originally, the plan was to subject the government-run national health insurance fund to private competition through the creation of private, employment-based health insurance companies, each catering to the specific health care needs of the enrolees, such as miners, teachers, or transportation workers. Each group was required to cover the government's list of health benefits and to pay for services using the point system. Competition among them and the social insurance fund was to be based on quality of services and, perhaps, additional benefits if they could find a way to provide them with the same funds. In principle, they could derive savings if they were able to negotiate lower point prices with physicians and hospitals. This strategy proved untenable, however, because the value of the point was already low and continued to decline as the number of points billed increased dramatically under the fee-for-service reimbursement system. By 1995, most of these privatised insurance companies had severe financial problems and had to be taken over by the General Health Care Insurance Office, which administers the national health insurance fund. By all accounts, especially as measured in terms of the substantial debts left unpaid to public and private providers by the bankruptcies of the private sector companies, this element of privatisation was a major failure of the reform efforts.[1,2,4]

Health care financing and expenditures in the Czech Republic: 1990–95 trends

The Organization for Economic Cooperation and Development (OECD) 1997 database on public sources of financing and health care expenditures in the Czech Republic includes both nominal and real values, percentage of gross domestic product (GDP), and percentage of total government expenditures. Health revenues, expressed in one-million-koruna units, show an overall nominal value increase of 60,946 – a real value increase of 5,710 – between 1990 and 1995. The state budget accounted for the bulk of these funds from 1990 through 1992; the breakthrough year is 1993 for the national health insurance fund, when government funding continuously and dramatically decreases through 1995 and the health insurance fund increases through the same period. The figures for percentage of GDP parallel this trend: the state budget revenues average

around 5.42 per cent for 1990–1992 and then decline to 2.05 per cent in 1993, down to 1.12 per cent in 1995. In 1993, the national health insurance fund represented 5.56 per cent of the GDP, up to 6.19 per cent in 1995.

The pattern of overall health expenditures matches the trend in health revenues: rapid growth between 1990 and 1995, as can be expected in a system of fee-for-service reimbursement where there are no incentives to contain volume and costs of services. In the area of personal health services, these steady increases include the categories of worker wages and benefits, drugs, other consumables and supplies, and maintenance. Expenditures on public health activities also increased. The percentages of GDP as well as percentages of total government expenditures over this period follow suit, though there is a dip between 1994 and 1995: from 7.82 per cent to 7.31 per cent of GDP and, correspondingly, from 15.85 per cent to 15.60 per cent of total expenditures. Capital expenditures show a reverse trend over the 1990–1995 period; for example, expressed in one-million-koruna units, real value expenditures dropped from 2,355 in 1990 to 1,279 in 1995.

Compared to its eastern European neighbours, the Czech Republic shows the steadiest increases in public sector health expenditures from 1991 to 1994 as percentage of GDP. With respect to the evolution of real spending, the Czech Republic significantly outpaced these other countries in total health expenditures from 1992 to 1994, but lagged in drug expenditures over this same period.

Conclusion

There is little doubt that the privatisation of medical practice, combined with an open-ended fee-for-service point system of reimbursement, has had a profound impact on the Czech health care system. Health care expenditures grew rapidly. Since privatisation, physicians' incomes have more than tripled and nurses' have doubled. Although these increases are substantial, they were for physicians 30 per cent more than the increase in the average wage. The true income position of physicians is hard to discern, since those in private practice do not report all earnings as income and there are no official data on their incomes available at this time.

Privatisation and the fee-for-service point system have had a predictable and major impact on costs. It is common for physicians to bill for more than one hundred hours per week, which is hardly a realistic work schedule. Privatised surgeons billed for over 25 per cent more points than those in government hospitals. A similar pattern was also found for the charging of supplies. For example, orthopaedists billed over twice as much for supplies when they were in private practice.

It is not surprising that privatisation without an economic and organisational structure increased costs dramatically. The actual rate was not anticipated by the government. Hospitals and physicians with lower historical costs were the economic winners, and the losers were teaching hospitals and physician specialists. This was an intended consequence of the point system coupled with privatisation. The process of privatisation of facilities in health care is quite complicated and should be done in an orderly, open way. The actual value of facilities based on historical costs is hard to estimate. Because of this, windfall profits can be made. Privatisation also requires time so that the actors in the health system can understand the nature of privatisation and respond appropriately. Rapid privatisation can also be disruptive to patients seeking care. Well-established networks of primary care and public health are important components of the health system. They should be guarded during the privatisation process. The role of the consumer in a private system needs to be developed and supported with public information on the health care system so that informed choices can be made.

The role of the incentive system must also be carefully considered. A fee-for-service system with privatisation will increase volume and costs. Therefore, a complete vision of privatisation needs to include a mechanism for controlling costs and improving the quality of care. Indeed, the government is already moving in the direction of cost containment by incorporating capitation into the payment system for general practitioners.[4]

Overall, the lessons learned from the reform efforts to-date make one point especially clear: privatisation remains the all-encompassing challenge of the Czech health care system into the next decade and beyond as the government moves to stabilise the financing and delivery mechanisms and to formulate and implement coherent regulatory policies.

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Introducing health insurance:

The challenges faced by the Kyrgyz model

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Since independence, Kyrgyzstan, as with many other former Soviet Union (FSU) countries, faced the difficult challenges associated with the transition from a centrally-oriented administrative system to a market economy. A deteriorating economic situation has led to limited financial resources being directed into the health sector, and this abruptly limited both the accessibility and quality of health care. The introduction of mandatory health insurance has become part of the reform agenda in almost all FSU, as it was perceived as a means of change in some cases, or as a way to tackle the under-financing of health care in others. Some countries have taken immediate actions and initiated a health insurance scheme such as Russia and Kazakhstan.

The sharp decrease in health financing, twinned with the irrational use of available resources fostered imperfect financing methods and highlighted the need for drastic action. In Kyrgyzstan, such action took the form of the development and adoption of the National MANAS Healthcare Reform programme, which ensured the development of a 'masterplan' for health care reforms.

Introduction of health insurance

Attempts to introduce health insurance in Kyrgyzstan came with the adoption of a health insurance law in 1992, but the national context was not conducive to immediate implementation. During the process of developing a strategic 'masterplan', the health insurance issue was explored and discussed thoroughly, and its introduction was planned for the long–term; at least 5 years later.[1]

However, in 1996, financing in many health care facilities reached critical levels, making the delivery of health services in the Republic extremely difficult. It was necessary to seek additional sources of health financing, and mandatory health insurance was considered as a possibility. Through the exertion of political pressures, therefore, mandatory health insurance was instituted in 1997, and, by Presidential Decree, the Mandatory Health Insurance Fund (MHIF) was established as an executive body of the insurance system.

The early introduction of health insurance and the creation of the MHIF under the authority of the government – independent of the Ministry of Health (MoH) – was the cause of some debate. A concern was that this would limit the ability of the Ministry of Health to effectively implement the policies that would be developed. For as the role of the planned insurance fund was to purchase health services on behalf of an oblast's (region's) population, its decisions would have a major impact on the implementation of health policy, thereby undermining the MoH's role in policy implementation.

Another concern was that the existence of two funds would cause inefficiency because of the additional administrative services that it would require; costs which take money away from the provision of health care. Expenditure would, therefore, increase, and more resources would be needed. It was also feared that it would foster inequity as different levels of protection would be created for employees – whose coverage would be funded through contributions to the Social Health Insurance Fund – and the rest of the population – for whom coverage would be funded through budgetary transfers. Although the government's intention is to extend insurance protection to the latter group, the experience of many countries suggests that this may be difficult to achieve.

Thus, following a lengthy period of discussions, the MHIF and Ministry of Health agreed to establish jointly-used systems, such that both employ the same information system and payment mechanisms, and can act as a single payer. The MoH and MHIF jointly use date collected by a centralised national information and computer centre, through which financial and statistical

information is collated and processed. The information systems of the MoH and MHIF are integrated with the Social Fund databases, and a monthly exchange of information on the insured population is undertaken. As well, clinical-statistical forms – a basis for database, financial and statistical accounting – have been developed and confirmed for hospitals and primary care facilities.

In order to coordinate the mandatory health insurance system with the ongoing health reforms, efforts have been made to avoid the duplication in functions between the MoH and MHIF, and to limit unnecessary administrative costs that are especially important in current economic conditions. One of these measures has been the collection of premiums for mandatory health insurance through the Social Fund, which has already been collecting premiums on government social insurance (pension, social, and employment), rather than through a separate collection system. In order to utilise resources rationally and avoid duplication, premiums on mandatory health insurance are collected by the Social Fund. It also collects employers' premiums which it then transfers to the MHIF. Furthermore, the Social Fund provides work on the personificated account of all payers under government social insurance. The MHIF uses a fourteen-digit number to identify insured citizens along with the dates for making contributions under government social insurance. Such an approach enables the coordination of different social insurance programmes while maintaining minimum administrative cost.

Coverage

The phased introduction of mandatory health insurance coverage has been envisaged both in terms of population and services. Primarily, coverage will include population categories such as:

– *Employed citizens:* Employers make contributions for staff as 2 per cent of the Salary Fund, while the self-employed make contributions independently as 2 per cent of income.

– *Pensioners:* Contributions are made by Social Fund as 1.5 per cent of the minimum salary.

– *Officially registered unemployed:* Contributions are made by the Social Fund from the Employment Fund at the same rate as for pensioners.

Between the three categories, approximately 30 per cent of the population is covered. Currently, however, dependants, children, students and those employed part-time, as well as those in the informal sector, are not covered. A gradual extension of coverage is planned, and, in the year 2000, mandatory health insurance is envisaged to cover children and students as well as invalids from childhood, and other people receiving social benefits.

In terms of benefits, the Mandatory Health Insurance programme of 1997 only covered in-patient care in general hospitals. Contracts for health services delivery were made with 13 accredited and licensed hospitals situated in different regions of the Republic, and this has since been extended to 60 hospitals covering the whole country. In 1998, along with the inclusion of general hospitals in the mandatory health insurance system, primary health care facilities were involved as well.

Provider payment mechanisms

In-patient care: The MHIF has provided an opportunity to test the envisaged provider payment methods which aim to move from infrastructure-based allocation, to output-oriented payment mechanisms. The new payment mechanisms are also expected to provide incentives for providers towards the better use of resources. Case-based payment is used in paying hospitals. The process is as follows: hospitals submit oblast MHI funds with clinical-information forms for each patient treated. In accordance with the form, payment is made to the hospital after checking with the Social Fund database regarding the premium collection.

The main challenge faced in paying hospitals with case-based reimbursement, was defining the case categories. Initially, 54 categories were employed in 1997, which was based on a limited study. In late 1998 these categories were then revised on the basis of 200,000 cases from the 30 largest hospitals As the resources mobilised through the MHIF are limited, it is not possible to cover the full cost of the cases, but the payment serves as an additional supportive revenue. Therefore, the calculation of the payment for cases is based on the forecasted premiums collected and the expected number of admissions. This basic rate is adjusted with the coefficients of various cases.

Outpatient care: The MHIF extended its coverage to the primary care providers and started to contract with newly-formed family group practices. This attempts to provide some incentives to primary care providers. Currently, it is based on a simple capitation adjusted with the proportion of the insured population in that oblast. It is calculated each year.

Utilisation of revenues at the facility level

The MHIF has issued some guidelines on how to use the revenues from health insurance for the facilities. The revenues at hospital-level support the salaries of the staff and drugs for the patients. The revenues at the primary care level are used for salary support, some emergency drugs, and procurement of some basic equipment to improve infrastructure. The MHIF has also developed some lists for drugs and equipment. In-patient drugs are supposed to be provided under the budget, however, this does not actually happen. Nevertheless, the MHIF ensures drugs for the insured population; though this seems a duplication of benefits.

Quality management system

The MHIF has also contributed to the development of quality management. There are quality indicators developed for both in-patient and outpatient care aimed at assessing final treatment results. Assessment is based on the data received through the clinical information system, and is carried out both on an institutional – by organisations with expertise

in the facility – and non-institutional basis – by experts and consultants working for the MHIF. It is expected that feedback from the MHIF will raise awareness in the facilities about their shortcomings.

The role of the MHIF

The common expectation in Kyrgyzstan vis-à-vis health insurance, is that it will raise additional funds. However, the ability of the health insurance system to mobilise additional resources for health care is dependent on the country's macroeconomic situation and the level of formal sector employment. In light of the poor economic situation in Kyrgyzstan at the moment, the role of the MHIF as a source of funds will be limited for the foreseeable future. Therefore, it is essential that the MHIF management not focus on resource mobilisation – which, ultimately, can have very little impact – but rather on efficiency improvements. It can contribute to such improvements through changes in resource allocation mechanisms along with other functions of the jointly-used systems.[2] The semi-autonomous status of the MHIF has provided more flexibility for innovations by exempting the Fund from some of the strict budgetary and management procedures. To date, the MHIF has already played a significant role as a facilitating agency for:

– the implementation of new methods of provider payment;
– the improvement of information system;
– monitoring the implementation of new clinical protocols and quality assurance systems;
– accelerating the restructuring in primary care such as the formation of family group practices; and
– providing some management autonomy to the facility managers.

Challenges ahead

Among the challenges facing policymakers in the future is the fact that, as mentioned, the MHIF is not expected to mobilise much in the way of resources. For it seems unlikely to be able to increase the premiums above current levels in the short-term. There is also a serious risk of deficit as the number of contracted providers increases. This means that either the amount of payments will be reduced and become increasingly marginal, or the fund will run a deficit.[3]

The implementation of jointly-used systems has proved a challenge since the Ministry of Health and the MHIF are actually two separate payers. However, the approach has so far shown the potential for the two to coordinate benefits and systems, thereby acting as a single entity. A common benefit package could facilitate this process, but it has proved very difficult in the short term. The pressure on the MHIF to pay providers in a visible and separately identifiable way also makes it difficult.[4]

Pooling public budget funds at oblast level is one of the most important institutional components of the reforms in health care financing and resource allocation in Kyrgyzstan.[5,6] Without this, the proposed reforms in provider payment and in ensuring a single-payer system will be difficult and costly. As long as budgets continue to be managed at the local (rayon) level, the rayons will be inclined to maintain their own facilities, and payment will come from two levels: MHIF payments from the oblast fund and the rest from rayon budgets. Though it is often considered to be a positive measure intended to make government services more responsive to the needs of the population by decentralising authority for resource allocation to rayon level, this is not so for Kyrgyzstan considering the size of the country and the nature of the reforms.

The coverage of only a limited part of the population leads to some equity concerns. However, by regulating the use of revenues from the MHIF at the facility level, it is considered a means of overcoming this issue. The benefits go into the improvement of services and the motivation of health personnel for better services to all, rather than only for individuals, especially in primary care facilities. This promotes the solidarity principle, though there is always the risk that contributors to the system may ask for more direct benefits.

Specialist outpatient care remains an uncovered service type, but consideration is being given to methods of including it within the limited budget. Another envisaged extension of service coverage is co-payment for outpatient drugs, which may help reduce in-patient admissions.

Conclusion

Health insurance has been introduced under difficult conditions and faced a considerable amount of potential risks, including a lack of resources, the emergence of a two tier system (and the erosion of equity), along with cream-skimming among the population. Though there is still a long way to go and many issues to be tackled, Kyrgyzstan has managed to develop its own model of insurance, turning the disadvantages of early introduction into some advantages by creating a facilitating agency for reforms.

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A basis for the establishment of federal solidarity in health care in the Federation of Bosnia and Herzegovina

Boris Hrabac

The Government of the Federation of Bosnia and Herzegovina has recently launched a public debate on subsidiarity between ten cantons within the Federation, in order to finance health care equitably. The Ministry of Health is highly committed to the value of equity and equality within a basic package of health care entitlements for the entire population of the Federation.

'health resource accounts' indicate remarkable inequalities between the average values of collected health care contributions throughout various regions and cantons in the Federation. Analyses undertaken at the municipal-level show profound inequalities and inequities within resource allocation to the municipalities. These inequities are not acceptable with health care being funded by compulsory health insurance. And the establishment of transparent schemes for resource allocation during the reform process represents a way to overcome those inequities.

"it is proposed as a first step, that health care spending per capita be equalised throughout the country in order to decrease inequity."

The issue of solidarity and the political-administrative trend of decentralisation have been very clearly distinguished and reconciled.

The overall health financing reform is coordinated by the 'Essential Hospital Services' Project Implementation Unit (PIU) which, in turn, is financed by a World Bank loan. Within the PIU there is a division for 'Health Finance Reform' (HFR) which is set to deal with the specific issues. The HFR office has recently prepared two policy documents: the first, entitled the *Policy and Strategy of Health Finance Reform in the Federation of Bosnia and Herzegovina*, and the second, called the *Basis for the Establishment of Federal Solidarity*. This latter document has clearly defined a concept of federal solidarity delineating the following areas: the reasons for establishment; 'milestones' in legislation; prerequisites for the establishment of solidarity mechanisms; the financing of the solidarity scheme, and allocation mechanisms.

Preliminary results of the use of

The process of intercantonal subsidiarity should be conducted through the employment of transparent criteria. Important prerequisites for the establishment of federal solidarity are:

- transparent work of cantonal insurance funds (health care resources must not be a domain of cantonal governments' budgets);
- health resource accounts being institutionalised in the Federal Health Insurance Fund;
- approved network of health care institutions, especially a hospital network; and
- transparent and equitable methodology of resource allocation being endorsed by all cantons.

It has been proposed that 20 per cent of health revenues from all cantonal health insurance funds be transferred to the Federal Health Insurance Fund (FHIF) in Sarajevo. It has been estimated that health revenue for the entire Federation for the year 2000 will be DEM 400 million. Therefore, it is expected that we could collect 80 million for the funding of federal solidarity in the FHIF. Amendments to the necessary legislation have already been developed in order to enable the establishment of such a solidarity scheme.

Allocation formulae have also already been considered. The areas of activities to be funded by these resources are defined as follows: basic package of health entitlements (3.37 per cent), vertical programmes of health care (14.56 per cent), referral clinical centres (43.75 per cent), centralised purchasing of pharmaceuticals and medical equipment (1.25 per cent), administrative costs of the FHIF (1.06 per cent). Experiences in countries with well-developed 'risk equalisation' schemes between regions refer to the need for data to be accumulated according to: age groups, gender, morbidity data, life styles, socioeconomic status, number of dependant family members, retired and disabled persons. Countries without precise data on, at least, age groups and the distribution and morbidity, will not be able to reliably cost a basic package of health entitlements for their regions. Therefore, it is proposed as a first step, that health care spending per capita be equalised throughout the country in order to decrease inequity.

The existence of vertical health care programmes will also decrease inequalities, because, for example, haemodialysis services will be contracted between the Federal Health Insurance Fund and those health

care institutions providing these services. Vertical programmes will, therefore, remarkably decrease the burden on cantons in financing a basic package of health entitlements.

The costs of the tertiary level of health care have been estimated at 8 per cent of total health expenditure (DEM 35 million). Allocative formulae are to be established on the basis of cantons' population sizes, the number of required beds (0.4 beds per 1,000 inhabitants), and the consequent percentage of available resources for tertiary-level health care within overall budgets. There are three tertiary level clinical centres at Sarajevo, Mostar and Tuzla, and referral will be on the basis of political decision-making by the cantonal ministry of health. Although specific services are provided by only one of three clinical centres, some services are now in fact offered by one or more. Heart surgery, for instance, is performed in both Tuzla and Sarajevo. The policy is to foster a competitive relationship between these two centres and to allocate resources in accordance with the percentage of services provided; nonetheless keeping within the ceiling of available funds for heart surgery. This also enables the pursuit of cost containment policies.

The Federal Ministry of Health and the FHIF will create mechanisms for the centralised procurement of pharmaceuticals and medical equipment in order to take advantage of economies of scale. It is well known that pharmaceutical and medical equipment prices are much lower if the quantity is higher. The incentive for cantonal participation in these tenders is the possibility for remarkable savings. Decentralisation of health care encompasses decentralised planning at the cantonal level in accordance with needs. Therefore, the federal level must respect cantonal decisions in the way mentioned earlier. At the moment, out of planned resources for federal solidarity in the year 2000, it will be possible to only purchase ampoules for the cantonal hospitals, pharmaceuticals for tuberculosis, and consumables for haemodialysis.

The author would welcome any comments or feedback from readers. E-mail: piu.hfr@bih.net.ba

The Albanian health system: Past, present and future

Edlira Gjonça

Arjan Gjonça

Health of the population

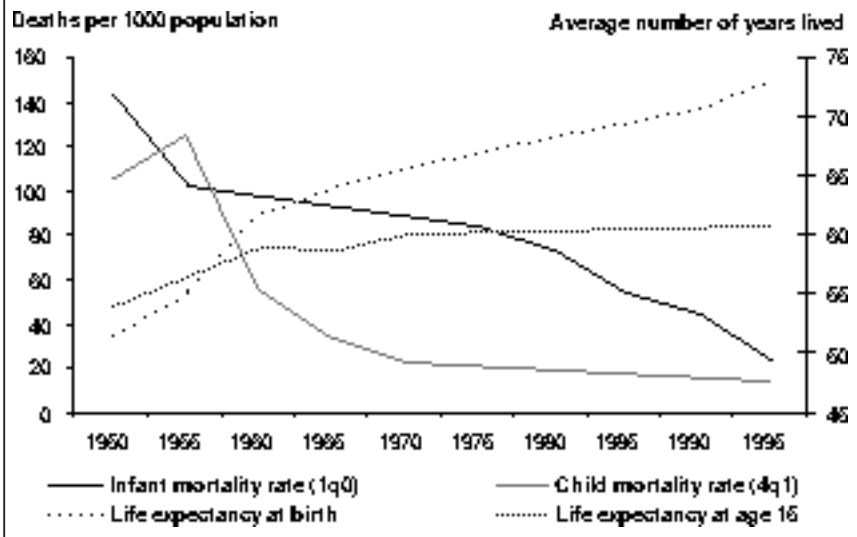
Albania has long been perceived as the poorest country in Europe. Within the social sciences, the country is often addressed as the only former communist country not to have gone through the mortality deterioration of Eastern Europe during the 1980s and 1990s.[1] Albania has also been addressed as an exemplar of developing countries with regard to its health transition. High life expectancy at birth was achieved (72.2 years in 1990) despite a stagnating economy in which GDP per capita did not exceed US$400 in 1994.[2] The low adult mortality in the country is mainly attributed to the healthy Mediterranean dietary pattern (low in saturated fats and high in fruits and vegetables), which is present in the country in its traditional forms.[3]

Despite high life expectancy at birth, the infant mortality rate in Albania – estimated at 22.5 per 1,000 live births in 1997 – is worse than that of wealthier European neighbouring countries, though substantially better than the average performance of countries with similar income levels. However, the opposite is true when adult mortality is considered. In 1990, Albania had one of the lowest mortality rates for ages 15–60 years (probability of dying between the ages of 15 to 60 was 10.2 per cent); lower than in substantially wealthier European countries (Figure 1). The cause-specific pattern of mortality in 1990 shows a very low rate of cardiovascular diseases and cancers compared to countries with the same level of life expectancy at birth. On the other hand, the incidence of infectious diseases such as viral hepatitis, measles, dysentery and typhus has increased and remains high. There is an increasing incidence of accidents and injuries, as well as chronic non-infectious diseases. This might reflect the ongoing epidemiological transition in the country.

Health system and its financing – past and present.

At the start of its transition towards a market economy, Albania inherited a health system conditioned by 40 years of command economy and isolation from most of the world. The health care system was state funded, and health care facilities were

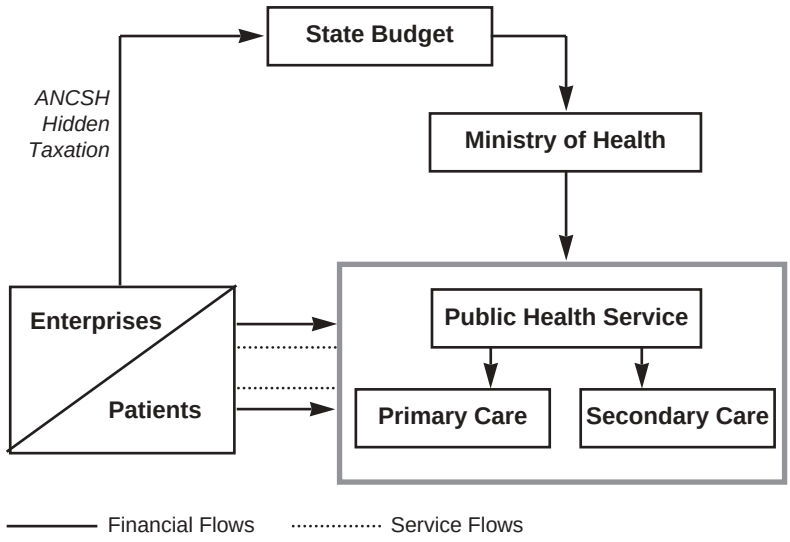
Figure 1 MORTALITY TRENDS IN ALBANIA, 1950—1995



Source: Authors calculations based on data from Albanian National Archives.

designed mostly to ensure accessibility in geographical terms. Access to health care was universal and was never denied to people on economic grounds. Although only occasional postgraduate training was available, doctors were considered to be well trained, particularly in clinical areas. However, in a context of a shortage of resources and a lack of explicit rules and discretionary power, health care institutions in Albania were barely functional. The institutions were overstaffed and the system suffered from low levels of medical technology in either primary or secondary care, which came predominantly from the country's isolation. Indeed, scarcity of resources should preclude us, for example, from speaking about any 'tertiary' type of services in Albania in the past. These deficiencies can be accounted for by the fact that, despite the success in reducing infant mortality at about 22.5 per 1,000 births (1997), it is still today by far the highest rate in Europe.

Figure 2 FINANCING THE HEALTH CARE SYSTEM IN ALBANIA PRIOR TO 1991



ANCSH: the net centralised state income, which was a sort of taxation paid by economic enterprises.

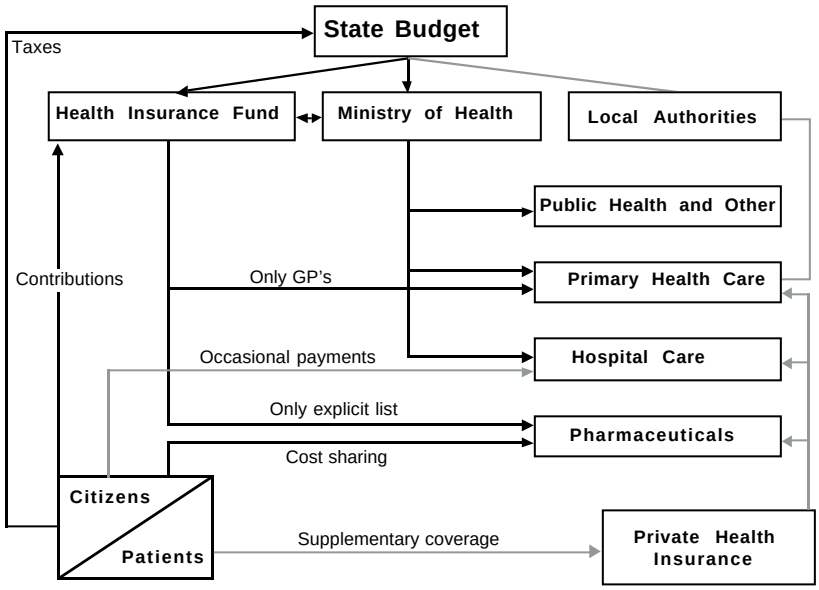
The system can, therefore, be characterised as predominantly extensive rather than intensive in its orientation. In such a context, hospital care had an obvious pre-eminence over primary health care. This focus can explain some of Albania's success in reducing infant mortality dramatically in the past 45 years, as well as in the disappearance of infectious diseases such as tuberculosis and malaria which were major killers in the country after WWII.[4] Figure 2 outlines the structure of health care financing in Albania prior to 1991. Some of the consequences of such a funding system were common to all former socialist countries (health services suffering from a chronic shortage of funds, lack of quality and motivation in the personnel, social dissatisfaction, etc.).

Following political changes in 1992, a series of health care reforms aimed at ensuring equity while also improving quality were undertaken. Of particular importance was the creation of the Health Insurance Institute in 1995. Additionally, private practice and private insurance became legal in Albania. Most pharmacies and dentist clinics have been privatised, whilst service financing and delivery are going through a process of substantial re-organisation.[5] In the context of extreme poverty, Albania introduced an innovative scheme regarding health insurance funding. Instead of establishing a high fraction of the gross salary or pension as a universal basic rate to cover contributors and their families, a step-by-step approach was chosen.

First, only a list of essential pharmaceuticals and salaries of the primary health care doctors were originally included in the 'basic package'. Premiums and coverage would only increase when the economic situation improved and the Health Insurance Institute achieved some stability.

Second, different rates were established for different population groups. Employees would contribute 3.5 per cent of their net salary (half of it paid by the employer).[6] Apart from employee's premia, specific contributions were set for

Figure 3 FINANCING THE HEALTH CARE SYSTEM IN ALBANIA FROM 1995 ONWARDS



'owners of agricultural land'. The self-employed would also contribute variable amounts; depending on whether they lived in rural or in urban areas (either 7 per cent, 5 per cent or 3 per cent of the basic salary). And the state would pay for citizens otherwise not insured (i.e. the elderly, the disabled, students, unemployed, etc.). In 1996, the Health Insurance Institute was given financial autonomy and full independence from the state budget. Figure 3 represents the financing of health care in Albania involving the Health Insurance Institute from 1995 onwards.

The future of health care financing in Albania.

Taking into account both economic and political developments in the country during recent years, the main sources of funds for the future of health care are expected to remain mostly public. Some direct and indirect taxes, plus pre-payments deducted from pay roll (as opposed to private insurance) should be the main forms of contribution. Fund raising for covering a defined package of health services should, therefore, consist of a mixture between:

– money directly raised by the state (including direct and indirect taxes) to fund some institutions;
– other funds from citizens/patients and a 'third party' (the Health Insurance Institute), which in turn should later pay the providers; and
– some direct out of pocket payments by the users, in a more or less generalised co-payment arrangement.

In the future, health services in Albania should be based on three functional tiers of care, all professionally managed and hierarchically linked with each other: primary health care, secondary care and tertiary care. Some form of gatekeeping and referrals should be adopted from primary health care doctors, the only professionals to whom patients would have direct access outside of emergency situations. A major challenge regarding the future organisation and financing of the Albanian health care system will remain the provision of cost-effective services in an equitable and efficient way. These will include developing the capacity of the Ministry of Health (MoH) and central agencies to perform fewer strategic tasks, and to do so more effectively.

Regarding the financing of the system, the following measures are needed:

– An increase in the overall level of resources available to the health sector;
– Improving the fit between revenue allocation and needs; and
– The maximisation of the efficiency with which resources are utilised, as well as transparency in the use of funds.

A system of integrated health services, with an emphasis on primary care provided by general practitioners and community nurses, as well as efficient hospital services should be developed. And, in a break with the past, a system of professional managers should be introduced.

It goes without saying that Albania is currently facing remarkable challenges that will shape health and health care in the country for the 21st century. The success of the reforms applied in the health care system will be evaluated against improvements in the health status of the population. In order to evaluate this process one has to carefully observe the changes in the health of the Albanian population. In such a context, Albania needs not just to maintain the low mortality levels achieved to present, but further improve them in the future.

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Health sector reform in Georgia

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Introduction

Georgia's decoupling from the Soviet economic system followed independence in 1990. This, combined with a rapid transition to a market economy and civil war, left Georgia with collapsed economic and health systems. The per capita GDP declined from around US$ 2,000 to US $350 between 1990–1994. This rapid decline has created much poverty. Since then, the per capita GDP has risen to US $984 in 1997, but this has only benefited a small segment of the society and further widened income distribution, inequalities, and the rich-poor gap.

However, economic stability has resumed. Despite the Russian rouble crisis in 1999, the economy is projected to have achieved double-digit growth in 1999. Inflation, as measured by the consumer price index (CPI) is projected to be around 6.5 per cent for 1999. The revenues for the state budget are projected to grow with a stable current account deficit.

A recent World Bank household budget survey demonstrated the existence of significant poverty and widening income distribution in Georgia. This report shows that only 11 per cent of the population is above the new experimental poverty line (based on 52 GeL, or US$23) per adult per month[1]. World Bank projections show that economic growth would have a major impact on poverty, but that this may be negated by rising inequality. The distribution of money and income in Georgia is extremely unequal, with trends similar to those seen in Latin America.

Table 1 HEALTH EXPENDITURE IN MILLION GEL

	1997	1998	1999 (forecast)	% change 1998 to 1999
Research	0.6	0.2	0.2	0.2
Health services	25	50.2	39.1	
Total	25.6	50.4	39.3	-22.3

Source: MoH data, 1999.

Health Sector expenditure

The fiscal crisis in the early 1990s hit the health sector particularly hard. Government expenditure on health declined to US$ 0.40 per capita in 1994. In 1998, this level was US$7, representing 6 per cent of public spending and 1 per cent of GDP.

In 1998, total public sector expenditure on health amounted to 90 million GeL (2.2 GeL = US$1). This includes central government transfers, local authority financing and social insurance contributions, but only represents 13 per cent of the total expenditure in the health system. A staggering 87 per cent of total health spending comes from patients themselves. This is an unprecedented level of out-of-pocket spending and a major factor that causes families to slip into poverty.[2]

The central government expenditure for the health sector in 1998 was 54 million GeL. This represented 5.1 per cent of the state budget. For 1999, the amount was 39.3 million GeL, or 3.4 per cent of the state budget (Table 1). This is a decline of 11 per cent on 1998 figures. Of this, 18.2 million GeL (47 per cent) are transferred to the State Medical Insurance Company (SMIC); 6.6 million GeL (17 per cent) are used for preventive health programmes; 6.9 million GeL (17 per cent) for other health care programmes; and 1.2 million GeL (3 per cent) used mainly for the purchase of medicines.

In addition, 22 million GeL is earmarked to health care from the municipality budgets. The SMIC receives a further 27.5 million GeL contribution from individuals and employers to the State Insurance Company. Therefore, in total, the public sector expenditure on health amounts to around 90 million GeL. This represents only 1 per cent of GDP but around 7 per cent of the state budget, and is within the target set by the World Bank Structural Adjustment Credit facility (SAC-II).

Total expenditures on health are projected to increase to 6 per cent of GDP

by 2009. The state financing of health as a percentage of the state budget is projected to increase to 15 per cent by 2009 (Table 2).

Table 2 PROJECTED EXPENDITURE ON HEALTH SECTOR

	Health expenditure	
	Total as percentage of GDP	State as percentage of budget
2000	2.5	8.0
2001	2.5	8.5
2002	3.0	9.0
2003	3.5	9.5
2004	4.0	10.0
2005	4.0	11.0
2006	4.5	11.0
2007	5.0	12.0
2008	5.5	13.0
2009	6.0	15.0

Source: Strategic Health Plan data.[3]

Health Status

Health indicators have deteriorated significantly since 1990. Between 1990 and 1993, the Infant Mortality Rate (IMR) worsened by 13 per cent, reaching an estimated 21.4 per 1000 live births. One-third of these infant deaths occurred in the first three days of life. Recent IMR figures are unreliable as there is significant under-reporting of infant deaths due to a registration fee. The last reported IMR was 15.2 per 1,000 live births (1998).

The Maternal Mortality Rate (MMR) has increased twofold to 69 per 100,000 live births. The current figure is five times the WHO-target for the European Region (Table 3). The MMR is expected to rise further due to an increase in the proportion of unassisted home deliveries and abortions. Abortion remains the most widespread form of contraception (45.3 abortions per 100 live births). A significant proportion (22 per cent) of abortions is followed by complications.

Deaths due to cardiovascular diseases have increased by 35 per cent since 1990. Likewise, the morbidity rates for ischaemic heart disease have increased significantly (Table 4).

The overall age-adjusted mortality rate has risen by 18 per cent in the period 1988–1994. The average life expectancy in 1992 was 72.6 (76 for women and 69 for men).

Tuberculosis (TB) is on the rise among children and adults; the incidence of which has increased from 28.7 per 100,000 in 1988 to 105.2 per 100,000 in 1997. With an increase in multi-drug resistant cases, TB has emerged as a national priority.

Most sexually-transmitted diseases (STDs) and HIV cases go unreported. Official figures suggest a total of 69 cases of HIV/AIDS in 1998. However, other estimates indicate a figure closer to 1,000 cases. A serious rise in the rate of HIV transmission is expected due to a high use of injectable drugs; an acute shortage of disposable syringes and sterilised medical instruments; poor public knowledge and awareness of HIV; low condom use; increasing migration; and a dramatic rise in STDs.

There also is a considerable increase in psychological problems, especially amongst internally-displaced persons (IDPs). A threefold increase has been observed in the number of suicides since 1990, and the reported cases of major mental disorders has reached an all time high.

To compound these problems, inadequate preventive activity and a low immunisation uptake in children led to an outbreak of measles and diphtheria in 1994. The number of diphtheria cases increased from 28 in 1993 to 425 in 1995.

Tobacco smoking has reached epidemic proportions. Surveys indicate that 53 per cent of the male and 15 per cent of the female population smoke (1998 data of the National Tobacco Control Centre). A recent survey of 220 children between 12 and 17 years of age, showed that 55 per cent of the boys and 45 per cent of the girls smoked. Worryingly, the rates in pregnant women aged between 17 to 25 were 28 per cent.

The poor are bearing the brunt of these worsening indices, a clear demonstration of the widening

Table 3
MATERNAL MORTALITY RATE PER 100,000 LIVE BIRTHS, 1993—1998

	MMR/100,000 live births
1993	32.4
1994	39.6
1995	55.0
1996	59.9
1997	71.1
1998	68.6

Source: MoH data, 1999.

Table 4
MORBIDITY RATES DUE TO CARDIOVASCULAR DISEASE

	Morbidity rate per 100,000
1992	150
1993	140
1994	170
1995	160
1996	175
1997	245

Source: MoH data, 1999

Table 5 MORBIDITY AND MORTALITY RATES IN DIFFERENT INCOME GROUPS (1997)

Average income/month	Morbidity level/10,000	Mortality level/10,000
Up to 30 GeL	82	36
30–50 GeL	27	27
higher than 50 GeL	8	2

Source: MoH data, 1999.

inequalities, not just in income, but also in health (Table 5).

Health Services

Health service indicators show the inefficiency and excess structures that exist within the health system (Table 6).

Primary care is characterised by fragmentation and overcapacity. In 1998, primary health care (PHC) facilities comprised 859 independent outpatient facilities, 114 outpatient hospital departments, 53 medical posts and 512 midwife posts.

The PHC network includes polyclinics (adult, paediatric, women), district/village clinics ('feldsher points', ambulatories), factory polyclinics (largely closed) and specialised outpatient clinics in urban areas ('dispensers' for endocrinology, tuberculosis, dermato-venereology, psycho-neurology, rheumatology and cardiology).

The infrastructure in the hospital sector is in a state of disrepair. Excess capacity is reflected in the low occupancy levels of 28 per cent, with more than half of all hospitals operating below 10 per cent capacity level. A second World Bank project will finance a radical hospital rationalisation programme through an 'Adjustable Loan Programme'. This project is scheduled to start in 1999.

The population currently has little confidence in the public health system, and this is accompanied by very low satisfaction levels. A user survey in 1998 showed that 60 per cent of the 830 people surveyed were dissatisfied with primary health and outpatient care. Widespread mistrust, combined with cost-sharing schemes, has meant very low utilisation of the health system in general. The poor in particular have been most adversely affected.

Health Policies

The strategy for health sector reform was first published in the 1996 national health care policy document.[4] The major directions of the reform as articulated in this were to: (i) create the legal basis for the new health care system; (ii) decentralise health care system management; (iii) prioritise the importance of primary health care; (iv) reform the san-epid system; (v) transition to the principles of health insurance; (vi) ensure the social security of employees of the health care sector; (vii) reform medical education; (viii) reform medical science; and (ix) reform the health information system.

The 'Georgian National Health Policy'[5] was developed with assistance from the World Health Organization (WHO) and received Parliamentary approval in July 1999. Its objectives are to improve equity, accessibility and affordability of health services for the population. The vision it espouses is a health system financed by semi-public social insurance – maintaining the principles of solidarity and equity – led by primary care, with an emphasis on health promotion and disease prevention. The policy forms an integral part of the wider Presidential Programme. A Special Committee, charged with overseeing the implementation of the policy, was established under the leadership of the President.

A large number of donor agencies and multilateral organisations are collaborating with the government to implement the health reforms. The World Bank has provided financing for health reform and hospital rationalisation projects, and the United Kingdom Department for International Development (DfID) is assisting in primary care development and pharmaceutical sector reform with the WHO.

Conclusions: key initiatives

Separation of provision and financing

A change in the legal status of hospitals and polyclinics has enabled the financial separation of health facili-

Table 6 SELECTED HEALTH SERVICE INDICATORS

Health Service Indicators	1990	1991	1992	1993	1994	1995	1996	1997
Total No. of beds	53,079	53,122	52,900	46,256	44,444	33,870	24,234	24,481
No. of Beds/1,000 population	9.8	9.8	9.6	8.5	8.2	6.3	4.5	4.5
Occupancy rate	57%	51%	36%	35%	28%	27%	28%	28%
Average length of stay (days)	14.8	14.7	15.3	16.2	15.3	13.4	10.5	10
Doctors/1,000 population	5.0	4.9	4.6	4.6	4.4	4.1	3.7	4.0

Source: MoH data, 1999.

ties from the national budget. Simultaneously, staff salaries were removed from the government budget, and health employees are no longer considered civil servants.

A new case-based payment method for hospitals and a bipartite payment system for primary care (from municipality and federal funds) were introduced in 1996. Competition between providers was introduced, and reimbursements for services provided are now paid through a new intermediary agency, the State Medical Insurance Company, which receives its funding from two sources: the '3+1' payroll tax, and the central budget funded by general taxation.

Licensing and Accreditation:

The Ministry of Health has assumed the role of licensing health facilities. This began in late 1998. So far, 900 medical facilities, including 250 hospitals, have been licensed.

Graduating medical students are required to take a certification exam to progress to postgraduate training. The first exam, taken by 600 recent medical school graduates, yielded a 60 per cent failure rate. Practising physicians are required to take a licensing exam in their field, as prepared by expert groups in the National Health Management Centre. The first exam failed 60 per cent of obstetrics/gynaecology specialists. All practising physicians will be licensed by December 31st 2000.

More than 50 private medical schools have opened since 1991, with an enrolment of 14,000 and an expected annual graduating class of more than 3,000. A Commission of Accreditation was formed in 1996. New legislation in 1998, however, passed this responsibility over to the Ministry of Education and the accreditation process has been stopped.

Privatisation

In 1996, the 'Law of Privatisation of Public Enterprises' divided health facilities into three groups: (1) pharmacies and dentists' offices; (2) ambulatories and polyclinics; and (3) hospitals. In addition to the three groups, facilities are divided into three categories. Categories A and B create restrictions in the property right of purchasers, while category C gives unrestricted property rights.

Provider facilities will be privatised, except for strategic ones which will remain in public hands in order to ensure access to remote areas and specialised services.

Four hundred facilities were privatised between 1996–1997. Originally, the revenues from privatisation were earmarked to go to the State Health Fund, however, as part of the budget reforms, the money has been reassigned to the central budget.

Reform of the Sanitary Epidemiological Services (SES)

Georgia is the first Former Soviet Union (FSU) country to reform the SES with assistance from the United States Agency for International Development (USAID). The SES has been transformed into a public health department with a much broader remit, focusing on population health promotion, prevention and surveillance; in addition to the traditional disease control function.

Primary Care

Georgia is one of the first Newly Independent States to recognise family medicine as a speciality and develop a specialist-training programme with assistance from the DfID.

The Strategic Health Plan for Georgia identifies PHC as a priority. It puts an emphasis on improving PHC and preventive services rather than the curative sector. It states "This will be achieved by shifting considerable resources to primary health care from hospital services". The strategy sets targets of establishing national and regional centres for family medicine between 2000–2003, financing mechanisms between 2000–2005, and completion of the national network by 2008. In addition, a training programme for the PHC team, and in particular for establishing a cadre of specialist PHC nurses, is planned.

The hospital sector

A radical hospital rationalisation and rebuilding programme is planned under World Bank auspices. The programme aims are to decrease actual bed capacity in the capital, Tbilisi, by 60 per cent; reduce the number of hospitals in Tbilisi from 67 to 17; and lower total hospital bed capacity in 6 major cities of the country by 66 per cent.

The government has embarked on an ambitious health reform programme. For the reforms to succeed, a number of issues must be addressed:

(i) improving the tax and health insurance collection systems to raise additional resources for the budget;

(ii) improving the efficiency by reducing structural and human resource capacity, especially in the hospital sector;

(iii) reorienting the system towards primary care and interventions towards health promotion and prevention;

(iv) allocating resources equitably to improve equity and access; and

(v) (most importantly) improving the trust of the population in the system.

Despite all the difficulties, the government is committed to meeting the challenge and reforming the heath sector.

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The early experience of Poland in introducing a quasi-market in health care

Ewa Aksman

The Case for Reform

Until 1999, Poland was administratively divided into forty-nine *voiwodships* (cantons). Each voiwodship housed an office representing the central government (VGO) though each was run by the voiwoda itself. Until the beginning of the 1990s, the public sector strongly dominated the health care system in Poland (Figure 1), although this changed in 1991. In turn, there were forty-nine Voiwodship Health Departments (VHDs) which served as the main public purchasers.

Allocation of central budget funds at the VHD level was coordinated by the Ministry of Health; subject to the approval of the Ministry of Finance. Distributions within each VHD were mostly based on the need for each to maintain its own directly managed health care institutions (DMHCIs), with less attention having been given to the type and number of services provided (far less and demographic and epidemiological factors). The DMHCI budgets were usually changed on a yearly basis, after taking account of current deficits, political changes and particular interest group pressures. The voiwoidship health departments were typically characterised by bureaucratic management, subject to state administrative revision and weak incentives for effective performance.

The DMHCIs were crucial public providers of both primary and secondary care although, historically, they faced chronic low levels of funding. They generally operated as budgetary units required to keep within their financial allocations, with no discretion over the use of any savings they might potentially make. Only since the mid-1980s have they been permitted to seek other revenue and to vary salary scales according to staff workload. But these new options – designed of course to strengthen motivation for better performance – had very limited effectiveness in practice. Wages in the institutions remained very low, prompting staff to take second jobs and to accept informal out-of-pocket payments. The DMHCIs faced quality assessment – which was highly bureaucratic and only partially based on clinical performance – as well as marginal verification according to economic criteria. And, since 1989, due to high inflation, the units rapidly went into increasing debt.

In general, the operation of the public health care sector was based on classical integration between public purchasers and public providers. What made the situation very difficult was that the integration model referred to both primary and secondary care levels. Consequently, the system did not perform effectively in terms of meeting the wide range of universal health policy objectives. There was a relatively low quality of care, great inefficiency in public resource utilisation and very limited choice of care and the providers of services (queues and waiting lists were ever-increasing). Particularly important, was the fact that social dissatisfaction with the system was increasing sharply, as there were no systematic financial incentives to serve patients' needs and preferences. As well, the role of the private sector was marginal which derived predominantly from

Figure 1 ORGANISATIONAL STRUCTURE OF THE POLISH HEALTH CARE SYSTEM UNTIL 1991

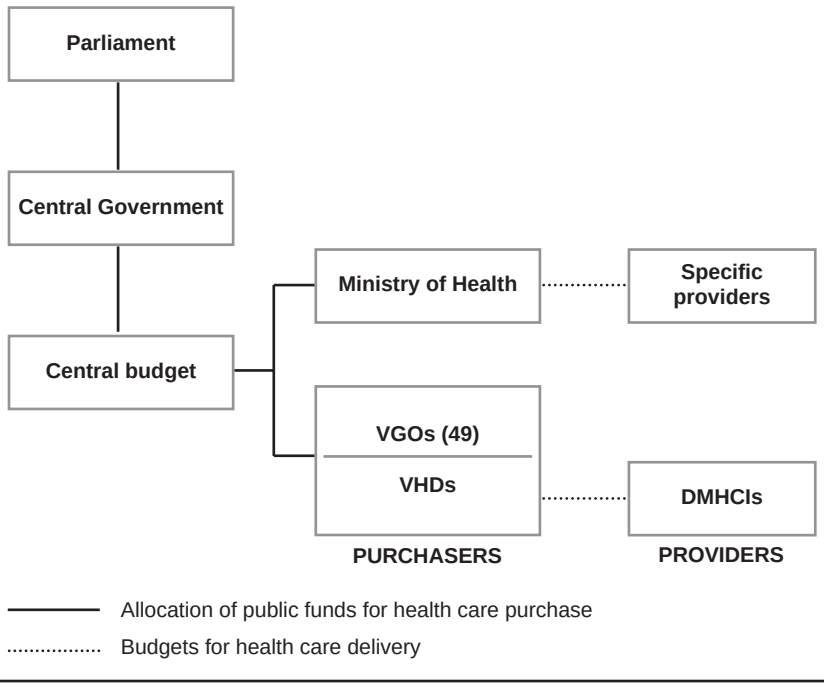
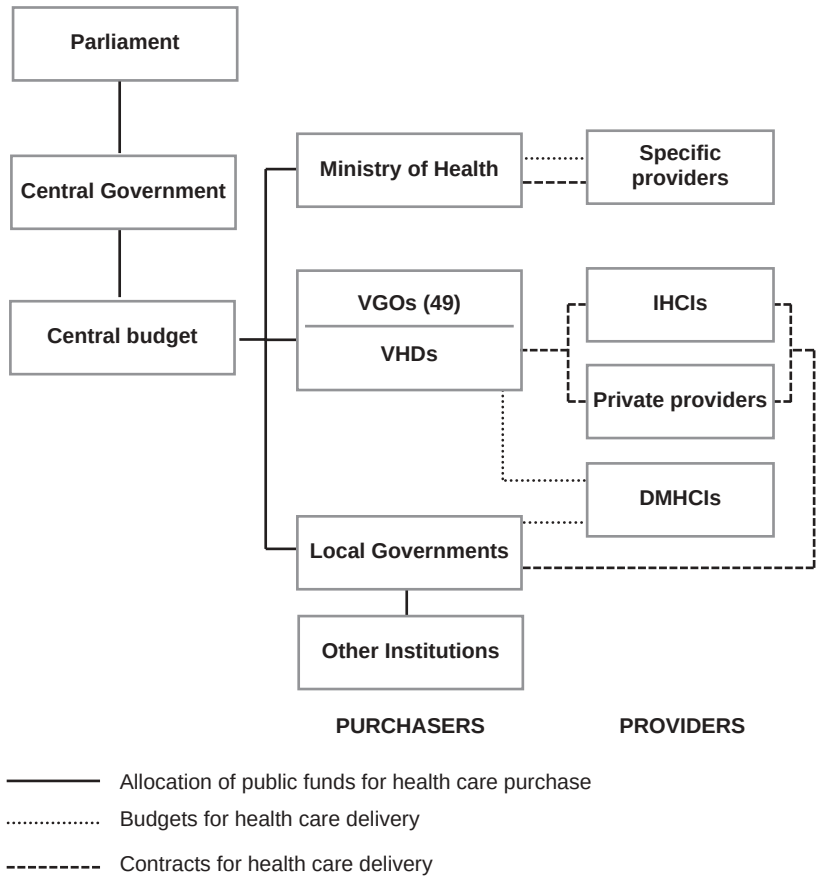


Figure 2 ORGANISATIONAL STRUCTURE OF THE POLISH HEALTH CARE SYSTEM IN 1998



unfavourable attitudes towards conducting any private activity in the health care system.

The establishment of a quasi-market

The main element of a new law in 1991 was the introduction of a clear purchaser/provider split. This was achieved by taking the DMHCIs out of the control of the voiwoidship health departments, and setting them up as independent health care institutions (IHCIs). These new units were designed to utilise public assets to deliver services, and to sell these services to any purchaser so as to earn profits which they could then partially dispose of themselves (They were also to be free to set their own remuneration schemes). Under the changes, the VHDs and local governments – which played the role of public purchasers – were to be permitted to enter into contracts with both the independent health care institutions and private providers for the delivery of constitutionally-guaranteed health care. Consequently, with the passing of the 1991 act, the quasi-market idea became legislation.

In 1993, the ordinance on contracts between public purchasers and private providers was published and, in 1995, the instructions on transferring public funds to the IHCIs were issued. These laws represented strict regulation of the issues concerned and were in fact the last two adjustments necessary to introduce the quasi-market in practice.

Apart from establishing the quasi-market, other complex reforms of the Polish health care sector have also occurred since 1991. The four main directions of these changes were: strengthening the primary care level; passing the Act on the National Health Insurance System (NHIS) of 1997 – which stipulated January 1st 1999 as the date for its introduction; activating local government participation in the health care sector; and introducing a national system of health service registration. In general, however, all the above reform measures were highly stratified, extremely inconsistent and very gradual. This was in large part the result of frequent changes in national political situation and the complete lack of a strategic vision of the health care system reform process.

Performance of the quasi-market

Because of the stratified, inconsistent and gradual nature of the reforms, the Polish health care sector has become increasingly hybrid (Figure 2).

In the past, the 49 VHDs maintained their DMHCIs – allocating total budgets between them – with the latter usually remaining in significant debt. Under the National Health Insurance System Act, all voiwoidship health departments were bound to change their directly managed institutions into independent units by January 1st 1999; so as to allow the latter to contract a full range of care to the insured with regional and employer-provided insurance funds. The VHDs were very often given considerable financial support from the central budget in order to split from their DMHCIs, permitting the latter to reach quasi-autonomy.

However, to a rapidly increasing degree, the cantonal health departments contracted with the IHCIs. They commonly made agreements only with those independent institutions which had formerly been their own DMHCIs. These were almost always block agreements which assumed the exchange of the aggregate scope of services for fixed expenditure. Typically, the value of these contracts was roughly the same as the global budgets previously allocated in the DMHCIs. These agreements were in force for at least one year (usually a fiscal year). The VHDs very rarely contracted with IHCIs which had not formerly been within their jurisdiction, and where they did do so, these agreements entailed an insignificant part of their total funds.

Additionally, since the NHIS Act, about 50 per cent of the VHDs have already purchased from private

providers. At the beginning of 1998, they were estimated to have about 4,000 agreements with such providers, but these contracts were very diverse with respect to the size of population covered, the scope of services delivered, total financial value and the number of providers (joint contracting). These agreements are most frequently applied to specialists, dentists, family doctors and the providers of emergency care. They were generally signed on a cost-per-case form providing strict ceilings on the providers' activities, and were for the most part in force until the end of a fiscal year. Generally, however, the VHDs – which have already contracted with private providers – spent but a marginal part of their total funds on such agreements.

At the end of 1997, local governments possessed about 2,500 directly managed health care institutions operating at local level. They have allocated global budgets between these DMHCIs, and these units operated predominately as primary care clinics, occupational health centres and specialist clinics. Only a small number of the DMHCIs taken over by local governments became independent institutions and could consequently contract care at the market independently. Similarly to the voiwoidship health departments, because of the NHIS law, local governments were also compelled to transform their DMHCIs into the IHCIs by January 1st 1999, and local governments also bought care from private providers. These contracts were relevant primarily to family doctors, but sometimes also to dentists, family nurses and providers of rehabilitation care. In 1997, all local governments were estimated to allocate about 8 per cent of all public funds to health care.

At the end of 1997 there were about 150 independent units out of 800 main public health care institutions in Poland. Emerging IHCIs usually sold services only to parent VHDs; in fact, most of their contracts were with the parent VHDs. These contracts were renegotiable to adjust for yearly inflation and regularly provided precise floors on their activity. The units derived an insignificant share of their total revenue either from other public purchasers or from private purchasers – usually making agreements with local governments, with employers (providing care for their employees) and various health care foundations. These were predominantly cost-and-volume agreements. As a rule, IHCI status was given to almost all types of DMHCI.

Conclusions

Despite all the above structural changes, there were no remarkable effectiveness gains in the Polish health care sector from introducing the quasi-market. In fact, it served to highlight the crucial health reform objectives that were necessary. Issues such as: quality of care; efficiency in public resource utilisation; responsiveness to patients' needs and demands; and choice of services and the providers of services, were all shown to require address. Also, the emerging market has generally imitated the former 'integrated model' of health care – in part due to the historical links between the VHDs and the previously subordinate IHCIs. The key issue, therefore, was that the old pattern of public funds spending on health care remained unchanged.

This situation can be explained for two basic reasons. First, the VHDs, while being strategic public purchasers, were not forced to compete for their purchasing competence and simultaneously, did not have proper incentives (they remained motivated mainly by the aim to keep within central public funds and meet centrally defined targets). Second, although the IHCIs had a very strong monopolistic position over the private providers, their originally strong motivations were constrained by their very weak economic situation on entering the market (limited opportunity to gain economic surplus in the short time after transformation from DMHCI status). So, as the introduction of a national health insurance system in Poland has already been decided and acted upon, it is now important to amend the NHIS Act so as to implement optimal public purchase of health care. The prime concern must be to introduce at least partial competition between various health insurance funds for their purchasing role, and to assure the proper motivation of those agents to act effectively on behalf of the insured.

The best argument in favour of the changes made, is that even in such an early stage of the quasi-market, some positive results have already been observed. Namely, a few of the IHCIs were indeed able to increase (even if only slightly) their effectiveness in terms of almost all important dimensions. In their case, they did not become totally constrained by the monopolistic power of parent VHDs and were strong enough economically themselves. Additionally, many private providers have shown adequate incentives to perform effectively under the contracts with public purchasers. But, all such gains were observed only with respect to a marginal part of the quasi-market.

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Interviews

In what we envisage as becoming a regular feature of the *eurohealth* Special Issue, the editorial team is pleased to include a section of interviews with key decision-makers in the health field from Central and Eastern Europe and Central Asia. This new element aims to offer regional health(care) leaders a unique opportunity to present their own views on specific issues in a more relaxed manner than is otherwise required by a formal article. This provision of the policy-makers' perspective – as expressed by those palpably involved in the health care reform and transition process – serves as an important juxtaposition to the more academic findings and views indicated in other articles.

Appreciating the multiple demands on the interviewees' time, the number of questions which have been set are limited. Based on an initial template, the questions were designed to be flexible enough to allow them to make any changes, whilst at the same time maintaining grounds for cross-country comparisons. The premise underlying the use of 'one-to-one' interviews was to enable the interviewee to voice her or his opinions in as casual or formal a way as they feel appropriate.

In this, the first such section, we are privileged to be able to include: *Dr Leonard Solis*, Minister of Health of Albania (interviewed by Besim Nuri); *Dr Bozo Ljubic*, Minister of Health of the Federation of Bosnia & Herzegovina (interviewed by Virginia Jackson); *Mr Advantil Jorbenadze*, Minister of Health of Georgia (interviewed by Tamar Gotsadze); *Dr Naken Kasiev*, State Secretary of Kyrgyzstan and former Health Minister (interviewed by Jan Bultman); and *Dr Eduard Kováč*, Director of the General Insurance Company, Slovakia (interviewed by Stjepan Orešković). All interviewers are representatives of the World Bank (with the exception of Professor Orešković of the Andrisa Štampar School of Public Health, Croatia), and we are most grateful for their help.

In comparing the interviewees' responses, it is interesting to note, for example, that the main factors identified as hindering the health care reform process range from the inability to mobilise adequate public financing (Georgia) to the wider issue of the state's political fragility (Albania). Unfavourable economic conditions, particularly regarding unemployment and the lack of money for privatisation in the health sector are deemed to be setting back the reform process in Bosnia & Herzegovina. In Kyrgyzstan, arguably the most advanced of the region's countries in terms of health sector reform, the inadequate dissemination of information about the reform process has been deemed the major failing. At the same time, however, similarities do exist. The need to improve access to health, the challenge of developing efficient funding mechanisms and the retraining of existing medical professionals are requirements mentioned by all interviewees. So too do they all acknowledge the role played by international organisations such as the World Health Organisation and the World Bank. An important theme which is emerges from the interviews – though is manifest in different ways – is that decision-makers are faced, to varying degrees, with an underlying resistance to change. Whether from within the medical profession or amongst the population, overcoming this challenge promises to remain a difficult task for years to come.

We hope that the *eurohealth* readership will welcome this addition to the format of the Special Issue, and will regard it as an important one in fostering relevant and practical debate on the health care reform process in Central and Eastern Europe and Central Asia. On behalf of the editorial team, we are extremely grateful to both the interviewees and interviewers for their time and effort in having been willing 'guinea-pigs' on this occasion.

The Albanian Minister of Health,

Dr Leonard Solis

What do you see as major challenges for health in Albania?

I consider as the greatest challenge for health in Albania, the process of adaptation of the whole society to the new system of a market economy, and to a structure of new values and a different lifestyle. This difficult transition has a price and health is paying part of it. Certain groups in Albanian society are becoming more vulnerable because of low revenues. Some health indicators have worsened or, in the best case, have not improved. New phenomena are making people more exposed to health risks such as rapid urbanisation, social violence, higher consumption of alcohol and tobacco, drug abuse, prostitution and new sexual behaviours.

In addition, the health system of the socialist era was a reflection of the centralised and collective organisation of the whole society. In this over-controlled context many things were easier to impose, bringing, consequently, a series of achievements. This health system inherited from the past does not fit with the conditions of the present, and we are witnessing many distortions. Thus, we have already started a reform process for our health system, and it is one which will go on for a relatively long period.

What, in your opinion, are the greatest problems facing your health system?

One of the most important problems in our health system is insufficient financing. Albania is a poor country and its public spending on health amounts to about 3 per cent of GDP. This is very low if you also take into consideration the low national incomes. In addition, the available resources are probably not spent in the most efficient way. This is due to the lack of managerial capacities at all levels of the system.

Moreover, our system of public spending is very rigid and does not leave much room for an increase in the salaries of health personnel. This is one of the main reasons for the low motivation of doctors and nurses in our health care settings, as well as for the 'brain-drain' out of the country. Furthermore, despite of our investments for rehabilitation, our health facilities infrastructure is in disrepair, and equipment is far from meeting modern standards. All these factors do not allow us to improve the quality of health care services.

What are the priorities of the health system reform in Albania?

It is difficult for politicians or for policy-makers to identify priorities in such a challenging environment where everything seems to be a priority. However, the Ministry of Health (MoH) has identified some priority areas. First, we would like the MoH to perform its natural role as a policy-making and regulation body, and for it to give more autonomy to the sub-national levels for the management of their own day-to-day activities. This careful and well-studied decentralisation requires a lot of effort to improve the regulation and management capacities at the national and district level. The second priority is our aim to increase funding for the health sector. This will be done through different mechanisms such as the improvement of health insurance contribution collections and the introduction of some co-payment mechanisms. In addition, we aim to expand the scope of private practice with a concurrent reduction in hospital beds and a streamlining of the hospital sector. The health insurance system will be extended to cover all primary health care service expenditures and, later, hospital payments as well. One of the main objectives of the reform is to improve the quality of services, and this will be made possible through the introduction of family medicine, the improvement of infrastructure and equipment conditions in the hospitals, and an increase in the revenues of health care personnel.

What do you see as major obstacles to achieve these identified priorities?
In the process of addressing these priorities, I consider as the major obstacle the fragile political stability of the country. This has a strong impact on the continuity of the reform process. The rapid turn-over of senior personnel creates a handicap in the institutional memory and consequently brings confusion among donors. Moreover, we need a critical mass of policy-makers and managers who would lead the process of reform in Albania. Unfortunately we do not have them. The few nationals with a solid training in health related sciences are attracted by international organisations or the private sector, where they are well remunerated.

What do you see as the appropriate public and private role in Albanian health care?
The combination of the public sector with private services is necessary because it contributes to improving the quality of service. I think that the public sector financed out of the public budget will dominate the Albanian health system for a long time. The private sector in Albania consists, in almost all cases, of outpatient services, mainly diagnostic centres where consumers pay out-of-pocket. Only these type of services are affordable by the population at large. The development of private services is also related to the establishment of private insurance schemes. However, I think that the privatisation process should be accelerated, though as it will be very difficult to stop once it has developed its own momentum, some prudence is needed.

Where do you get your policy advice from?
The MoH has some experts trained in Western schools. In addition, we get advice from experts at the World Health Organization (WHO), the World Bank, the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) who are either resident or often come to Albania.

Where has the best support and advise that you have received come from?
The best advice to the MoH has come from the WHO, and the best support was provided by the World Bank.

What would be your advice for other Ministers of Health?
The Minister and his team should have as few executive powers as possible. Long-term strategies need to be developed via a participatory process. The Minister should make his staff feel as though they are genuine participants in both the successes and failures of the reform process. In a system with low salaries, satisfaction from success is more effective then pressure and sanctions. Individuals must have courage in making decisions, and then the decisiveness to implement them.

What has surprised you most about being Minister of Health?
Nothing surprises me in this world. I am curious, and I try to discover the mechanisms of everything. But I am almost never surprised.

The Georgian Minister of Health

Mr Avtandil Jorbenadze

What do you see as the major challenges/priorities for health in your country?
As in many countries of Central and Eastern Europe (CEE) and the Former Soviet Union (FSU), the co-existence of the characteristic health problems of developed countries with those health threats which prevail in developing countries, perhaps poses the major challenge to the population's health in Georgia. An ageing population and associated increase in morbidity and mortality related to chronic conditions such as cardiovascular

and oncology diseases, are accompanied with the resurgence of major communicable diseases such as tuberculosis, sexually transmitted diseases, anthrax, waterborne infections, diphtheria and other vaccine-preventable diseases.

This situation is aggravated by the continuing social-economic disequilibrium and widening gap between rich and poor that fosters inequity in health and accentuates existing public health problems. In the last six years the infant mortality rate increased by 13 per cent along with maternal mortality rates. The life expectancy of 72 years which stood in the early 1980s is steadily decreasing. Deaths due to cardiovascular disease increased by 35 per cent, and an increased mortality rate (by 18 per cent) was observed in all age groups.

The major priorities for the maintenance and improvement in health for Georgia, which, I think, are common for many other countries in similar conditions include:

– improvement of maternal and child health;
– reduction of morbidity and mortality caused by cardiovascular diseases;
– improvement of prevention and detection and treatment of oncological diseases;
– reduction of trauma;
– reduction of morbidity and mortality induced by communicable and socially dangerous diseases;
– improvement of mental health status;
– health promotion and establishment of healthy lifestyle;
– provision of safe environment for human health; and
– reduction of inequity in the health status related to socioeconomic conditions.

What do you consider to be the greatest problems facing your health system?

During the initial years of independence (since 1992), political turmoil and civil war, along with externally inspired separatist movements and the disruption of state governance, a deepening economic crisis, the total deterioration of the financial system, and the disruption of traditional economic links with neighbouring republics and lost markets for Georgian products, all contributed to an almost total paralysis of the country's social-economic system. The health system, an important part of the extensive Soviet social welfare structure, has also been deeply affected by these processes. Georgia's devastated economy was no longer able to support the centrally financed and administered health system: with universal entitlement for the population and excessive health infrastructure. As a result, the public health system virtually stopped functioning by 1993. The immunisation programme failed, and medical facilities were unable to provide most of the essential health services for the population.

Now, after almost four years of radical health system reforms, despite considerable success in the reorientation of the health system, many critical problems still remain. First is the chronic deficit in public financing of the health sector that shifted a major part of health care costs to patients. Private out-of-pocket expenses account for approximately 83 per cent of national health expenditures. This is a significant financial burden on the population. According to the recent poverty assessment conducted by the World Bank, these unexpected health expenses represent a major risk factor for driving Georgian households into poverty. Second, a continued surplus of physicians and sustained excessive infrastructure considerably affects the quality of medical services and drives up health care costs. With 272 hospitals, some 23,500 beds and 21,000 physicians for a population of 5 million, the hospitals are operating at 30 per cent utilisation rates and there are 1.5 physicians per occupied bed. Finally, poor awareness amongst Georgian citizens about their health care entitlements constrains the realisation of a system based on the citizen's individual rights in health care. It also contributes to the inefficient utilisation of health services and creates a conducive environment for corruption in medical facilities. These problems largely impair the impact of the implemented changes and hamper the progress towards achievement of reform objectives.

What do you see as the major obstacles/threats to achieving the priorities that have been identified?

Difficulties in the mobilisation of public financing (and subsequent severe underfinancing of the health sector) will remain as a major obstacle for further reforms and the realisation of priorities. The absence of an adequate social security mechanism for retired and laid-off medical personnel will considerably complicate the optimisation process of the provider sector. Citizens' poor awareness and participation in the reform process and the realisation of their own rights, also pose additional threats for achieving the reform priorities.

Can you describe how you have tried to respond to these challenges?

The deep crisis in essential health care services provision and worsening of the population's health status described above, prompted the Georgian government to launch radical health care reforms in the middle of 1995. An ambitious, multistage health system reform package was an integral part of the Presidential Programme 'For New Democratic Georgia', and was prepared with the participation of World Health Organization (WHO) experts, and the technical and financial assistance of the World Bank. This process was envisioned as a sustainable long-term treatment for the collapsing system.

The reform initiatives entailed: limiting the public spending to a basic package of essential services; shifting the role of the government away from direct provision, and financing towards regulation and policy setting; and introducing new financial incentives for providers to improve quality and efficiency. Major changes in the public health system, health services provision, medical education and research, legal environment and financing of the health

care system have been planned.

One of the major and most courageous steps on behalf of the government towards this process, was to remove the declarative universal right for free health care for all from the Constitution, and to limit entitlements to a basic package of essential health services. As in many other countries, the objectives for Georgian health reform included the transition from curative medicine oriented around secondary health services, to a more efficient system based on prevention and primary health care.

Conceptually, the actual implementation of the health sector reform during the 1995-1998 period, can be divided into the following stages:

Stage 1 Reorganisation of the system, which started in August 1995 and was almost completed in spring 1996.

Stage 2 Adopting new relations and introducing health insurance, which lasted until spring 1997.

Stage 3 Comprehensive implementation of a new model of health system management and organisation which was completed by the end of 1998.

Stage 4 Adaptation, improvement and achievement of sustainability for the new model to be continued through 2010.

The health reforms have led to certain positive outcomes. Namely, the immunisation programme was resumed between 1995 and 1996, the process of health infrastructure deterioration and worsening of the population's health status was slowed down, and in some cases these negative trends were even reversed. For instance, transition to a programme-based management of the health system made possible the determination of priorities and the more efficient mobilisation of resources for their achievement. And, state programmes on the promotion of healthy lifestyles and the reduction of harmful environmental factors on the health of the population began to take effect. Vulnerable and unprotected groups were given social health insurance coverage. Unification of the medical treatment process and guidelines, and the licensing of health institutions and certification of medical personnel laid the foundation for the provision of adequate quality control. The process of bringing order to the complicated situation in medical education is in progress, and the principles of financing medical research and development have changed.

Further significant efforts are nonetheless required to address the major challenges that the Georgian health system currently faces in the transition period. Future policies should attempt to:

– ensure adequate financing for health within the national budget;

– identify alternative ways to finance health services and, by better targeting the poor, thus ensuring adequate coverage for the most vulnerable;

– improve the technical efficiency of the existing system by reducing excess capacity with adequate social protection mechanisms for laid-off staff – by improving the quality of services, allowing higher provider salaries and decreasing illegal payments made by patients;

– improve the efficiency of the health system by really shifting resources from specialised in-patient services to primary health care; and

– conduct public information programmes to inform consumers of their rights and to explain the current constraints faced by the public system.

There are several significant steps planned to begin addressing most of these urgent problems. With the technical assistance of the World Bank, the 'Hospital Sector Restructuring Master Plan' for Georgia was prepared. The plan envisions quantitative and qualitative optimisation of the hospital sector and medical personnel by means of wide-scale consolidation of medical facilities, and privatisation and reform of the legal status and governance structure of the hospitals. Innovative approaches in the provision of adequate compensation mechanisms, retraining opportunities for the excess medical personnel, along with broad public information campaigns and transparency, will be critical for the success of this plan. Part of the World Bank 'Structural Reforms Support Credit' given to the Georgian government (effective since July 1999) will be used to initiate this process. Another major development planned in cooperation with the World Bank and the United Kingdom Department for International Development (DfID), is a radical reform of the primary health care sector that will be implemented until 2005.

All the above mentioned undertakings have been articulated in an important strategic document entitled 'The National Health Policy of Georgia'. This document was recently adopted by the government and represents a long-term vision for health sector development (until 2010). Prepared by the Ministry of Health in close collaboration with experts from the WHO Regional Office for Europe (WHO/EURO) and involving the wide participation of all stakeholders, the National Health Policy, I think, incorporates priorities for the health of the population and further reform of the health system.

The document includes country health goals, objectives and implementation strategies, levels of responsibility for different sectors, monitoring of achieved results, principles of management, and coordination of the policy implementation process. By means of such a policy, we plan to realise the WHO's appeal to its member states "to base their own objectives on current realities and dreams about the future".

The National Health Policy is based on the principles of 'new universalism', under which the government again becomes a leader in regulating and financing the health system despite limited resources. It is an integral part of the presidential programme of Mr. Eduard Shevardnadze, and the Special Committee established under the leadership of the President will conduct its implementation.

The National Health Policy and the 'Strategic Implementation Plan' it

incorporates, will serve another important purpose. Together, they can act as a unified framework for the more effective use of international financial and technical assistance. With effective coordination mechanisms, this unified framework can ensure better utilisation of external and internal resources in achievement of the country's health priorities.

To summarise, we now have a clear vision of where to go from this point. We have clearly defined long and medium-term goals and priorities. This is, I think, an important prerequisite for future success, provided that we strictly adhere to the course that we have taken.

Who do you get your health policy advice from, and how could these sources of advice be improved?

During all these years of changes, the health policy advice and technical assistance rendered by the WHO/EURO and the World Bank have been crucial. Health policy advice and support from the WHO/EURO was very important in the following regard: the establishment of a health information system and tuberculosis programme; the improvement of monitoring systems for sexually transmitted diseases and AIDS; the enhancement of monitoring systems for hepatitis and measles control; in the area of reproductive health; the preparation of tobacco and alcohol abuse action plans; and evaluation of the 'Euro Health' Programme. Thanks must also go to the WHO for its support of the National Health Policy Programme and the Strategic Implementation Plan. We expect that in future, collaboration with the WHO/EURO will become more intensive and even more focused on the specific health sector needs of our country.

The financial support of, and technical collaboration with, the World Bank is worthy of special mention. Under the framework of the first health project, the following have become possible:

- modernisation of the health financing system;
- reorganisation of public health service structures, with the emphasis on primary health care, surveillance, promotion of healthy lifestyle, improvement of morbidity and mortality indicators and population's health;
- optimisation of maternal and child care, with the establishment of perinatal systems in Tbilisi and Kutaisi and the launch of a referral system;
- the acquisition of a drug quality control laboratory;
- the development of a health information system;
- the establishment of a continuous education centre;
- the implementation of licensing for medical specialities; and
- the development of health insurance.

In future, we hope that the World Bank policies in general, and health policy in particular, will become more flexible in order to better accommodate the country's specific needs within the entire spectrum of sociopolitical developments.

Where has the best support and advice that you have received come from?

During the complicated and difficult times of the reforms, the best support and advice came from the President of Georgia, Mr. Eduard Shevardnadze. Regarding our international partners, besides the WHO/EURO and the World Bank, we are deeply grateful for continuous support from the United Nations Children's Fund (UNICEF) and other UN agencies, the governments of the United States, Germany, Netherlands and the United Kingdom.

What is your strategy for achieving sustainable financing of your health care system?

This is one the most essential and painful issues in relation to the health system reforms. Public expenditure on health declined from an estimated US$150 per capita in 1989 to an inconceivable US$0.40 per capita in 1994. After general economic recovery and the introduction of the social insurance-based health financing model, public health spending increased more than 20 times, to approximately US$8 per capita in 1998. Still, this remains one of the lowest levels of public spending on health in the world. It is clear that with these scarce financial resources it is almost impossible to ensure the adequate coverage of the population, even with the most essential health services. Further efforts are planned to improve the mobilisation of public financing for health, by increasing the earmarked health tax and widening of the tax basis. Several options for health financing reform and the identification of alternative sources for health financing are under intensive evaluation and will be tested on a pilot basis in the near future. As part of preparations for primary health care system reform, community based financing schemes are being explored.

I hope that the step-by-step implementation of these strategies will bear considerable positive results in achieving the sustainability of health financing in a period of four to five years.

What do you see as the appropriate public and private roles in health care?

According to economic theory, the health market is characterised by intrinsic market failures due to imperfect information, distorted demand and supply curves, etc. There are still debates regarding the perception of health care as individual product or public good and/or human right. I think every society determines this issue for itself based on its founding human and social values. We think that a specific feature of the health market should be the active involvement of the public in this sector. But this involvement should be restricted to setting the following 'fair rules of the game': defining the policy and regulatory framework, and ensuring adequate access to the most essential health services that bear the most distinctive features of collective good. It is ultimately the responsibility of the public sector to ensure solidarity, equity and equality in accessing health services, along with the reali-

sation of a basic human right to health and life.

With proper public regulation, the private sector will have an essential role in making the health system function efficiently. If rules of the game were the same for public and private providers, they can only foster healthy competition, support adequate price setting processes, and enhance the quality of medical services. That is why we are for the promotion of civilised market relations in this sector, and for the privatisation of medical institutions. Along with the further development of the public insurance system, we support the establishment of a strong private insurance system that may help to relieve the current daunting financial burden of health costs on Georgian citizens.

Do you have any advice for other Ministers of Health?
Based on my experience, the only advice I can give is to try to be consistent, and to match our ambitions and responsibilities with our means and reality.

What has surprised you most about being Minister of Health?
Perhaps the extent of the burden of responsibilities that I assumed when I became the Minister of Health. In particular, I found it most difficult to find a balance between advocating benefits for the population, and defending the interests of medical professionals in the most complicated and painful process of health system reform.

The Minister of Health of the Federation of Bosnia and Herzegovina

Dr Bozo Ljubic

What do you see as the major challenges/priorities for health in your country?
Our major objective and priority is building a sustainable health system. Challenges that need to be addressed in reaching that goal are of a multiple character given the recent history of Bosnia and Herzegovina (BiH).

Specifically, the first challenge to be addressed is the enactment of completely new legislation adapted to the very complex constitutional and legal structure of the country, with totally new administration arrangements. The reconstruction and (re)equipping of health facilities devastated during the war is the next challenge. Over 30 per cent of health facilities were destroyed and in most of the remaining facilities the equipment was stolen, is outdated or is not functioning due to poor maintenance during the war.

While these first two challenges are specific to BiH, transition or adjustment of the health care system to market economy conditions is a common challenge for all former, so-called, socialist block countries. Reform, (that is, modernisation of the health system) is a challenge faced by the majority of countries, including even the richest democracies of the world. A specific feature of BiH is that in a very short time period, it has had to address all these challenges simultaneously, whilst at the same time facing the issue of shortage in both financial and human resources at macro and micro levels.

What do you consider to be the greatest problems facing your health system?
The major problem at this point is insufficient financial resources. Funds currently available in the Federation are almost two thirds lower compared to before the war (i.e. less than 150 DEM per capita in 1999, relative to about 400 DEM before the war). In direct contrast to this situation of less finances is the fact that needs are much higher due to a change in the epidemiological picture. For instance, we are facing increased numbers of patients with tuberculosis, even among young people, although this disease was under control before the war. There is an increased risk of epidemics, with the spread of some diseases that earlier existed only as isolated cases, such as AIDS. Over 70,000 persons require some form of physical rehabilitation because of injuries suffered during the war. There is an estimate that almost 15 per cent of the total population suffers from some form of mental disorder caused by the war.

What do you see as the major obstacles/threat to achieving the priorities that have been identified?

An unfavourable political–economic environment is the major obstacle to the establishment of an efficient and sustainable health system at the macro level. Privatisation of public ownership in the economy has not yet started, and workers are without salaries (many in fact having lost their jobs), including a health fund without revenues. There is still a high level of contribution and tax payment evasion, and employees are either not registered or contributions are paid for lower salary levels than actually apply – both in the private and public sectors.

Can you describe how you have tried to respond to these challenges?

Immediately after the signing of the peace agreement in Dayton, we decided to work simultaneously on all four major processes. Already in 1996, with technical assistance from the World Health Organization (WHO) and financial assistance from the World Bank Reconstruction Programme, we designed the Federal Health Programme as a framework for reforms and reconstruction of the health system.

"In a country with 13 Constitutions, 13 Parliaments, 13 Presidencies, 13 Governments and 12 Ministries of Health, there needs to be a great deal of effort and skill to establish an effective and sustainable system."

Constitutional, legal and administrative arrangements are such that they make establishment of an efficient and sustainable system an extremely delicate task. It must be recalled that Bosnia and Herzegovina – a country with a population of less than 4 million – is actually composed of two 'Entities' and, according to the Constitution, health care is the full responsibility of each Entity. The Entity of the Federation of BiH is composed of 10 cantons and the responsibility is, according to the Constitution, shared between the cantons and Federal authorities. Thus, in a country with 13 Constitutions, 13 Parliaments, 13 Presidencies, 13 Governments and 12 Ministries of Health, there needs to be a great deal of effort and skill to establish an effective and sustainable system.

There is still no widespread consensus on the degree of coordination needed between Entities. In the Federation BiH specifically, there is insufficient agreement between major political representatives and constituent peoples on the degree of integration or decentralisation, in general, that should be applied to specific sectors. This all contributes to slowing down the decision-making process. Given this situation, it becomes clear how such intrinsic factors can make it even more difficult to achieve sectoral objectives.

Two basic pieces of legislation – the Law on Health Care and the Law on Health Insurance – were adopted at the end of 1997 and beginning of 1998 respectively. We are currently implementing these laws, but are also in the process of reconsidering and changing the legislation to incorporate relevant solutions that have emerged during the process of reforms. Numerous other laws and regulations have been enacted and now we are about to adopt a significant law on pharmaceuticals.

Simultaneously with the reconstruction process, there is a process of health system reforms. With the assistance of the World Bank, the European Union (EU) and other bilateral and multilateral donors, we have initiated an ambitious programme of reform. The first project implemented with the support of the World Bank – 'War Victims Rehabilitation' – will be finalised within the next several months. Through this project, a completely new system of rehabilitation, both conceptually and tangibly – based on the local community – has been put in place. Two basic projects are still ongoing, namely 'Essential Hospital Services' and 'Basic Health'. Their objective is to strengthen existing hospital services, primary health care, and public health in general. The main directions of reform are related to health care services and financing.

In the area of health care delivery, the reform milestone was the strengthening of primary health care, and the introduction of the family doctor (actually, a concept of family medicine) into the system. A great deal has been done in this field. All medical faculties in BiH introduced family medicine departments. Specialist training in family medicine has been introduced at postgraduate level and, at the beginning of September 1999, 80 new specialists started their training in the Federation. They will be educated in existing institutions but also in newly established centres for family medicine within universities and satellite education centres within cantons. There is an ongoing education programme for existing specialists, both from primary and secondary health care, to become family doctors. Strengthening primary health care will release the pressure from secondary hospital care that will, in turn, result in a reduction in the number of beds. Strengthening diagnostics and curative capacities in hospitals and staff training – that is, the contents of the Essential Hospital Services Project – will reduce the length of stay in hospitals.

Financial reform is ongoing with the expert and financial assistance of the World Bank, the EU and its PHARE project, and the British Know-How Fund. Positive results of the reform are now being noted and, early in the second half of the year 2000, there is a plan to start with a new concept involving the collecting and administering of revenues, their distribution and process of procurement.

Who do you get your policy advice from, and how could these sources of advice be improved?

WHO opinions and documents have been the most valuable sources of information in the area of health care, and World Bank advice was the most concrete and useful in the area of health system financing. Generally, it can be said that it has been most difficult to get advice on the issues and problems associated with systemic global concepts, and much easier on issues related to relevant elements of the system. This includes family medicine, the organisation of physical or mental rehabilitation, the organisation of the pharmaceutical sector or even, in more specialised fields, such as issues regarding prevention or treatment of individual diseases like diabetes and tuberculosis. In my opinion, it is more important for countries in the process of independence and transition to receive advice related to global policy and the organisation and defining of overall priorities.

Where has the best support and advice that you have received come from?

I would put the WHO in the top position on health system reform issues, and we have had the best experiences with the World Bank as far as reconstruction and health financing are concerned. Of course, this was related to the issue of advice. In humanitarian aid and reconstruction, it would be hard to list all multilateral and bilateral donors, governmental and non-governmental organisations that gave their support to the health system in the Federation BiH during the post-war period. I would, however, like to mention some of them, including: the European Commission Host Organisation (ECHO), the World Bank, the governments of Japan, the USA, Netherlands, Great Britain, Germany, Croatia, Greece, Italy, and Canada, along with numerous other organisations and individual donors.

What is your strategy for achieving sustainable financing of your health care system?

Defining the basic package or basic standard that will be guaranteed to each and every citizen in the territory of the Federation is the priority. Financing this package should be on the basis of health insurance from contributions within health insurance institutions. In order to satisfy the principle of solidarity at federation level, a Federal Health Insurance Institution will be established. Some of the funds will be centralised for the financing of intercantonal solidarity on the level of the basic package, as well as the financing of tertiary health care measures in three university clinical centres in the Federation for citizens from all cantons. Others will go to the financing of relevant vertical programmes (dialysis or TBC, for example), and central procurement of some pharmaceuticals and equipment.

A forthcoming law on pharmaceuticals anticipates the introduction of an efficient mechanism of price control. Allocation of part of the responsibility for health financing to cantons will provide an incentive to the cantons to maximise their involvement in both revenue collection and efficient spending. The introduction of additional and private health insurance schemes services beyond the basic package will mobilise both the local community and individuals to take greater responsibilities for health and, additionally, will inspire further sources of financing. Of course, reforms in the area of health care delivery and the strengthening of primary health care should also provide for cost reduction.

What do you see as appropriate public and private roles in health care?

The public sector should be the basis of the health care system, at least in the transition period. Privatisation was first initiated in the pharmaceutical sector, followed by dental services, and it happened spontaneously; though of course within the legal framework. We systematically plan to initiate privatisation in the primary health care sector through privatisation of service delivery, with contractual arrangements between family doctors and health insurance institutions on a capitation basis. But, offices and equipment from current health centers will be rented to doctors since they are not yet in a position (financially) to purchase those facilities or open their own ones – although they will eventually be able to do so. Currently, there are no plans to privatise or sell existing hospitals, although private practitioners may rent some parts of these facilities by signing a contract with the hospital, but without payment from compulsory health insurance funds. We see more accelerated introduction of the private sector in hospital health care only after the establishment of private health insurance.

Do you have any advice for other Ministers of Health?

It would be too pretentious to give advice on anything to Ministers of Health of developed countries in the western hemisphere. The advice I could give to countries in transition, or to those in the post-conflict period, is related to the good definition of priorities. It is necessary to build a system using the positive experiences from the inherited model and a very cautious course of privatisation. During the war and immediately after its conclusion, we identified the fight against communicable diseases as a top priority, especially those that could be prevented with vaccination. We also gave priority to primary health care – because there we have the most favourable ratio between input and output – along with the prioritisation of essential hospital services.

What has surprised you most about being Minister of Health?

Most surprising was just how much the population health is affected by factors beyond the health care system itself, such as economic and social milieu, education level, cultural factors, genetics, etc. Generally, professional and administrative staff involved in health tend to overestimate their role. Therefore, I think maximum energy should be devoted to the promotion of health and the prevention of disease; particularly targeting the youngest categories of the population. Health cannot be improved, it can be only preserved.

The State Secretary of the Kyrgyz Republic

Dr Naken Kasiev[*]

What do you see as major challenges and priorities for health in the Kyrgyz Republic?

For me, the major challenge is to speed up the ongoing reform process. In particular, the creation of a sufficient number of family group practices is a central part of the revitalisation of primary care, along with a shift in focus from hospital to primary care.

Of equal importance are issues such as the adjustment of health care funding mechanisms, the fight against major health risks like infectious diseases (tuberculosis, HIV/AIDS, etc.), and the improvement of mother and child care. In the Kyrgyz Republic we have recently decided to introduce the pooling of funds (from the budget and health insurance contributions) at the oblast level. This, together with changes in the provider-payment system, creates more incentives for the effective and efficient delivery of services.

What, in your opinion, are the greatest problems facing your health system?

The lack of sufficient financial means and the budget deficit are certainly the greatest problems for the Kyrgyz health care system. Many times it is difficult to pay salaries. Money for urgently needed building repairs is scarce. Next to that is the difficulty in collecting all contributions for the Health Insurance Fund. Our new law on health insurance, which has just has been accepted by Parliament, will organise some more transparency in the collection and distribution of funds.

What do you see as major obstacles to health care reform and what have been your response(s)?

Implementation of health reform is not an easy process. It has been difficult to sell the reform to the doctors, who were at one stage trying to torpedo the reform. It is, therefore, crucial that one adequately explains everything to one's colleagues in this process. Inadequate press releases regarding the aims and intentions of the reforms and how they were intended to work, have also proven an obstacle. Nevertheless, the reform coordination committee, called the Manas Team, has proven very supportive in the implementation of the reform. I am proud to say that 90 per cent of the Members of Parliament are strongly supporting our reform. The new insurance law and the pooling of funds also represent great leaps forward.

Where do you get your policy advice from ?

The World Health Organization (WHO) and World Bank – both with offices in Bishkek – have been sources of information. But also, the support of the British Know How Fund for the restructuring of the hospitals in Bishkek, and the contribution of the United States Agency for International Development (USAID) to the retraining of nurses were quite useful. As regards advice on specific diseases, I would like to refer to the introduction of the new Directly Observed Treatment Short-course (DOTS) approach to tuberculosis, as supported by the WHO.

Health care reform will be an ongoing process. The WHO is planning to create a regional committee for Central Asia, but I prefer direct advice addressing the needs of my country specifically; or else, to secure the financing necessary to allow us to organise it in the manner we see best.

* In November 1999, Dr Kasiev resigned as Minister of Health to become State Secretary. His successor is Dr Tilek Meimamaliev, who was deputy minister before, and is now in charge of implementing the reform programme.

What are your views on the sustainability of the reform process?

An important tool in reaching financial sustainability is the extension of the health insurance system, i.e. funding health care to a greater extent from insurance contributions as well as expanding coverage to a larger part of the population under the insurance umbrella. We must try to find a solution for the system of informal payments, especially for the poorer people in our country. These informal payments can sometimes prevent people from getting timely access to the system.

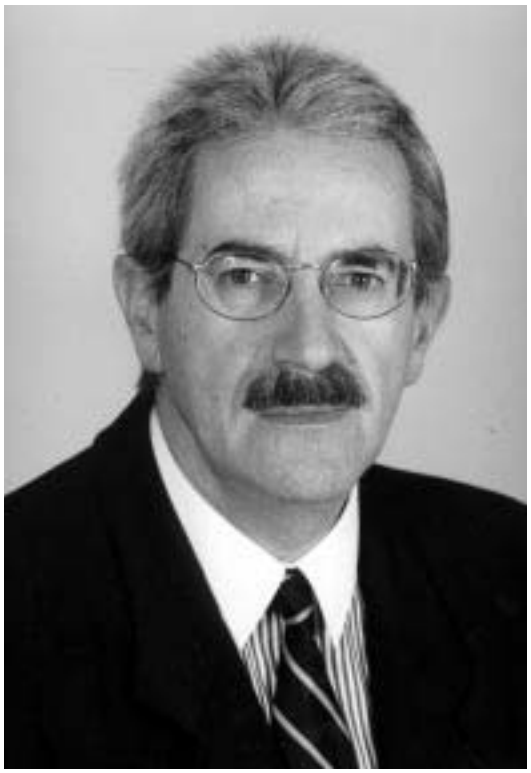
As regards funding, I see a 50-50 division between the national budget and the health insurance scheme. The state should prevail in guaranteeing access to appropriate health care for the population. I would like to prevent the private sector from growing too much. Certainly some regulation of private practice is needed, especially regarding the quality of care.

What has surprised you most about being Minister of Health, and have you any advice you could impart to ministers in other countries?

First, if there is anything I have learned in the past 6 years that I have been in office, then it is the need for reform to be taken step-by-step; and sometimes it is necessary to think things over and over again before you decide on any reform policy or concrete step. Paying attention to public relations policy is also advice I would like to give to my colleagues.

The difficulty in convincing my former colleagues working in the hospitals and polyclinics of the need to reform, was my biggest surprise. One really needs to create adequate communication lines with all the stakeholders.

Considering changes in the Slovak health care system



The Director of the General Insurance Company

Dr Eduard Kovč

What are the main characteristics of the new Slovak health system as compared to the previous one?

The health care system in Slovakia has undergone fundamental changes since 1989. In November 1990, the government approved a policy document entitled 'The principles of the health care reform'. The main reform principles it suggested were: de-monopolisation and decentralisation of the system, and a process of privatisation to be carried out through changes in the organisation and management of health services, and in legislation and financing. The state health care model was to be replaced by a mixed system of state and non-state elements.

And, since 1993, the funding system under the previous Semaško model was switched into funding under the Bismarck model.

Health policy reform in the Slovak Republic has been extensive – in some regards positive or even impressive – but has also seen several failures and controversies. From this standpoint it is necessary to note that during the nine years of transition, there have been eight ministers of health. The Ministry of Health (MoH) nevertheless still played the dominant role in managing the health care system during this period of turmoil, but the changes of ministers did result in divergences – of varying magnitude – from the reform policy objectives.

The most permanent feature of the reform process was the constant change. In 1997, the need for a redefinition of the reform steps became apparent. Parliamentary elections in September 1998, crystallised sufficient political will to actively pursue with the implementation of the reform.

What changed and what remained the same?

Mainly the thinking has changed. Not only the thinking of health care workers but even that of citizens, policy-makers and funders. That said, this cannot unequivocally be seen as positive or even as progress. For, unfortunately, the behaviour of people often remained the same.

One of the biggest issues of the transformation process in Slovak health care is the difficulty in implementing specific strategies (despite their clear definition) and objectives into practice. Two main reasons for this exist. First is the fact that implementation is often political and managerial rather than a common sense issue. Second, the external environment exerts pressure on the Slovak health care system, particularly in terms of public expenditure growth.

Expenditure on health care in Slovakia is growing faster than GDP. The population is ageing, the birth rate is sinking, and the structure of illness is changing. The implications of medical technology developments are also subject to dramatic change; both in direction and speed. And, consequently perhaps, citizens' expectations and patients' demand are rising constantly. What has remained from the old system, however, are the limited financial resources. They are not only limited, but also their structure is poor. Some 96 per cent of health expenses come from public sources. The indicators in Table 1 attest to these pressures.

Table 1 SELECTED HEALTH INDICATORS IN THE SLOVAK REPUBLIC, 1999

Number of inhabitants	**5,387,000**
Male (%)	48.7
Female (%)	51.3
65+ (%)	11.2
Life expectancy at birth (years)	
Male	68.8
Female	76.7
Mortality rate (per 100,000) by:	
cardiovascular diseases	519.2
cancer	207.3
respiratory diseases	70.4
Infant mortality (per 1,000 live births)	**10.1**

The pressure on public resources is constantly growing and, moreover, the system is not sustainable. This is the reason why, at present, the political will exists not only for increasing the percentage of GDP dedicated to health care, but also for changing the structure of resources; mainly aimed at attracting private resources.

How would you evaluate the changes in the Slovak Republic compared to those in other neighbouring countries? What was achieved and what would you not repeat if you were to do it again?

All Central and East European countries (CEEC) have, in general, been undergoing the same overall process. They are founding new systems which are in permanent conflict with their 'wide' legislation and their very limited financial resources. The idea of free health care has been retained in the minds of most people, but currently, the basic benefits packages are too large and funding too low.

On the other hand all CEEC have carried out major changes in their health care organisation and management, and in legislation and funding. Many positive changes have resulted, including a general enhancement in health care quality and the improvement of the managerial capacities of top managers. However, the fundamental objective of reform – the reasonable improvement of health status of population – has not yet been achieved.

If, theoretically speaking, there were a chance to go back to the beginning of the reform process and to start again, I do not believe that procedures would be changed in general. We are people and people often repeat the same mistakes. However, in considering each case or step individually, I would, myself, spend much more time over its theoretical preparation. Proper and practical preparation of managers who were responsible for implementing the changes should have been given more emphasis. More time too, could be spent on changing incentives for providers, and last, but not at least, I would spend more time on keeping citizens fully informed about the reform process. No matter how perfectly a specific reform pro-

posal might be planned and prepared, its chances for success are slim without having ensured an adequate institutional basis responsible for its implementation.

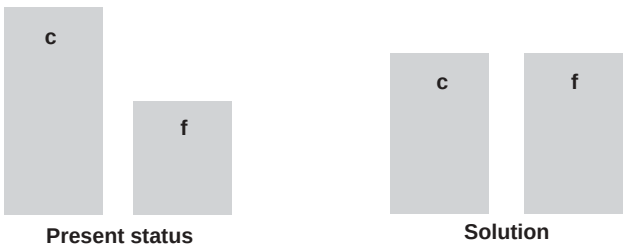
Looking at the recent financial situation of your Institute: are you faced with debts as is the case in many other CEE countries?

Five health insurance funds share responsibility for health insurance in the Slovak Republic. The General Health Insurance Fund Company (GHIC) is the biggest insurance company and covers 67 per cent of insurees in the health insurance market. The whole system is working at a deficit which amounts to more than 20 per cent of total Slovak heath care financial resources for 1999. The situation in the GHIC is similar: total resources for 1999 will be around 120 million Euro and debts are about 46 million Euro. In reality, the indebtedness results primarily from the necessary prolongation of the terms of payment extended to providers; these significantly deform the system on the whole.

You have recently begun introducing a new basic health package: what would be included and excluded?

One of the most enduring characteristics of Slovak health care is the discrepancy between the extent of services provided – as stipulated by the Basic Benefit Order Law – and the disposable financial resources for health care coverage. It is a typical post-socialist condition. Citizens are used to a situation where accessibility, adequate quality, and the free of charge delivery of health care are guaranteed to them in accordance with the constitution. Health care has, however, never really been free of charge in reality, but not even the decision makers who support the reforms are willing to acknowledge this reality. Thus, the fundamental balance needed between the extent of health care coverage and disposable financial resources available has not yet been realised. Compulsory health insurance can only cover such a health care package which is first afforded by current financial resources – in other words, that which is covered by insurees or state contribution.

Figure 1 SOLVING THE HEALTHCARE DILEMMA



c- number of providers, number of hospitals, number of beds, number of health workers, poor structure of hospitals and insufficient human resources allocation, quantity of medical technologies, large legislation

f- financial resources

What could be a potential solution to such difficulties?

To improve the current situation, it is necessary to take a closer look at our history and to take into consideration our mistakes. The need for change can be represented, in simple format, in Figure 1.

Based on this situation, political decisions were taken towards restricting the existing health care package covered by compulsory insurance. The proposal is to limit coverage for drugs, medical aids, dental care, and transport services. Co-payments are to be introduced for in-patient care, and full payment for homeopathy, acupuncture, social services, some services of rehabilitation and in-vitro fertilisation.

Are there any changes in managerial skills in the Institute as well as in the hospitals and on the primary health care level?

The shortcoming, mainly in 1990 and 1991, was that few people were prepared either for reform or the processes of management changes this brought. However, the intensive training and education of a wide range of employees working in the fields of strategy, finance, service, human resources and information management has been developed very quickly.

How do you see the insurance business developing in Central and Eastern Europe over the next few years?

There is no doubt that social insurance can be developed, but the system will be under a good deal of pressure. For as the population is ageing, this will lead to a limited flow of resources coming from insurance and a restriction of costs from public financial sources. The principles of solidarity, equity, economy, not-for-profit along with maintaining the public character, must be balanced against future principles of competition and state regulation. In order to ensure the free movement of persons, goods, services and capital, CEE countries will have to undertake intensive efforts to consistently ensure conducive legislative and economic conditions.

The unofficial business of health care in transitional Europe

Tim Ensor

"Very few of the health reforms proposed in transitional countries directly address the problem of unofficial payments."

The popular Kazakhstan newspaper *Caravan*, regularly asks readers why they pay money to doctors. These are not private doctors. Neither are they officially recognised charges. These are payments made to those employed by the public sector to deliver free of charge care. In the transitional economies of Eastern Europe and Central Asia this is increasingly being recognised as the foundation of a third health care sector which is neither public nor private.

In the early stages of transition such practice was recognised usually as a footnote to reports on the process of change. There is now a growing amount of evidence, both systematic and anecdotal, that unofficial payments for health care contribute significantly to funding in countries as diverse as Poland, Bulgaria, Russia, Kyrgyzstan, Turkmenistan and Kazakstan.[1,2] Although payments were certainly a feature of the Soviet system, there is evidence that their scale has increased since the start of transition.[3] Just as importantly, the reasons for these payments could distort the impact of policy reforms now being pursued across the region.

Tim Ensor is currently based in Dhaka, Bangladesh, where he is working as Team Leader of the Health Economics Unit in the Ministry of Health.

Typology

There are a number of ways of distinguishing between types of unofficial payments. A basic distinction is between those that are paid to facilities and those to individual practitioners. Institutional payments are sometimes described as quasi-official, informal or grey payments, reflecting their semi-institutionalised status. A second distinction is between in-kind and monetary payments.

At the individual level there is a difference between payments that contribute to the basic costs of care, those that provide patients with enhanced services and, finally, those that are obtained without any benefit to patients as a result of a misuse of a health worker's power.

Contributions to cost

The macroeconomic decline experienced in most transitional economies of Eastern Europe and Central Asia has contributed to a corresponding reduction in real health spending. This has led to a growing gap between the spending required to fund the existing infrastructure and available resources. This gap has probably been increased by a growing awareness and demand for expensive health care technologies commonly available in Western Europe.

Spreading resources more thinly means that patients must commonly contribute towards the cost of medicines, food and other supplies required for their treatment.[4] Given the very low relative level of medical wages, the payment of which is often delayed, some unofficial payments to medical staff might also be thought to be contributing to the costs of services. Otherwise, staff would take other action to ensure a subsistence income by reducing numbers of hours worked or turning up tired for work because they are forced to do night shifts in other employment.

Improvement in quality

Patients can seek enhancement to service by paying for better quality services. Non-medical quality can be improved by obtaining better food or rooms. While these are often the subject of unofficial payments in developing countries,[5] in transition countries it is more usual either for patients to make official payments for such 'luxuries' or for relatives to bring 'home comforts' to the hospital.

Perhaps more important is the ability to enhance the medical quality of care. One example is to obtain treatment from a doctor of choice. In the *Caravan* survey reported above, the most often cited reason for unofficial charges was to ensure access to good quality doctors. Another is the ability to choose superior treatment technologies such as minimally invasive surgery or orthopaedic pinning rather than leg traction.

Misuse of power and market position

Staff may also seek to obtain payments as a result of their powerful position in the market. It is alleged, for example, that one of the reasons for long patient lengths of stay in Romania is because doctors keep

patients waiting for operations, not because supplies are unavailable, but in order to increase the payments.

In Central Asia, there is a story of a doctor talking to a patient on an operating table. "How many goats can you see" the doctor says to his patient. "One goat" the patient replies to which the doctor replies "not enough try to see more". Once an acceptable number of goats is described the operation proceeds.

There are an increasing number of reports of doctors receiving large payments from patients that appear to exceed reasonable 'contributions to costs'. In Albania, for example, *Klan* magazine found that payments for a single procedure could exceed a month's income for a doctor.[6]

The above stories point to a fundamental problem with unofficial payments. This is that it is often difficult for patients and policy-makers to distinguish between genuine reasons for delays in treatment requiring unofficial expenditure, and those that are based on the misuse of power and lack of accountability.

How do payments influence reforms?

Unofficial payments are important for a number of reasons. First, they may distort priorities by channelling resources to services that are more profitable to individual staff rather than necessarily the most effective. Second, some represent waste since patients are forced to pay extra for a service as a result of a misuse of power. Third, they represent a growing barrier to obtaining access to services by those on lower incomes. Arguably this effect may be greatest in urban areas where community solidarity to protect the poor is less strong.

"It is often difficult for patients and policy-makers to distinguish between genuine reasons for delays in treatment requiring unofficial expenditure, and those that are based on the misuse of power and lack of accountability."

One way to view unofficial payments is as visible evidence that a hidden economy, neither private nor public, is operating in the health sector. Staff within hospitals may be operating, either individually or in teams, as mini firms selling services to patients at market rates but subsidised by public resources. Although such a hypothesis is difficult to sustain for an average district hospital where the hospital director has considerable influence, in large urban hospitals where many respected specialists work it is perhaps more tenable.

Thompson and Rittmann,[7] for example, writing about a large specialist hospital in Kazakstan show how patients are referred and treated by an informal network of doctors within the hospital, all of whom benefit financially from unofficial payments made by the patient. Treatment may be carried out partly in the public facility and partly in private facilities used by the treating doctors. The doctor uses the hospital a bit like a private physician would use a public hospital for treatment in the west. The difference is that the behaviour is unregulated and there is no accounting for money that changes hands.

A fourth reason is that they may render health reform policies less effective. An example is the reform of payment systems. Many transitional countries are changing the basis of reimbursement of hospitals from one based on a bed capacity led system to one determined by the number of patients treated. Hospitals are encouraged to discharge patients quickly. Unofficial payments could contradict this incentive if staff find they can obtain more revenue by keeping patients in hospital for longer to provide more, perhaps ineffective, medical treatment and extra hotel services. The overall impact requires empirical validation, but it is inevitable that if staff obtain a significant or even dominant proportion of income from unofficial sources, then the effect of changing the way in which they receive their official income will be diluted.

Regulating unofficial payments

Very few of the health reforms proposed in transitional countries directly address the problem of unofficial payments. Reducing the level of services guaranteed by the state can be used as a way of increasing real wages within the sector and so reduce the level of cost contributing unofficial charges. Such changes imply substantial reductions in health care infrastructure and overall staffing. Few countries, with the exception of Georgia, which was forced to address a decline in budget of 95 per cent, have managed to undertake a radical reduction in the scope of services promised by the state.[8]

One possible solution is to formalise unofficial payments. Logical as this may seem, there are objections. One is that it could take away some of the ability to choose treatment or doctor since patients would pay a cashier and then be assigned a doctor. A second is that the payments may not directly benefit staff and unofficial payments, which are also 'tax-free' additions, would still be required. Finally, it might eliminate informal cross-subsidy where doctors choose to provide treatment to the poor using resources obtained from the rich. On the other hand, it could correct the less equitable aspects of unofficial payments when patients are forced to pay what they cannot afford.

If doctors regard their job as their own to exploit as they wish there is a need for a change in health sector governance. This could be done in a variety of ways. One way is to use incentives such as limited term contracts that increase remuneration for good staff in return for a commitment to the organisation that is regularly assessed. Another is through a more transparent and

easy-to-understand complaints process and system of patient rights. The latter assumes that patients consider payments to be fundamentally unfair and may require policy-makers first to address the resource inadequacies that cause unofficial cost contributions.

To distinguish between the payment types is of crucial importance. Policy-makers could, for example, mistake cost contributions for a misuse of professional power and introduce harsh sanctions for accepting payments. Since unofficial payments are a main motivation for staying in their job, some would leave their posts. Since it is likely that the first to go will also be the better motivated and well trained staff who could also obtain high incomes outside the sector, the policy would be counter-productive.

Finally, it is important to recognise that, for many countries, unofficial payments are part of a wider corruption malaise that is endemic in all parts of society. If resource allocation decisions over where to build a hospital or how to use the funds of a health insurer are influenced by civil servants or politicians outside the health system, it is largely futile to penalise a doctor for taking a few dollars 'under-the-table'. Lasting action requires a more wide ranging policy-debate and agreed action by society.

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Affording out-of-pocket payments for health services:

Evidence from Kazakhstan

Nazi Sari, John Langenbrunner, Maureen Lewis

Publicly funded and provided health care systems are typically characterised by services that are free of charge, or have nominal user fees collected. This is certainly the case for a number of Former Soviet Union countries – even now – as they struggle to modernise and diversify their health care sectors. In this article we look at the evolving role of financing of services, in particular the increased reliance on out-of-pocket spending in Kazakhstan.

Health status and the use of services

The countries of the Former Soviet Union (FSU) enjoyed a tradition of universal access to health care services, as well as considerable investments in curative medicine, prevention, water and sanitation. Health service coverage was, in principle, comprehensive and free to all citizens. Kazakhstan has had relatively good human development indicators and is ranked somewhere between established market economies and middle income countries. However, the country has seen a marked deterioration in such indicators in recent years. Life expectancy has been dropping through the 1990s, and in 1996 was only 58.9 years for males and 70.3 years for females, compared to an average of 64 and 74 respectively for the 1990–1995 period. There have been slight increases in infant mortality, and there are worrying signals regarding the re-emergence of infectious diseases.[1]

Some of the deterioration in health indicators can be attributed to the country's economic collapse following the

break-up of the Soviet Union. GDP has been decreasing dramatically (-10.4 per cent in 1994, -17.8 per cent in 1995 and -8.9 per cent in 1996), through to the mid-1990s. The economic base has been further eroded by high inflation, the end of subsidies from Moscow, and difficulties in collecting tax revenues.

Out-of-pocket spending

The funding crisis has encouraged health sector leaders to consider alternative forms of revenue over the last 5–6 years: such as a employer payroll tax, supplemental private insurance and consumer co-payments. Nominal co-payments have been introduced in some areas, including flat payments for each polyclinic visit, and for each day in the hospital.[2] Pharmaceutical prices have been de-regulated and are no longer covered on an outpatient basis unless an individual falls into one of the special subsidy categories; such as the elderly, disabled, poor, children under three years old, and Chernobyl workers.

Political leaders need to seek alternative sources of funding for the health sector but, given the tradition of free care, are not always willing to openly make large-scale changes such as cutting the use of free benefits through the political or legislative process. Nevertheless, informal direct consumer payments for a variety of services are apparently being used (perhaps with greater frequency) to generate more revenues for providers and local facilities in FSU countries. Anecdotal reports and household surveys further suggest that individuals and families are being asked to pay more for services on both in-patient and outpatient bases through the use of informal payments.

For instance, a 1994 survey of some 5,000+ households in the region of South Kazakhstan found that informal payments to providers were common for both outpatient and in-patient care.[3] On an outpatient basis, payment was made for 27 per cent of home care visits (with a single payment estimated at 32 per cent of average monthly income), 3 per cent of polyclinic visits (with payments at 26 per cent of average monthly income), and 6 per cent of preventive check-ups (with an estimated single payment of 55 per cent of average monthly income). On an in-patient basis, payment was made to providers 11 per cent of the time, and 12 per cent for surgeons. In addition, 25–42 per cent of those who were hospitalised had to provide their own bedding, clean laundry and food, and 57 per cent even had to provide their own pharmaceuticals.

While the 1994 study looked at one region, the statistics we refer to as our own are generated on broader-based data on out-of-pocket spending from a 1996 Kazakhstan Living Standards Survey. This was multi-purpose household survey implemented by the Kazakhstan National Statistical Agency under a World Bank-financed technical assistance project. The information collected from sampled households includes income, expenditures, the nature and quality of housing, characteristics and demographics of the household, labour force status, educational attainment, health status and use of health services. The sample consisted of 1,996 households and 7,223 individuals, and was conceived to be nationally representative. Thus, although not designed to be representative at a sub-national level, it is sufficiently large to obtain indicative results at the regional level for five main regions of the country.

Table 1 PATIENT PAYMENTS BY LOCATION AND INCOME GROUP (as a percentage of monthly income)

	Rural	Urban	Poor	Non-poor
Physician visit				
Direct payment	6.16	4.29	17.33	4.23
Cost of travel time	1.09	0.63	0.65	0.78
Cost of waiting time	0.41	0.38	0.30	0.39
Direct travel cost	3.03	0.50	2.62	1.23
Total cost	10.69	5.80	20.89	6.63
Hospital	56.94	90.12	251.69	54.31
Medicine	15.50	10.84	39.06	10.83
Additional medical procedure	6.73	7.07	38.06	4.85
Preventive care	6.72	2.99	2.78	3.84

Findings

The 1994 survey in the South Kazakhstan oblast found that the average cost of pharmaceuticals per household for each hospital admission was 289.6 per cent of monthly household income; cost per physician visit was 171.7 per cent of household income; and 110.6 per cent of household income for home care.[4] Interestingly, our survey, based on the 1996 national data, does not show such a severe impact regarding payments for pharmaceuticals.

As a percentage of income, rural patients paid relatively more for physician visits, medicines, and preventive services (Table 1). Urban dwellers paid more as a relative percentage of income for hospital care. For both groups, hospital care was, on average, a sizeable portion of monthly income. The poor appear to be especially hard hit, as hospital service costs were more than 2.5 times their monthly income.

Costs of physician care

There are both monetary costs (i.e. payment for travel) and non-monetary costs (i.e. travel and waiting times) in seeking physician care, and together they are important determinants of medical care choices. Specific to the latter, several studies have shown that time cost is an important device in rationing demand for services.[5]

Access to health services in Kazakhstan is a significant issue, either because of the cost of travel, or because of the difficulties involved in travelling long distances

during the winters. Other contributing factors include a lack of access to private cars, and significantly reduced public bus transport between rural areas and health facilities. Time and transportation costs must be factored in with the relatively low density of population and a relatively low 57 per cent of population in urban areas. Likewise, time and travel costs may have an impact on the equity of services.

Individuals in rural areas spend 2 per cent more of their income on payments to physicians, but the effective cost of a visit is 5 per cent higher than that in urban areas (Table 1). The difference is due to higher travel costs to health facilities. What we do not know is whether rural patients are using local facilities in rural areas or travelling to urban areas for what is perceived as higher quality care.

As in generally the case, the poor are hardest hit; spending over 17 per cent of income for direct payments to physicians per visit; this figure is only 4.2 per cent among non-poor. When we compare the effective cost for visit, the divergence between the poor and non-poor increases to 20.9 per cent and 6.6 per cent.

Implications for national health sector expenditures

While hospital care is 'free' under the constitution in Kazakhstan, there were no direct questions in the survey about the formal or informal nature of the payments. There are, however, different approaches in quantifying the extent of total consumer out-of-pocket payments, both formal and informal. For instance, a 1998 study used different residual costing methods to calculate estimates for informal patient payments for pharmaceuticals in hospital, then extrapolated to health expenditures overall.[6] Their results suggested an overall out-of-pocket contribution of between 25 to 30 per cent of the 1996 national health budget. To compare our results with these, we calculated per capita spending estimates for all services (Table 2), then extrapolated to the national level. Our estimate of patient contributions of 32.5 per cent of overall expenditures are slightly higher, but still very similar, to those of the 1998 study.

Table 2 NATIONAL EXPENDITURE ESTIMATES FOR OUT-OF POCKET PAYMENTS

Type of Service	Payment per capita (tenge)	Payment per capita ($ US)	Implied national spending (million $ US)	Portion of total health spending (%)
Physician visit	59.72	0.88	14.54	1.60
Hospital	236.91	3.50	57.69	6.36
Medicine	814.15	12.02	198.25	21.85
Additional medical procedure	64.87	0.96	15.80	1.74
Preventive care	36.80	0.54	8.96	0.99
Total	1212.44	17.89	295.24	32.53

Discussion

The survey methods and data only permit a partial perspective on formal versus informal payments by consumers for health services. As we know what is legally covered and that which, formally, is 'free', these findings provide a relative measure of the degree informal payments are a feature of Kazakh health services. At the same time, survey questions do not allow one to disentangle precise amounts regarding pharmaceutical payments on an in-patient versus outpatient basis. Nor do the low response rates for some categories permit a more focused analysis by region or by population group. The analysis here nevertheless raises some general questions about the relative utility of the World Bank's Living Standards Survey for health sector decision-making purposes; either by the Bank or the government. The Bank's interest in poverty and health is, for example, very incompletely addressed through this survey effort.

Nevertheless, some of the findings can be of assistance to current (and future) analysts and policymakers interested in the reform process. First, the data clearly provides the most complete picture of consumer spending for health services to-date. Second, the analysis suggests that both formal and informal payments constitute a significant part of health spending in Kazakhstan. Of definite value – despite being discouraging – is that the data suggests that the poor are being disproportionately hurt. This, despite the special coverage extended to vulnerable groups by the government. Finally, the time and travel, as well as direct costs, suggest that there may be crucial issues relating to access to health services. Consumers are often asked for payments at the point of service, even for services of high public health benefit such as preventive care, and this serves to wider already extant inequalities.

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User fees in Azerbaijan

User fees play an increasing role in the financing of health care services in low and middle income countries, especially as part of World Bank supported structural reforms. This article is aimed at describing the current status of user fees utilisation in Azerbaijan.

Kamil Melikov

Ramiz Alekperov

User fees have, as a financing instrument, been widely introduced in Azerbaijan since 1994 (following Presidential decree).[1] Prior to that, user fees were collected in only a very limited number of medical facilities, where well-known specialists provided consultations on a part-time basis. During the Soviet period, perhaps no more than five facilities in the whole country were charging for their services. In 1998, the number of public health care facilities that obtained permission from the Ministry of Health to charge for their services was 414 (or 10.4 per cent of all public health care facilities).

In 1998, the breakdown of those facilities charging user fees was as follows: 53 per cent by in-patient centres; 31 per cent of out-patient centres; 8 per cent of dental centres; and 8 per cent 'other'. The 'other' category includes medical research institutions, resort clinics and blood-transfusion centres. It is necessary to point out that outpatient clinics that were entitled to charge for their services made up 14.5 per cent of a total of 875 public outpatient facilities. Those dental care facilities charging user fees comprised 72 per cent of 45 public dental care facilities, and for in-patient clinics, the corresponding number was 33.7 per cent of 656 public hospitals in country.[2] It also should be mentioned that in hospitals, only the provision of diagnostic and hotel services for fee has been authorised.

In Azerbaijan, user fees were introduced mostly in order to attract additional financing for the health care services, so as to help alleviate the burden health expenditures imposed on the budget. In 1996, with these aims in mind, the plan was to finance not less than 40 per cent of health care needs via user fees. In 1997, user fees provided 40 billion manats (approximately US$ 10 million) or, up to 20 per cent of the overall health budget.[3]

Two mechanisms are utilised by the financial department of the Ministry of Health to increase funds raised by user fees. One is the shadow pricing of health services; where prices in public health care institutions are set at the level of under-the-counter payments and fees charged by the very limited number of private providers available. Another mechanism is that prices recommended by the Ministry of Health are the lower limit of fees that might be charged by health care facilities. Actual fees chargeable for the services by facilities should be approved by the financial department at the Ministry of Health and made available for review by all clinic attendants.

An important issue is the potency of user fees to raise funds for health care and their effect on the system of under-the-counter payments. Unfortunately, there has not been any research carried out to estimate the value of the 'black market' in health care, neither before nor after the introduction of user fees in health services. The only way to judge the gross amount of under-the-counter payments is via totals of population health care expenditure obtained from household survey(s). These are given in table form on the next page and show that health care expenditure actually decreased by 21 per cent between 1990 and 1994, though was followed by an increase of 41 per cent by 1995. While the reduction of health care expenditures between 1990 and 1994 might be explained by the 55 per cent decrease in population income since 1990, the following increase in health care expenditures cannot really be correlated with the simultaneous reduction in population income by 17 per cent over the same period.

The impact of user fees on the 'black market' in health care is quite difficult to evaluate, though it should be noted that revenue from user fees made up 1.5 per cent of total health care expenditure in 1994 and 1.7 per cent in 1995. It is obvious that the rest of total health care expenditure

HEALTH CARE EXPENDITURE IN AZERBAIJAN

	1990	1994	1995
Total income of population in real terms (manats)*	974,900,000	1,215,941,700,000	6,702,722,700,000
Total income of population in 1990 manats	974,900,000	438,345,379	363,266,462
Total expenditures of population in real terms (manats)[4]	930,100,000	966,342,500,000	6,378,896,100,000
Total expenditure of population in 1990 manats	930,100,000	348,365,196	345,716,080
Health care expenditures as % of total expenditures[5]	1.70%	3.60%	5.10%
Health care expenditures of population in real terms (manats)	15,811,700	34,788,330,000	325,323,701,100
Health care expenditures in 1990 manats	15,811,700	12,541,147	17,631,520
Revenue from user fees reported by ministry of health (in 1990 manats)		536,200,000 (193,299)	5,600,000,000 (303,502)
% of reported user fee revenue in health care expenditure of population (calculated from household survey)		1.54%	1.72%

* Data collected from Household Survey.

of the population was spent on medicines, 'under-the-counter' payments and other health related activities; though it is impossible to estimate the value spent on 'under-the-counter' payments from the data available, and the pharmaceutical market is largely uncontrollable.

A separate issue that arises in connection with user fees is the question of an exemption mechanism. In Azerbaijan the exemption is based not on means testing, but by association with characteristic groups of population. Direct targeting with means testing is administratively expensive and is, for this reason, as yet unavailable. Thus, there are five main exemption groups: veterans of different wars – beginning with the Second World War – and relief campaigns; disabled people, victims of diabetes mellitus, and pregnant women; pensioners (men above 65 and women above 60) and adolescents and youth of conscription age; internally displaced people (IDP) and refugees; and finally, medical personnel and educators. The latter are exempt only from user fees for obligatory periodic examination.

Exempted groups make up at least 26.8 per cent of the population. This estimate includes 219,000 refugees and 571,000 IDPs; 950,000 adolescents and recruitment age youth; 430,000 pensioners; and 167,000 disabled.[6] Although a substantial part of the population is currently exempted, it might serve the purposes of equity if a more adequate system of exemptions could be developed. For, it is the case that some exempted groups i.e. the disabled and elderly population, are in fact the most frequent users of health care services; that which might affect the revenue from user fees.

The last, but not least, issue related to the application of user fees in Azerbaijan is that of using the finances collected. Up to 50 per cent of collected monies could be allocated for the salaries of personnel involved in the provision of services. However, according to existing financial regulations, as approximately 37 per cent of an individual's salary should be contributed towards different social security funds, this might serve as a limiting factor where the salary allocation of raised funds are concerned. This is an important consideration in the case of substantial amounts being raised by user fees. A further 5 per cent of collected fees should be transferred to the Ministry of Health, and the rest of out-of-budget funds could be spent on activities related to the provision of services. This amount varies significantly in both real and proportional terms, depending on the revenues raised from the user fees.

Discussion and recommendations

The problems associated with user fees are basically related to issues of equity and the fundraising power of the mechanism. Population living standard is decisive in determining funds that might collected. In this sense, the situation in Azerbaijan is not entirely favourable for the use of user fees. In this vein, a World Bank poverty assessment classification denoted 68 per cent of households as 'poor' and 'very poor'. The average salary in Azerbaijan (US$ 19) makes up 24 per cent of the minimum consumer basket (US$ 77.4).[7] Nevertheless, user fees compose a substantial 20 per cent of the total health care expenditure. Considering the practice of 'under the counter' payments in Azerbaijani health care services since Soviet times, the introduction of user fees was quite an important measure to regulate

patient charges and mainstream them into health facilities' budgets.

It was with respect to considerations of equity and, given the administrative expenses involved with means testing, that the Ministry of Health defined the exemption groups already mentioned. It is, therefore, not surprising that that this system was adopted and that an exemption system which included all of the vulnerable groups in the population was initiated. However, the uneven geographic distribution of wealth and exemption groups undermines the value and process of collecting fees. Thus, average funds raised by user fees make up 20 per cent of local budgets, though in one of the poorest rural districts of Azerbaijan, Qusar, collected fees comprised only 2.2 per cent of the budget. A similar situation has been reported in other rural facilities as well.

"The situation in Azerbaijan is not entirely favourable for the use of user fees. A World Bank poverty assessment classification denoted 68 per cent of households as 'poor' and 'very poor'."

Conclusions

There are further problems to be addressed. These include the participation of facilities in paid services, and the complex issue of pricing mechanisms. Concerning the former, it should be noted that there is still a long way to go for the extension of user fees. As mentioned, where in-patient facilities participate in the collection of user fees, only hotel and diagnostic services are paid for. Under-the-counter payments for all types of treatment continue as usual practice, along with an absence of medication that forces patients to purchase it from pharmacies. These patient expenses could be mainstreamed into hospital budgets, thereby increasing revenue from user fees.

As regards pricing mechanisms, shadow pricing by the financial department of the Ministry of Health might be a reflection of a lack of administrative capacity, but ultimately represents a loss of revenue which might be collected through a more elaborate pricing mechanism. As an alternative, cost-based pricing might be applied, with the determination of unit costs for some major procedures. Finally, the administrative practice in collecting user fees is another issue of concern. The Ministry of Health has revealed that some facilities under-report the collection of fees by 10 to 20 per cent. The common practice of 'under-the-counter' charges suggests that the tip of the iceberg might only have been discovered so far.

The distribution of money raised by user fees plays an important role in influencing demand for paid health services. Directing part of fees to improving the quality of care might help reduce demand after the introduction of user fees. Meanwhile, equity considerations require some forms of targeting within the health care system as a whole.[8] Consequently, a better way of dealing with the problems involved with user fees – in particular the equity problem – could be through:

- The wider introduction of user fees, especially into secondary and tertiary hospital and specialist care level, with a simultaneous enhancement of financial control over collection.
- Collection of a higher proportion of user fees revenue from public health care facilities by the targeting of budgeted funds into poor geographic regions and/or primary health/public health services.
- A wider application of evidence-based pricing of health care services; for example, cost-per-unit based pricing might be more appropriate than the current practice of shadow pricing and could increase the revenue from user fees.

The introduction of user fees in Azerbaijan, considering the administrative capacity of the Ministry of Health and public facilities, was sound and in line with equity issues. However, measures to enhance equity, and the fund raising capacity and efficiency of user fees do require further consideration.

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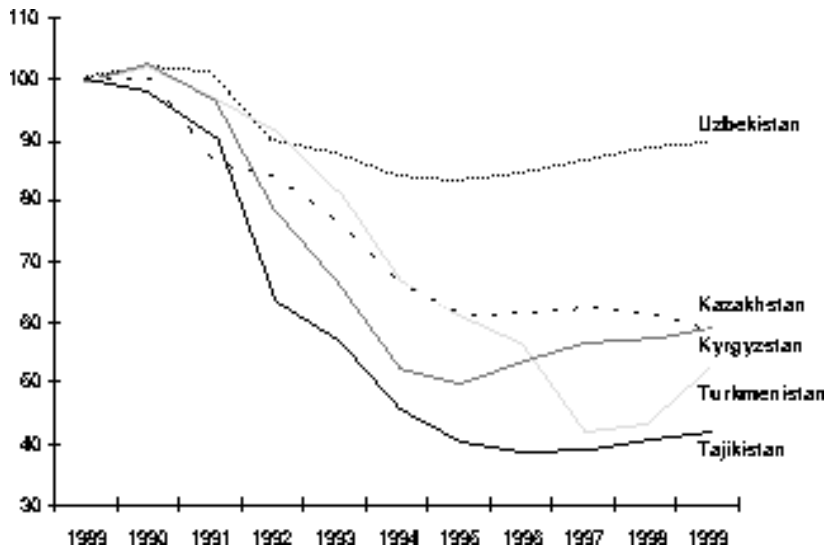
The human cost of transition: health in Central Asia

There is now a growing recognition that the political and economic upheavals in Central and Eastern Europe (CEE) and the countries of the former Soviet Union (FSU) have been accompanied by a decline in the well-being of their populations.

Jane Falkingham

The recent UNDP report *Transition 1999* had as its central theme the growing threat to human security and the human costs of transition.[1] Most work has, however, concentrated on the trends in welfare in CEE and the European republics of the FSU. Much less is written about the Central Asian Republics (CARs) despite the fact that the five countries in the region have experienced amongst the most dramatic changes in output (two notable exceptions, however, are Falkingham et al, 1997,[2] and the UNICEF Transmonee Monitoring reports which, since 1998, have also been extended to include Central Asia)

Figure 1 CUMULATIVE CHANGE IN REAL GDP IN CENTRAL ASIA, 1989-1999 (1989=100)



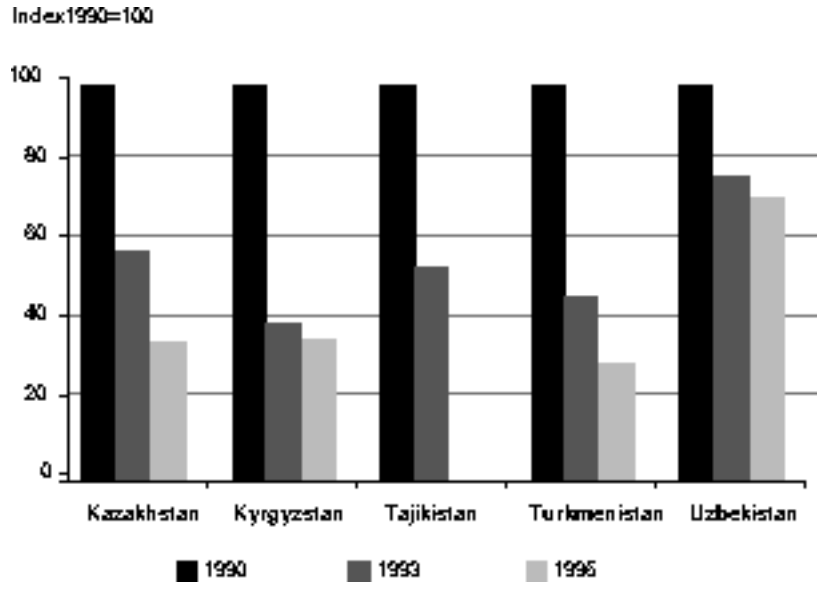
Source: 1989-98 from Transmonee database;[3] projections for 1999 from EBRD (1998).[4]

Figure 1 shows the annual change by country in real GDP since 1989. Growth was negative in all countries in the region up to 1995, since when there has been a gradual reversal of fortunes (with the exception of Turkmenistan which experienced a 25 per cent drop in GDP in 1997 alone). But, despite recent improvements, real output remains significantly *below* pre-transition levels. The fall in output and declining real wages has led to a rapid increase in the proportion of the population of the region living in poverty. Poverty rates are currently estimated to be around 30 per cent in Uzbekistan; 35 per cent in Kazakhstan; 50 per cent in Turkmenistan; 60–70 per cent in Kyrgyzstan; and over 80 per cent in Tajikistan.[5]

The collapse in GDP combined with lower government revenues has meant that real allocations to the social sectors have declined precipitously. Public expenditures on health are running at about a *quarter* to a *third* of pre-independence levels in real terms in all Republics except Uzbekistan (Figure 2, on next page). Such declines are unprecedented, with the result that national health systems are now under severe strain from the reduced availability of drugs, equipment, spare parts and consumables. Construction and maintenance of infrastructure have all but ceased. There has also been significant loss of personnel in the sector. In Kyrgyzstan, for instance, in 1995 a chief doctor earned the equivalent of US$ 25 a month, a less senior doctor, US$ 13, and a nurse only US$ 11 a month; and very often even these low wages were not paid.

What are the consequences of these falls in output and social expenditures for the health of the popula-

Figure 2 REAL EXPENDITURE ON HEALTH CARE, 1990=100



Source: Transmonee database

Figure 3 ECONOMIC TRANSITION AND HEALTH

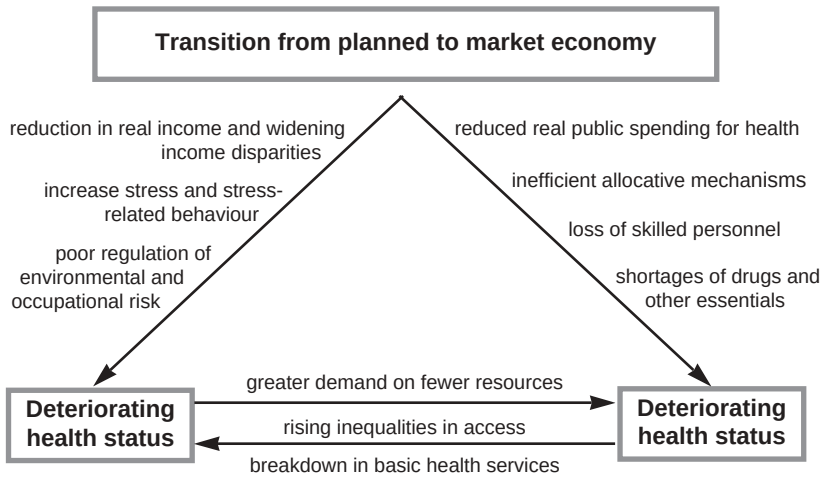


Table 1 TRENDS IN LIFE EXPECTANCY AT BIRTH

	Men			Women		
	1991	1995	Years lost 1991—95	1991	1995	Years lost 1991—95
Kazakhstan	63.3	59.7	3.6	72.9	70.4	2.5
Kyrgyzstan	64.6	61.4	3.2	72.7	70.4	2.3
Tajikistan	67.6	65.8	1.8	73.2	65.7	7.5
Turkmenistan	62.3	62.0	0.3	69.3	69.0	0.3
Uzbekistan	66.1 *	66.0	0.1	72.4[1]	72.0	0.4

Notes: * data for 1992

Source: Transmonee database

tion? Figure 3 presents a schematised view of some of the possible pathways.

Health in Central Asia – mortality

The negative impact of the transition process on the health of the population of the Central Asian region is clear across a number of morbidity and mortality indicators. The most fundamental measure of the well-being of a population is how long its members can expect to live on average. Life expectancy at birth fell between 1991 and 1995 in all of the republics (Table 1). The deterioration in life expectancy has been greater for men than women, with the exception of Tajikistan where the country has been affected by armed conflict for much of the period. The fall has been highest in the Republics which have pushed ahead with reform fastest (i.e. Kyrgyzstan and Kazakhstan). Over a four year time period, Kazakh male life expectancy fell by 3.6 years to 59.7 in 1995. This compares to a decline of 2.5 years for Kazakh women, where life expectancy fell to 70.4 years in 1995. The largest increases have been in deaths from heart and circulatory diseases – which are related to stress, diet, and lifestyle. These diseases account for between 30 per cent and 90 per cent of the increase in death rates, except in Tajikistan where external causes including homicide have been major contributing factors.

In those countries where recent data is available there is some evidence that life expectancy has now begun to recover. Life expectancy for men in Kyrgyzstan rose to 62.7 in 1997 and in Kazakhstan it was 62.1. Nevertheless, levels remain below those enjoyed at the beginning of the decade.

The negative trends in life expectancy are, in part, a reflection of changes in infant mortality. The trends in infant mortality presented in Table 2 show that nearly all the Central Asian republics, experienced sharp rises between 1991 and 1993, and then improvements between 1993 and 1996. Turkmenistan and Tajikistan have the highest infant mortality rates among the republics, with 42.2 (1995) and 31.8 (1996) per

1,000 live births respectively. Recent figures indicate that the infant mortality rate has risen particularly sharply in Tajikistan, reaching a level of 53.4 per 1,000 live births in 1997.[6] These rates reflect the impact of the civil conflict and, in particular, poor maternal health, poor nutrition, poor sanitary conditions, infectious diseases, a lack of pharmaceuticals, low quality medical care, and fragmented health services.

Uzbekistan experienced a slight worsening between 1991–92, from 35.5 to 37.4 per 1,000 live births, but since then infant mortality rates have improved, reaching 22.8 in 1997. This improvement may be associated with a marked rise in contraceptive use, resulting in fewer births, longer spacing between births and a lower birth rate among women over thirty-five.[7] For instance, contraceptive use increased from 12 per cent of women of child-bearing age in 1990, to 21 per cent in 1991; 33 per cent in 1993, to 38 per cent in 1995.

Indices of women's health in the CARs are, on average, significantly worse than in developed countries. Maternal mortality rates are particularly high in Tajikistan, at 74.0 per 100,000 live births (1993); in Kyrgyzstan the ratio is 62.7/100,000 (1997); in Kazakhstan, 59.0/100,000 (1997); and in Turkmenistan 49.6/100,000 (1996).[8] These rates compare to an average of under 10 in most European Union countries.

Prior to independence, maternal mortality rates in Uzbekistan were of a similar magnitude to its neighbours – 42.8 per 100,000 live births in 1989 – but since then, rates have improved to reach just 12.0 in 1996. This is almost certainly a direct result of a new reproductive health programme, demonstrating the positive beneficial impact of increased contraceptive use on women's health.

Morbidity

Evidence on morbidity, rather than mortality in Central Asia, is limited and most of the available data relates to the incidence of particular diseases. There is no consistent series across the region on chronic morbidity, self-reported general health status or, importantly, during the stress of a transition period, psychological well-being (although trends in suicides do give some indication of extreme psychological stress).

Table 2 TRENDS IN INFANT MORTALITY RATE (per 1,000 live births)

	1991	1992	1993	1994	1995	1996	1997
Kazakhstan	27.3	25.9	28.1	27.1	27.0	25.4	24.9
Kyrgyzstan	29.7	31.5	31.9	29.1	28.1	25.9	28.2
Tajikistan	40.6	45.9	47.0	40.6	30.9	31.8	27.9
Turkmenistan	47.0	43.6	45.9	46.4	42.2	39.6	37.5
Uzbekistan	35.5	37.4	32.0	28.2	26.0	24.2	22.8

Source: Transmonee database

Table 3 CHANGES IN THE INCIDENCE OF TUBERCULOSIS AND SYPHILIS IN CENTRAL ASIA SINCE INDEPENDENCE (new cases per 100,000 population)

	Tuberculosis			Syphilis		
	1991	1997	% change 1991—97	1991	1996	% change 1991—96
Kazakhstan	65.8	91.4	+ 39	2.1	231	+11,000
Kyrgyzstan	56.9	112.7	+ 98	2.1	137	+6,524
Tajikistan	38.3			1.6	12	+750
Turkmenistan	59.5	71.8	+ 21	5.4	28	+518
Uzbekistan	45.4	43.4 *	- 4 [1]	1.9	24	+1,263

Notes: * data for 1995

Source: Tuberculosis incidence from Transmonee database; syphilis incidence derived from Renton and Borisenko (1998).[9]

Reduced standards of living, coupled with a breakdown in public health services and behavioural and social changes, have led to outbreaks of some diseases not seen in the region before – such as cholera – and increases in others which used to be far less common – such as hepatitis A. The last seven years have witnessed a growth in the incidence of diseases related to poverty and economic disadvantage. The unusually high incidence of tuberculosis in Kyrgyzstan and Kazakhstan shown in Table 3 reflects the deepening of poverty in these two countries. Mortality rates by respiratory diseases for children under five also rose between 1991 and 1993. Since then, child cause-specific death rates have recovered, but standardised death rates from this cause continued to rise.

There has also been a spectacular increase in incidence of syphilis and gonorrhoea in a number of countries. This also reflects the multiplicity of economic and social shocks experienced in the region. The rise of sexually transmitted diseases is particularly worrying as the incidence of HIV/AIDs has been found to follow the trends in STDs in other countries. The number of newly registered cases of HIV in Kazakhstan has increased exponentially over the last 3 years; from 5 in 1995 to 46 in 1996 and 429 in 1997.

It is not clear whether the *quality* of the health care received by people themselves has improved or worsened. Routine child immunisation fell in early years of independence in most of the CARs. For example, in Kazakhstan the proportion of children immunised against measles fell from 95 per cent in 1990 to 72 per cent in 1994, whilst in Uzbekistan they decreased from 84 per cent in 1991 to just 21 per cent in 1994. In Kyrgyzstan the DPT immunisation rate (against diphtheria, pertussis

Table 4 REAL GOVERNMENT PHARMACEUTICAL EXPENDITURES IN CENTRAL ASIA (index where 1990=100)

	1990	1991	1992	1993	1994	1995
Kazakhstan	100	114.86	55.86	79.40	72.95	60.23
Kyrgyzstan	100	57.56	75.83	52.96	31.68	26.65
Turkmenistan		100	33.94	45.92	17.35	73.30
Uzbekistan	100	78.53	41.72	39.06	40.46	74.65

Source: Chellaraj, Heleniak and Staines (1997).[10]

and tetanus) of children under 2 years of age fell to 64.4 per cent in 1993. However, immunisation rates have since risen across the region and are now approaching 100 per cent in all Republics. In addition, real government expenditure on pharmaceuticals has declined dramatically across the region (Table 4).

There is growing evidence that the poverty of families is becoming a major barrier to universal access to health care. State-sector facilities charging for supposedly free services is now common practice.[11,12] By far the most significant item of private medical expenditure is on drugs and medical supplies.

Concluding comments

Many of the trends discussed above illustrate the negative consequences of transition for human development in Central Asia as countries begin to consume their human capital. There is no doubt that the health systems of Central Asia are in need of structural reform. The inherited health care system of the FSU was inefficient, with a highly centralised, rigid and hierarchical administration of services. Too high a reliance was placed on curative rather than preventative medicine and hospital rather than primary care.

Reform is now underway in most CARs, both in terms of the provision of health care and health finance. For example, proposals to introduce health insurance in Kyrgyzstan are now well underway. During reform, however, it is easy to lose sight of the key objective of health care systems: to improve the population's well-being. As such it is essential to protect *universal* access to basic social services for the poorest in society. The long term development prospects of the country rest on its human, intellectual and social capital.

The human costs of transition in Central Asia have already been high – most notably the loss of lives represented by the decline in life expectancy, and the rise in morbidity from diseases such as tuberculosis that previously had been reduced to marginal risks to health. It must be a priority of any reform to ensure that these costs do not rise any further.

Summary

Health status has deteriorated – especially in Tajikistan, Kazakhstan and Kyrgyzstan. Uzbekistan has suffered least and by some indicators health there has improved.

Life expectancy fell between 1991 and 1995 in all countries, the fall being greater for men than women.

Infant mortality deteriorated up to 1993. Since then, there has been improvement in all countries except Tajikistan where it has continued to rise.

Maternal mortality rates are particularly high in Tajikistan, at 74.0 per 1000,000 births (1993); 62.7 Kyrgyzstan (1997); 59 in Kazakhstan (1997); and 49.6 in Turkmenistan (1995) .

The last decade has witnessed *a growth in incidence of diseases related to poverty and economic disadvantage*, such as tuberculosis, especially in Kazakhstan and Kyrgyzstan (the early reformers).

There has been a dramatic rise in *Sexually Transmitted Diseases* with worrying consequences for HIV/AIDs.

There is evidence that *access to health care is being affected by the growth in private (informal) payments.* State-sector facilities charging for supposedly free services becoming commonplace and patients are often expected to buy the drugs and medical supplies required. The higher the cost of health to the individual, the greater the barrier to access.

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High childhood mortality from injuries in transition countries:

Action is needed

"Children aged between 1 and 14 years in the NIS and CEE are 4.5 and 2.4 times more likely, respectively, to die from injuries than their counterparts in the European Union."

Background

This paper has arisen from a study of childhood injuries in Central and Eastern Europe (CEE) and the Newly Independent States (NIS) which revealed much higher death rates from injuries in these areas than in Western Europe.[1] Although East-West differences and the effect of sociopolitical transition on adult health and on life expectancy are increasingly well understood, little attention has been devoted to differences in child mortality.[2,3]

The study, funded by the United Nations Children's Fund (UNICEF) highlighted the large difference in childhood mortality between East and West and demonstrated that injuries, both unintentional and intentional, make the greatest contribution to this gap. Children aged between 1 and 14 years in the NIS and CEE are 4.5 and 2.4 times more likely, respectively, to die from injuries than their counterparts in the European Union (EU). If deaths from injury could be reduced to the average in the EU, 80 per cent of the overall difference in childhood mortality between these areas would be eliminated. However, there has been little evidence of a policy response to this problem; a major deficiency given the growing body of evidence regarding the effectiveness of interventions in reducing their public health burden.[4]

Causes, circumstances and the context need to be defined if interventions are to be implemented effectively and appropriately. This paper reports the development and application of a relatively simple method to obtain valuable information on the policy priority given to injuries in transition countries; an important initial step in seeking to encourage a more effective and sustained policy response.

Methods

We developed a questionnaire to assess key elements of the policy response to injuries. The questionnaire highlighted knowledge of the magnitude of the problem, the current public health response and priority accorded to injuries, and sought details regarding the presence of a range of well known policy responses to injuries. The questionnaire also sought to identify the extent to which the media and non-governmental organisations have been involved in responding to this set of health problems. No attempt was made to make the questionnaire fully comprehensive given time constraints on the respondents. English and Russian versions of the questionnaire were developed.

An opportunistic sample was established to take advantage of a meeting of 41 experts in child and maternal health from the CEE and NIS. The nature of these experts varied by country: in some cases they were key policy-makers while in others they were leading academics in the child health field. Fifteen countries returned the questionnaire. Although the response rate was poor and it is inappropriate to generalise about an entire region on the basis of the survey, we nevertheless believe that it provides useful information from those who responded. Results are presented for the eight transition countries from which responses were obtained: Moldova, Georgia, Kyrgyzstan, Belarus, Poland, Slovakia, Lithuania and Latvia. A selection of the questions asked and the responses from each country are shown in Tables 1 and 2.

Results: Policy priority and national programmes

Table 1 reveals that childhood injuries have a low policy priority with Ministries of Health (MoH) in many transition countries.

Few countries have national targets to lower the burden of injuries and even in those countries where injury control had a high priority, there were no injury control programmes initiated by the MoH. Many respondents felt that other government departments should take the lead on injury control efforts. The lack of ownership of injury control by the MoH contrasts with countries such as Sweden, where strong leadership in injury prevention has been provided by health authorities. Injuries were not regarded by governments as a research priority. Non-governmental organisations did not exist, or failed to address the problem. The media played little role in highlighting injuries. Health education regarding injuries was rarely taught in schools. There was little donor interest in injury prevention; a factor that may have contributed to the limited policy response.

Respondents were asked to rank the causes of injury in children in order of magnitude for their country. Most felt that the biggest burden was due to motor vehicle accidents (MVAs) followed by falls. In these eight countries, drowning was rated as the fifth most important injury, and poisoning was ranked sixth. These rankings contrast with the finding that drowning killed twice as many children under 5 as did MVAs in the NIS, and that in both the NIS and CEE poisoning among 1– 4 year olds was at least 40 times higher than in Western Europe.[1]

Few countries in the region have multi-sectoral traffic safety committees or national targets for injury reduction. As shown in Table 2, most countries have a speed limit of 60 kph for built up areas. There is good evidence that mortality can be reduced by implementing lower speed limits. Although the legal upper limit for blood alcohol levels is lower (0–40mg%) than in the West (50–80mg%), it was widely believed that few countries enforced it rigorously. Noteworthy is the fact that the questionnaire did not ask about random breath testing, for this is an intervention shown to be effec-

Table 1 Priority given to injuries in children and young people (0-19 years) in the CEE/ NIS countries: responses to questionnaire

Item	Moldova	Georgia	Kyrgyzstan	Belarus	Poland	Slovakia	Lithuania	Latvia
How importantly does the Ministry of Health regard injuries as public health problem?	high	high	high	high	medium	low	medium	medium
Are injuries stated in national policy priorities, targets or objectives?	no	no	no	no	yes MVA all ages	no	don't know	no
Are there any injury control programmes initiated by the Ministry of Health?	no	no	no	no	yes	yes	no	no
Have other government departments been involved in injury control programmes?	no	don't know	Interior Ministry	Interior Ministry	Education Transport Labour Interior	Education Interior	Education Interior	don't know
Which ministry should have the lead?	Interior Education	–	Interior Health, Educ.	Education	Injury prev centre	Education	don't know	Welfare (Health)
Are injuries a leading cause of mortality in children <5 inEurope	no	yes	no	yes	no	yes	no	yes
Highest burden due to injuries (one of: MVA, burns, falls, poisoning, drowning, violence, suicide)	Falls	MVA	MVA	MVA	MVA	Falls	MVAs	Falls
Injuries as government research priority	*	low	low	medium	low	low	medium	negligible
NGOs working in prevention other than children's rights and protection	*	don't know	no	none	no	yes	no	don't know
Donor funding of injury prevention	*	don't know	no	no	don't know	no	no	no
Has the media showed any interest in injuries as a social or health problem?	*	no	yes	no	yes	no	yes	yes
Is legislation adequate to protect children and young people from accidents and injuries?	*	don't know	no	no	no	yes	yes	no

Key: Injury prev centre = Injury prevention centre; – signifies not relevant or left blank; * = missing items on questionnaire; MVA = motor vehicle 'accident'

tive in reducing alcohol related crashes. And in Georgia, for example, there was little promotion of seat belts and the legal age limit for a driving license is only 16 years.

Discussion

Successful injury control requires a multi-sectoral approach, with a clearly identified lead sector, often health.[5] Such an approach should not only involve different government departments, such as Transport, Education, Health and the Ministry of Interior, but also other stakeholders, such as health professionals, the media and civil society organisations. In the United Kingdom, for example, non-governmental organisations such as the Child Accident Prevention Trust and the Royal Society for the Prevention of Accidents, have played a pivotal role in advocacy around injuries and their prevention.

Mortality from MVAs in the CEE and NIS was as great a problem as in the West despite lower vehicle kilometres travelled. Traffic activity in transition countries is likely to increase rapidly with economic development, and a consequent increase in mortality is predictable unless more stringent traffic safety measures are implemented. In children, much traffic-related mortality is due to pedestrian 'accidents'. Thus, appropriate measures such as separating traffic from pedestrians and traffic calming in residential areas, are required. Drunk driving is also likely to be a major problem, and other measures of alcohol related harm have increased markedly since transition.[3]

Next steps

This rapid assessment survey revealed that injury prevention is not a policy priority in the transition countries studied, despite the fact that it is the largest contributor to the East-West gap in childhood mortality. The questionnaire has

Table 2 Legislation for road use in the CEE/ NIS countries: responses to questionnaire

Item	Moldova	Georgia	Kyrgyzstan	Belarus	Poland	Slovakia	Lithuania	Latvia
Legal age limit for a driving license for a car	-	16	18	18	17	18	18	–
Legal age limit for a driving license for a motor cycle	–	16	16	16	17	17	18	16
Is this law enforced? (rigorously to not at all)	–	rigorously	mostly	rigorously	rigorously	mostly	rigorously	rigorously
Is there compulsory testing of all cars for safety at set intervals? Interval (years)	–	no	yes –	yes annually	yes 1–2 years	yes 2–5 years	yes 2 years	yes –
Is it compulsory by law to wear car seat belts when seated in front?	–	no	yes	yes	yes	yes	yes	yes
Is this law enforced? (rigorously to not at all)	–	–	mostly	rarely	rarely	mostly	rigorously	–
Is it compulsory by law to wear car seat belts when seated in the rear?	no	no	no	no	no	yes (rarely enforced)	yes (rarely enforced)	yes (rarely enforced)
Is it compulsory by law to wear a motorcycle helmet?	yes	yes	no	yes	yes	yes	yes	yes
Is this law enforced? (rigorously to not at all)	mostly	mostly	not at all	mostly	rarely	mostly	rigorously	mostly
Is it compulsory for babies to be strapped in a child safety car seat?	no	no	no	yes (rarely enforced)	no	yes (mostly enforced)	don't know	no
legal speed limit for driving in town (kph)	60	60	60	60	60	50	60	50
Is this law enforced? (rigorously to not at all)	mostly	mostly	not at all	mostly	rigorously	mostly	mostly	rigorously
maximum permissible legal limit for blood alcohol while driving (mg%)	0	0	don't know	0	2.9	1	4	5
Is this law enforced? (rigorously to not at all)	rarely	mostly	–	–	mostly	rarely	rigorously	rigorously
Police testing of blood or breath alcohol in drivers if they breach the law	rarely	most of the time	most of the time	all of the time	most of the time	most of tthe time	all of the time	rarely

been a useful tool in highlighting areas for action, although it needs to be supplemented with situation analyses at country level. These would involve examination of data on morbidity, mortality and disability, costs (where available), identification of other sources of information such as police records, and an assessment of their validity and completeness, interviews with stakeholders, and an assessment of the civil society response to date.

Future work should include refinement of the tool, and improving the quality of data through triangulating information from a range of key sources within the relevant countries. The responses obtained from each country could be used to stimulate debate at national and local level, in combination with available mortality data. A more extensive questionnaire must be developed to obtain information on measures aimed at preventing specific types of injuries, such as drowning and poisoning, two unexpectedly high causes of childhood mortality uncovered by the study.[1] Such a questionnaire could also be used as part of an interactive teaching package at injury prevention workshops to stimulate debate on policy formulation, an exercise that was piloted at a workshop on injuries in Kyrgyzstan in November 1999.

Many of the transition countries have signed up to international initiatives such as the 'Health For All' and the 'National Environmental Health Action' plans, but have focused attention mainly on transport related accidents. More inclusive national injury control programmes need to be established and could use these and other initiatives as a framework for action. The recent declaration made at the 3rd Ministerial Conference on Environment and Health (London, 16th – 18th June 1999) attended by 54 member states of the European region, called for the implementation of public health interventions to reduce childhood injuries.

Countries such as Sweden and Norway have proved that injuries can be prevented through the organised efforts of society. Achieving this requires raising the public profile of injuries, involving civil society organisations, and working with public health researchers to make the problem visible and the effectiveness of appropriate interventions apparent. Donor support, which has been abysmal in the past, (donor agencies spend US$50 for every Disability-Adjusted Life Year (DALY) lost due to leprosy, $4 per DALY for HIV and sexually transmitted disease, and only $0.01 per DALY on injuries)[6] needs to be actively mobilised. Taking injury control forward requires adaptation of tried and tested methods to the local context of the CEE and NIS. It can and should be done if the loss of tens of thousands of children's lives, through avoidable causes, is to be prevented.

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The relationship between health and marital status during transition in Poland

Peggy Watson

"One of the more striking aspects of the decline in adult health that took place in all Soviet bloc countries from the mid-1960s onwards, was the extent to which unmarried men were at particular risk from increasing premature mortality."

Although a number of authors have pointed to the significance of marital status in the changing patterns of adult health in eastern Europe,[1,2] this aspect of health distribution in the Central and Eastern European (CEE) countries has not received a great deal of attention on the part of researchers. One reason for this may be that the impact of marriage on health has tended to be treated as a constant, partly because the health advantage afforded by marriage has not varied much over time within Western countries. From a British perspective, for example, the marital status mortality differential between people

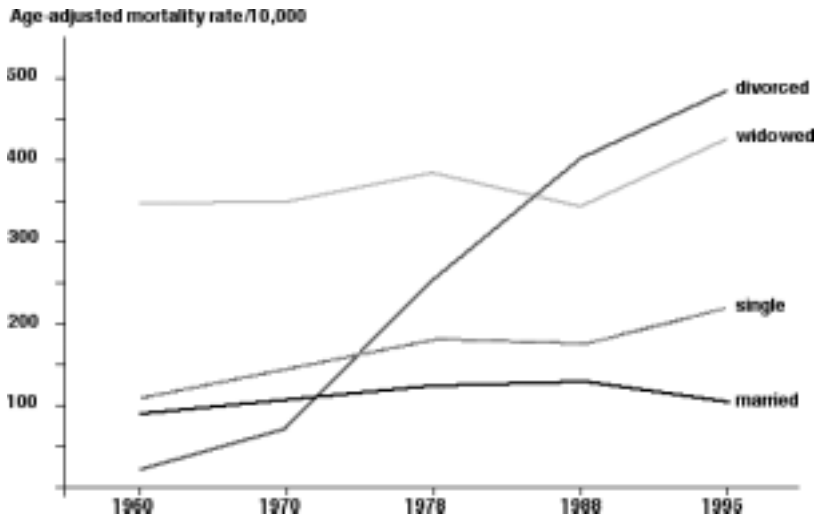
who are married and those who are not, has been very stable since before the Second World War. The impact of short-term changes as well as longer-term mortality trends in England and Wales has tended to be reflected comparably in all marital status groups, thus preserving the mortality differential between the married and the other marital status groupings, and creating the impression that the difference between them is fixed.

However, the eastern European experience has shown that the significance of marriage for health has been quite variable over time, and that understanding the nature of the relationship between them – the health advantage of being married, or the disadvantage of not being married – means taking account of differences in the wider socioeconomic and political context. Although internationally, marriage has been widely associated with better health, the nature of this advantage is not immutable.[3] The social distribution of health and ill-health is of central concern to public health research and policy, providing clues as to the causes of disease, as well as guidelines for practical policy development. A useful question, therefore, to ask is to what extent the distribution of health is being mediated by marital status during transition. Have the economic and political changes which have been taking place after the end of communism increased or decreased health differentials among the married, the never-married, the divorced, and widow(er)s? What lies behind this particular patterning of health? This paper raises a number of such issues in relation to Poland.

Poland is generally regarded as having had a more successful transition to a market economy than many other CEE countries. Following the initial trauma of 'shock therapy', the country has achieved significant levels of economic growth, although unemployment in Poland is higher than in many other CEE countries.

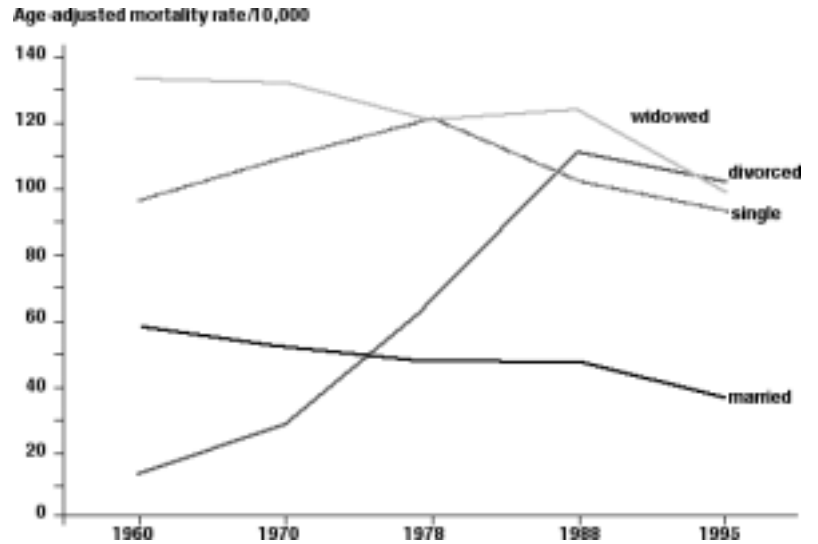
Figures 1 and 2 compare mortality in four marital status groupings in each of the post-war census years as well as 1995, when the population was

Figure 1 MORTALITY BY MARITAL STATUS IN POLAND: MEN AGED 35—69



Source: Polish Central Statistical Agency: published and unpublished data.

Figure 2 MORTALITY BY MARITAL STATUS IN POLAND: WOMEN AGED 35—69



Source: Polish Central Statistical Agency: published and unpublished data.

estimated on the basis of a 5 per cent mini-census. The year 1988 offers a convenient cut-off point marking the end of communism and the beginning of 'transition' in Poland – in fact, the 1988 census preceded the first postcommunist elections in the country by about nine months. How do marital status mortality differentials compare before and after 1988?

Between 1960 and 1988, mortality increased for all groups of men in Poland, but there was marked variability in this respect. Among married men aged between 35 and 65, the overall increase in mortality was about 29 per cent during this period, while deaths increased by 48 per cent among widowers and by as much as 14-fold among the divorced in the same age group. For married women between 35 and 65, there was a decrease in death rates by 27 per cent between 1960 and 1988. Mortality also decreased among single women and widows in this age group, but rose among divorced women by about five-fold.

Increasing marital status differentials prior to 1989, which were more marked among men, were not confined to Poland, but were seen more widely in the countries of the former Soviet bloc. The formation of these patterns coincided with the development of family-centred societies and the growing importance of personal and kin-based ties in everyday life given the relatively unresponsive state structures of socialism.[2,4,5]

What has been the impact of transition on marital status differentials on health? The restructuring of the state and economy in Poland since 1989 has been associated with an overall mortality decline from 1993 onwards, but for men in particular, this has not lessened the significance of the relationship between marital status on health. For men between 35 and 65, the health benefits of transition have been confined to the married. Mortality in this group decreased by about 20 per cent between 1988 and 1995, while it increased for single men by 25 per cent, and by 18 per cent for the divorced and widowed. In contrast, for women between 35 and 65, mortality decreased in all marital status groupings during transition. Among married women the decrease was 26 per cent, while among the single it was 15 per cent. However, mortality rose among single women over 70. Among older men, widowers experienced the greatest increases in death rates between 1988 and 1995.

The way marital status differentials are changing over time varies according to cause of death, as well as with age and sex. Rapid decreases in mortality due to ischaemic heart disease occurred among married men of all ages during the transition period studied – effectively from 1993 when the economic situation began to improve, following increases during the period 1978–1988. Heart attack deaths declined by about 50 per cent among married men in their thirties during this short period. Heart attack deaths also decreased in practically all age groups among single men. However, some notable increases in mortality from this cause did also occur, particularly among widowers over fifty. Heart attack deaths increased by about 50 per cent for widowers over 70 during transition. Deaths due to heart attack decreased for married women of all ages but tended to increase among single women and widows over 55.

"One question for further research is why marital status differentials appear to be widening during transition in Poland, particularly in the case of men."

In the case of deaths due to lung cancer, the transition period has seen some turnaround in mortality trends for men, but with a relatively even effect across marital status groupings. At the same time, death rates from this cause have continued to rise after 1988 in older age groups – that is among married men over 65, divorced men over 60, and single and widowed men over 55 and 50 respectively. While deaths from lung cancer have continued to increase among married women and single women during transition, the rate of increase has slowed among the married, but accelerated among single women of all ages.

Mortality trends for suicide contradict the general pattern of mortality change in a number of ways. During the ten years prior to democratisation, rates of suicide among men decreased among all marital status groups except the divorced. But transition has seen increased suicide rates amongst men of working age; with married men enjoying no particular exemption in this regard. Suicide rates also rose about 30 per cent among (unmarried) young men in their late teens. Together, these patterns suggest that increases in deaths from suicide are linked to unemployment – the rates of youth unemployment are particularly high in Poland. At the same time, increases in suicide have been smaller among women than among men, although in general, women have experienced higher rates of unemployment than men during transition.

Conclusion

During transition, the social patterning of health and illness is undergoing rapid change, offering new opportunities for research and challenges for policy. In Poland, health advantage and disadvantage is interacting in new ways with a range of social factors, not all of which are addressed in the present paper. Analysing continuities and discontinuities in relationships between marital status, age, sex, and health in this context of change is one important means of gaining insight into the processes of transformation that are involved. One question for further research is why marital status differentials appear to be widening during transition in Poland, particularly in the case of men.

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Responding to HIV / AIDS in Belarus:

The importance of early intervention

Damian Walker

"In the last few years this region has seen a nine-fold increase in the number of HIV/AIDS infections, and as much as seventy-fold in the worst affected areas; by the end of 1998, it was estimated that 270,000 people were infected."

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Until the mid-1990s, most of the countries of Eastern Europe* appeared to have been spared the worst of the HIV/AIDS epidemic. In 1994, the whole of Eastern Europe had about 30,000 infections, 15 times fewer cases than Western Europe, and 400 times fewer than in sub-Saharan Africa. However, in the last few years this region has seen a nine-fold increase in the number of infections, and as much as seventy-fold in the worst affected areas; by the end of 1998, it was estimated that 270,000 people were infected.[1] The predominant mode of HIV transmission in the region is through the injection of drugs. At present, Ukraine is the worst affected country in the region, though Belarus, Moldova and the Russian Federation have all registered large increases in recent years.

A characteristic of HIV transmission among injecting drug users (IDUs), relative to other risk groups, is its potential for rapid spread. Between 1995 and 1996 in the Ukrainian cities of Odessa and Nykolayev, HIV prevalence among IDUs increased from 2 per cent to 32 per cent and from 2 per cent to 57 per cent respectively.[2] However, in some countries injecting drug use (IDU)-associated HIV epidemics have also stabilised. The key difference has been the implementation of HIV prevention activities among IDUs relatively early on in the epidemic. One of the main messages learnt during the last two decades is that investment in effective prevention before HIV/AIDS becomes a major problem 'can avert suffering, save lives, and avoid potentially massive expenditures on AIDS treatment and care'.[3]

Experience from Belarus suggests that even a small-scale project can have significant impact on reducing the risk of HIV transmission among IDUs, but again emphasises the importance of acting early. In Belarus, the first HIV-positive case was diagnosed in 1987. Until 1996, the HIV prevalence figures were very low, but there has been a rapid increase in the number of people infected with HIV. As of September 1998, 2,173

* This region is defined here as comprising Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Krygyzstan, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Russian Federation, Slovakia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

HIV-infected individuals were registered – 83 per cent infected through unsafe IDU, 15 per cent through sexual transmission and the remainder through alternative modes of transmission. National AIDS Prevention Centre statistics indicate that each administrative region in Belarus has now reported HIV infections. However, the epicentre of the Belorussian epidemic is Gomel region, which accounts for 81 per cent of all HIV infections in Belarus, This is mainly due to the high levels of IDU among young people, particularly in the city of Svetlogorsk.[4]

While the actual numbers of people infected with HIV appear to be small at the moment, the prevailing economic and social conditions suggest that unless effective immediate steps are taken, the country is likely to face a rapid spread of the infection among the young population. Prostitution is on the rise within Belarus and, in addition, a number of women travel across to Poland and other neighbouring countries to work as 'sex workers'. There has also been a substantial rise in sexually transmitted infections (STIs) among the youth in Belarus, also increasing the risk of HIV transmission.

Given the increasing risk of HIV, a pilot project was implemented by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the non-governmental organisation 'Parents for the future of Children'. Seen as a pilot for both Belarus and neighbouring countries, 'Prevention of HIV-infection among the people using drugs by injections in the city of Svetlogorsk' began in January 1997 with behavioural studies in order to access the specific needs of the target population and the best ways in which to deliver services. (It should be noted that the carriage and distribution of syringes is legal in Belarus, however, legislation is likely to vary in the regions.) Following these studies, two syringe exchange points were established in the areas with the highest concentration of IDUs. The main types of activities performed in this needle exchange programme are:

Table 1 CHANGES IN RISK BEHAVIOUR FROM 1997 TO 1999 IN THE IDUs OF SVETLOGORSK

Risk behaviour	1997 (n=200)	1999 (n=110)
Percentage of sex partners that are non-IDU	37%	56%
Percentage of IDUs that do not use condoms	71%	37%
Percentage IDUs sharing syringes	92%	35%
Percentage of IDUs cleaning syringe with disinfectant	16% (10% with boiling water)	55% (35% with boiling water)
Rate of recruitment of new IDUs	13% IDUs injected for less than 1 year	5% IDUs injected for less than 1 year

(all significant with p<0.05)

- Informing and educating the town population and target group on the safe use of syringes;
- Reduction of risk of HIV infection through dirty needles (distribution of disinfectants and clean syringes, and the collection and incineration of used syringes);
- Promotion of safer sexual practices (distribution of condoms);
- Advice and counselling IDUs on safe behaviour, medical care issues, psychological and legal support; and
- Outreach services by volunteers.

In addition, via the syringe exchange points, IDUs are referred to consultations with a STI specialist, and treatment is provided confidentially and free of charge.

The project received funding from the UNAIDS and the World Health Organization (WHO). It has greatly benefited from a high degree of involvement from the community: the town council donated the premises; mass media was provided free of charge by the local multimedia company; a local factory donated plastic containers in order to collect used syringes and provided the use of its furnaces to incinerate them free of charge; and IDUs have worked on a voluntary basis in order to perform outreach activities. Given this use of resources, what has the project managed to achieve?

To evaluate the effectiveness of the intervention project, a behavioural study was undertaken in May 1999 and the results of it were compared with a similar behaviour study done before the implementation of the syringe exchange programme in 1997.

Although the intervention has not reduced the frequency of re-use with syringes or the proportion having frequent causal sex, Table 1 suggests that there has been a large reduction in many of the high-risk activities associated with IDU and sexual partnerships. The project has significantly reduced the amount of needle sharing and has reduced the incidence of HIV infections amongst IDUs. A significant cause for this reduction in the HIV incidence is not only the changes in risk behaviour of the IDUs but also the reduction in the recruitment of new IDUs. This is a very important aspect of the intervention as the HIV prevalence among IDUs in Svetlogorsk is now 75.5 per cent, and thus there is little scope for reducing many infections among the existing IDUs. As such, the main positive effect of the project in Svetlogorsk is that it has reduced the progression of the HIV epidemic to new IDUs.

Some of the lessons learnt from the project have emphasised:

Early intervention: While the project has been very effective in reducing many IDU risk behaviours, it was initiated at too late a stage to significantly reduce the effect of the epi-

demic on existing IDUs. So while it is having a substantial impact on uninfected IDUs, greater gains could have been achieved if the project began earlier when the prevalence among IDUs was lower.

The importance of multiple interventions (changing drug use, needle practices and risky sexual behaviour simultaneously) among IDUs: Failure to halt the rapid spread among IDUs will lead to HIV spreading into other groups. There has already been an increase in the incidence of babies born with HIV in Svetlogorsk and, from 1997 to 1999, the proportion of HIV infections occurring due to IDU has reduced relative to the number due to sexual transmission. Interventions also need to focus on preventing transmission to newborn babies and the sexual partners of IDUs. It is thought that the number of HIV cases in both these risk groups will continue to rise due to the large number of sexual partnerships that occur among IDUs and especially between IDUs and non-IDUs (50–60 per cent).

The multiple benefits of projects targeted at IDUs: This includes the reduction of other blood-borne infections such as hepatitis B and C, the stopping of IDU practices among current users as well as slowing the practice of IDU among non-users.

Given that IDUs play an important role in HIV transmission to the wider population, a national and community response must be early and sustained to achieve the greatest benefits. It is important to replicate projects targeted at IDUs and their sexual partners. While experience has been accumulating on factors influencing the effectiveness of HIV prevention interventions among IDUs, there is little known about their relative cost-effectiveness. Our research project, *HIVTools*, has been developing guidelines for identifying and comparing costs across interventions, as well as models to estimate the impact of these interventions on HIV infections averted. These tools are designed to capture lessons learnt from existing projects which can be used to guide replication elsewhere.[5]

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HEALTH21: Implications for Central and Eastern Europe and the Former Soviet Union

Serdar Savas

Background

The World Health Organization (WHO) initiated a movement in 1977 called the 'Health For All' (HFA) programme. It reflected a fundamental vision to put health at the centre of all political and economic activities, with the main goal being to achieve more health gain within an overall target of ensuring equity. In accordance with the global HFA strategy, each of the WHO classified 'Regions' developed their own specific HFA targets and strategies. The European Region adopted 38 HFA targets and strategies in 1984. These targets were revised in 1991 in light of the socio-political changes that took place in the region during the seven year period since inception.

Another seven years passed after the first revision. The social and political context of the region had changed again. At the dawn of the new millennium, therefore, new challenges were confronted and an updated HFA policy framework, Health21, was developed and adopted by the

member states of the European Region in September 1999.

Health21 is a careful blend of new initiatives and a continuation of the broad policy framework of the original programme. Thus, it embraces inter-sectoral concerns, including, lifestyle, the environment and health services – as have been stressed throughout the HFA movement. The crucial issue, however, is what is new in the Health21 programme. The major new innovations can be summarised as follows:[1]

– it recognises that social and economic conditions have a major influence upon patterns of disease and death;
– it puts health into the centre of development and health impact assessment is emphasised in every policy and intervention;
– the 'life course' approach is followed; and
– the mobilisation of partners for health is seen as an important condition.

Social and economic determinants of health

The new policy framework recognises that health results from the combined actions of society as a whole, and that people's social and economic conditions strongly affect their health throughout life. It has been proven that poverty, employment, education, social exclusion, stress, and lifestyle all have a strong correlation with health, such that health policy must be linked to the social and economic determinants of health.[2]

The WHO's European Region contains some very rich as well as many poor countries. Per capita GNP ranges from US$340 to US$40,000. There are no signs that these disparities will narrow in the near future; on the contrary, poverty in the eastern part of the region rapidly increased during the 1990s to affect one third of the population, or approximately 120 million people. These income disparities are reflected in huge health differentials as seen, for example, in infant mortality, which ranges from 3 to 43 per 1,000 live births. This is a statistic which is ten times higher in the eastern part of the European Region.

The political and economic transition in Central and Eastern Europe (CEE) and the Former Soviet Union (FSU) negatively affected the health and well-being of people. During the 1990s, GDP has fallen in the range of 15–70 per cent, with real wages falling even further. Full employment ceased and unemployment increased dramatically. Income inequality has grown and, at the same time, basic education coverage and access to health services has deteriorated. This corresponds with an increase in mortality in many CEE and FSU countries during the same period. The FSU also experienced an increase in infant mortality rates between 1991–1993, that which coincided with the largest average annual decrease in GDP in these countries. During this period, immunisation rates fell due to both lack of vaccines and social displacement. The rationalisation of health sector expenditures led to a weakening of child health monitoring systems. In some CEE countries, this was especially so because of the dismissal of many school doctors, thereby shifting the responsibility onto parents to take their children for health check ups. In some countries, such as Poland, an increase has been observed in child hospitalisation since 1989. This can be attributed to several factors including a more competitive labour market where parents cannot take leave, and an increased proportion of divorced or single parents.[3]

Lifestyle also contributes to the health status of a people, and it is quite significant that in the CEE and FSU 20 per cent of all men currently aged 35 are expected to die from tobacco related illness by the age of 69 – this is twice as much as that expected in western Europe. This can probably be related to the marketing practices of companies, price deregulation and a widespread lack of anti-smoking policies. Although there is no data on actual alcohol consumption, it is known to be quite high in the Newly Independent States (NIS) – especially in Russia – and is perhaps implicit in the sharp increase in alcoholic psychosis in these countries between 1992 and 1995.[4]

Health impact assessment

'An effective approach to health development requires all sectors of society to be accountable for the health impact of their policies and programmes and recognition of the benefits to themselves of promoting and protecting health. Health impact assessment must therefore be applied to any social and economic policy or programme, as well as development projects, likely to have an effect on health.'[5]

"Alternative packages of structural adjustment should be proposed which would pursue economic restructuring and balancing of budgets without destabilising people's lives".

Such a reorganisation in both thinking and practice would force a change in the economic paradigm of development to a more human-oriented one, where the focus is on the quality aspect of human life rather than only on the quantitative evaluations of economic growth. Health must be valued as the fundamental requirement to enhance the quality of life. This reorientation would require revision of the current concepts and techniques of investment analysis to make future investments environmentally sound, socially responsible, and financially profitable. Especially in the central and eastern part of the European Region, alternative packages of structural adjustment should be proposed which would pursue economic restructuring and balancing of budgets without destabilising people's lives. Long term development models should demonstrate consistency between growth, the environment and people's concern.

In the European Union (EU), the Amsterdam Treaty of 1997 recognises the need to consider the health impacts of any kind of intervention in the community. EU public health policy also highlights the need to take into account the prospects of enlargement. In this vein, the health care systems of the CEE compare poorly with those of the existing EU members – mainly on account of the inadequate resources available – and thus the improvement of effectiveness of health systems and interventions are to be sought. This raises a concern as to the potential impact of enlargement on health in the present member states.

Life course approach

Another concept which is brought into action with the Health21 programme is the 'life course' approach. Health is related to all phases of life and these phases cannot be separated from one another. Life involves a series of critical transitions: emotional and material changes in early childhood; the move from primary to secondary education; starting work; leaving home and starting a family; changing jobs and facing redundancy; and eventually retirement. Each of these affects an individual's health by pushing them on to a more or less advantaged path. An individual's current action relating to his or her own health will also have an impact on his or her future health. In addition, these actions will also have impact on subsequent generations. For example, a malnourished pregnant woman who smokes has a higher chance of giving birth to a baby with a low birth weight. In turn, this baby is more likely to have a narrow pelvis, resulting in an increased chance of birth complications in later life. Therefore, life course implies that interventions in health – preventive and promotive activities – should be planned accordingly, recognising the complex interactions between such life events, biological risks and health determinants. It is necessary to take life as a continuum, and health interventions need to provide the knowledge and skills relevant to the behavioural changes which come with each stage of life.

This is especially important in the context of the inherited health care systems in the CCE and NIS countries. For these were oriented towards fragmented care which was provided by specialists in separate polyclinics for children, adults, women. There are attempts in many countries to change this towards a more integrated system of care, training more generalists (especially for the primary care level) who can follow a holistic approach. Most countries welcome the family-oriented primary health care approach, however, there is still a long way ahead.

Multisectoral policies and mobilising partners for health

The new focus on determinants of health highlights the need for a multisectoral approach and the need for societal policies to be developed. The health sector has the principal, but not sole, responsibility for placing health higher on the agenda. All sectors of society must be accountable for the health impact assessment of their policies and programmes, and every sector and each individual can play a part in fostering health policies in their different and respective capacities.

This brings new challenges to the CEE and NIS countries, where the responsibility for health traditionally lies in the public sector, particularly with the Ministries of Health. The transition period has brought new partners to the system (private) which may become potential contributors to health improvement. However, individuals tend to be passive and rely on the health system even when their own health is a matter of concern, rather than being pro-active. It is, therefore, crucial to create awareness for new alliances.

Health21 reinforces the role of civil society in guarding health aspects of interventions. However, civil society groups are yet to be developed in the CEE and NIS. Placing health at the centre of development, at the forefront of human activity, requires a decisive desire for health in the society. Society can make demands for greater investments for controlling health risk factors in the environment and for maximising health determinants. It is expected that with their ever-increasing voice, the masses will become more and more effective in prioritising the policies that would contribute the health development.

Into the new millennium

Everybody is working towards a better future, but maybe not applying all well intentioned efforts in the most effective way. Health21 provides a policy framework and paves the way. However, health developments will only succeed if there is a commitment to health by the countries and by individuals themselves.

Under the political and economic transition in the CEE and NIS countries, comprehensive policies with strategic visions can be a mechanism to represent the commitment, to create awareness and to ensure continuity and sustainability. For this purpose, the development of such policy will require the involvement of many different groups in society and a national consensus. Ultimately, therefore, health concerns everybody and is everybody's responsibility.

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Specific characteristics of health targets in Hungary

Ivan Gyarfas

"The measures involved in ensuring the population's health and implementing the 'Health for All' policy did not get political support, and the medical profession in general was not supportive of health promotion."

Health target setting in the 1980s

Health targets and priority-setting became issues for debate in Hungary under the World Health Organization (WHO) 'Health for All by the year 2000' programme. The 1984 Regional Health Target document was well received in Hungary and was enthusiastically supported by the decision makers in the health sector. In 1987, the Hungarian government set out a long term programme for health promotion. The long term strategy was based on the Hungarian adaptation of the WHO health targets. A team of interdisciplinary experts was led by the Deputy Prime Minister. This Committee defined eight priority areas (accident prevention, AIDS, alcohol control, hypertension control, mass media, mental health, control of substance abuse, and tobacco) and developed action programmes between 1988–1990. The issue of health promotion was undoubtedly, therefore, put on the agenda.

However, the programme lacked legitimacy. The measures involved in ensuring the population's health and implementing the 'Health for All' policy did not get political support, and the medical profession in general was not supportive of health promotion. The programme thus failed to implement actions that would serve the population's interest and, in the long run, make it popular and well known to the public. Trapped in the contradiction between targets set and real possibilities, the programme could not exceed the boundaries of the health sector; although there were several examples of implementation at local level. The programme was not an integral part of a comprehensive social policy. An integrated countrywide movement was, therefore, not launched and, in the absence of political commitment and well defined objectives and means, the programme lacked support. Financial, personal and organisational resources were hopelessly scarce as compared to the over ambitious plans, which meant a situation of complete subjectivism where log-rolling flourished. Finally, the Committee sought to allay its own conscience by saying that whatever the programme did, it had some benefit somewhere.

Health targets after the political changes

The implementation stage of the programme should have commenced during the period when basic political reforms took place. But the collapse of the political system marginalised this initiative and it disappeared. In 1991, a new public health service was established on the basis of the former Sanitary Epidemiology Stations called the National Public Health and Medical Officer Service (NPHMOS). The main objectives of the new Service were to implement and manage health promotion and disease prevention – both in communicable and non-communicable diseases – and supervise health care under the direct guidelines of the Ministry of Health. However, the NPHMOS was not supported by clearly formulated plans for health policy. Under the leadership of the Chief Medical Officer, the director of NPHMOS, a long term public health policy document was issued and accepted as a government resolution. The document, Government Decree (1030/ 1994. [IV. 29.]), set forth the basic principles of long term public health policy. Priorities were established until the year 2000 and the decree was delivered a month before the administration changed. According to the Programme, five national health targets were to be attained:

- Health should be seen as one of the major values by an increasing proportion of the population. At the same time, efforts will have to be made to ensure that decision makers accept the improvement of health as a matter of prime importance both in legislation and budgeting.
- The years of life lived free from diseases shall be extended to at least 55 years.
- Life expectancy at birth shall be increased to at least 67 years for males and 74 for females (prior to the 1994 decree, this was 66 and 75 respectively).
- The difference in life expectancy at birth of population groups between those in the high and low social economic classes shall not exceed 3 years (in Budapest for instance, the difference in life expectancy between men living in the 2nd versus the 7th districts was five years.)

– The difference between the number of deaths and live births shall be reduced to the advantage of live births (before the 1994 decree, the number of live births was 97,301 and the number of deaths was 140,870).

These five health targets were based on the achievement of ten important tasks (Box 1), and were to be attained via twenty specific programmes (Box 2).

Through this web of health-related objectives and public health programmes, the health sector was to be responsible for many things; first of which was to shape healthy lifestyles amongst the population. Influencing the population's health status was to be carried out by means of health education through the mass media. People should be made aware of the harmful effects of unhealthy dietary habits, tobacco use and alcohol abuse as well as sedentary lifestyles. Health education should also be included in the national core curriculum. And medical care delivery should include counselling tailored to the needs of individuals.

The proposed health sector reforms were also envisaged to have a duty in shaping environmental factors as they relate to population health; with particular attention paid to decreasing pollution of the living environment, especially air, water, and at the workplace. This involves moulding social environments and enhancing health promotion and disease prevention. In this vein, full consideration should be given to the regulations existing in the European Union.

A priority commitment of the revised health care delivery system was to provide preventive services to children and young adults. In the middle-age population, priority should be given to early detection and treatment of disease. Acceptable levels of health should be ensured for the underprivileged and for the elderly by developing appropriate methods of extended and continuous care.

A revitalised health sector, as forwarded under the programme, would be required to take into consideration the most prevalent disease groups and most frequent causes of death. Control of cardiovascular diseases and cancer programmes should be introduced, and priority should be given to prevention, and to early diagnosis. Finally, the 1994 resolution stated that, among its many duties, the government should consider it a high priority to promote wider social recognition of the health sector. The overall responsibility for the implementation of the programme was to rest with the Minister of Welfare. Under the decree, he should regularly report to the government and parliament on any progress.

As mentioned, however, being only a government programme – and one not discussed by parliament – the resolution lacked the legitimacy required for proper enforcement. It offered a strategy, mainly for the public health service, and only up to the year 2000. The prerequisites for health, social and economic development were not given adequate consideration. A few weeks after the decree – following a change in the administration – the programme was in fact not further considered. The resolution is still valid, but the specific programmes have not been fully implemented. A loan from the World Bank has helped to support the programme, and some measures are being at least partly implemented.

Box 1 CRITERIA FOR ATTAINING HEALTH TARGETS UNDER THE 1994 DECREE

1. **Infant and maternal mortality should be reduced below 10 per cent.**
2. **Cardiovascular disease mortality should be reduced by 10 per cent in the 1—64 years old age group.**
3. **Cancer mortality should be reduced by 10 per cent in the 1—64 years old age group.**
4. **Mortality from accidents and suicides should be reduced by 10 per cent in the 1—64 years old age group.**
5. **Mortality from liver cirrhosis should be reduced by 10 per cent in the 1-64 years old age group.**
6. **Mortality from respiratory diseases should be reduced by 10 per cent in the 1—64 years old age group.**
7. **The elimination of communicable diseases preventable with vaccination, and a decrease in the incidence of new cases of AIDS and sexually transmitted diseases by 20 per cent.**
8. **Eliminate infant death from methaemoglobinemy; decrease the prevalence of ricket and rachitis below 5 per cent; and decrease DMFT by at least 20 per cent among children up to 12 years old.**
9. **Reduce significantly diabetes mellitus (II type), and osteoporosis.**
10. **Increase the number of health personnel by 10 per cent in the field of public health specifically.**

Box 2 HEALTH TARGET PROGRAMMES UNDER THE 1994 DECREE

- **Graduate and postgraduate education in public health.**
- **Public health monitoring.**
- **Secondary prevention (multiphasic screening).**
- **Family planning and family protection.**
- **School health.**
- **Physical activity.**
- **Healthy nutrition.**
- **Tobacco control.**
- **Alcohol and drug control.**
- **Mental health.**
- **Clean air.**
- **Noise control.**
- **Radiation control.**
- **Chemical safety.**
- **Optimal vaccination.**
- **Prevention of communicable diseases.**
- **Vaccination of hepatitis B.**
- **Tuberculosis control.**
- **Prevention of AIDS and sexually-transmitted diseases.**
- **Prevention of nosocomial diseases.**

In this vein, it is worth pointing out that the role of international players in the region has increased considerably over recent years. In 1991, the WHO modified its target system in accord with the new realities. Besides the WHO, the European Union, the Council of Europe and the World Bank also became very active. The European Union has secured special finances for promoting cooperation with the region, and the Tempus programme was of significant help in the modernisation of the public health training system. The World Bank has played a major role in financing developmental programmes: out of the twenty programmes cited in the 1994 resolution (Box 2), seven received support via a World Bank loan. Thus, performance indicators have been established in each programme to measure the attainment of objectives.

The Hungarian 'Healthy Heart Initiative'

Cardiovascular diseases are the leading cause of death in Hungary. The mortality rate from ischaemic heart disease is higher in Hungary than the Central and Eastern European average. Other related indicators are also very unfavourable: the hospital fatality rate for acute myocardial infarction is 22.4 per cent; dietary intake data shows 41 per cent of total calories are derived from fat; average blood cholesterol level is 5.7 mmol/l; 40 per cent of patients with hypertension are treated, but only 15–20 per cent controlled; 37 per cent of the population above 15 years of age are smokers; and only 21.4 per cent of males and 13.6 per cent of females engage in regular physical activity.

In light of these worrisome trends, the country's cardiovascular programme was taken over by a consortium led by the national institute of cardiology. The programme is called the Hungarian 'Healthy Heart Initiative' (HHI), and is a concerted action involving the widest possible range of stakeholders. Partnership and inter-sectoral collaboration has been developed among and between government agencies and profit and non-profit civic organisations. Measures specific to the following components of the HHI represent its main areas of activity: smoking, diet, nutrition and blood cholesterol, physical activity, high blood pressure, acute coronary care, and information technology.

Box 3 AIMS OF IHI SUB-PROGRAMMES

1. Anti-smoking programme

- Reduce the proportion of smokers above age 15 (37 per cent) by 8 per cent.
- Increase the proportion of smokers who quit smoking by 20 per cent.
- Reduce the number of smokers between the ages of 14 and 18 by 20 per cent.

2. Diet and nutrition programme

- Reduce average calorie intake delivered from fat from 41 per cent to 30 per cent by 2010.
- Reduce saturated fat consumption as a proportion of total calorie intake to 10 per cent by 2010.
- Reduce blood cholesterol levels of the adult population from 5.7mmol/1 to 5.3mmol/1 by 2010.

3. Physical activity programme

- Increase the number of people aged 15-65 who engage in regular physical activity to 35 per cent of population.

4. Hypertension programme

- To make 75 per cent of hypertension patients aware of their condition.
- Treat 60 per cent of hypertension cases.
- 30 per cent of hypertension cases should be controlled (monitoring blood pressure, to keep it below 140/90mm/Hg).

5. Acute coronary care programme

- Reduce lethality of hospital acute myocardial infarct patients to European average of 14 per cent by 2010.
- Determine adequate risk and revascularisation category for at least 75 per cent of patients by 2010.
- Provide all acute myocardial infarction patients with access to rehabilitation by 2010.

The overall target of HHI is to reduce current ischaemic heart disease mortality by 20 per cent by 2010, and it has several sub-programmes (Box 3). Further targets include:

– Reducing the proportion of smokers above age 15 by 8 per cent;

– Reducing blood cholesterol levels to attain an average of 5.3mmol/l in adults;

– Increasing regular physical activity in adults to an average of 35 per cent;

– Reducing the lethality of acute myocardial infarction in hospitals to attain 14 per cent; and

– Ensuring that 30 per cent of hypertension patients are controlled (i.e. maintaining blood pressure below 140/90mmHg).

Conclusion

Public health needs a long term strategy, and this requires the attainment of health targets so as to ensure full implementation of the 1994 health programme. That said, the programme needs government commitment and parliamentary legitimacy. Ratification of the programme would strengthen its legitimacy. Health target setting should become an integral part of developing the public health strategy, based on a priority-setting framework. Health target setting requires discussion amongst the broadest possible range of stakeholders to include different aspects of the problem and to garner as much support as possible. Finally, both a 'bottom-up' and 'top-down' approach are needed concurrently, and responsibility and accountability should be well defined. Incentives and sanctions should, therefore, be considered.

The state of mental health economics in the countries of Central and Eastern Europe and Central Asia

Ajit Shah

"Psychiatric disorders account for five of the ten leading causes of disability and include unipolar depression, alcohol use, bipolar affective disorder, schizophrenia and obsessive compulsive neurosis. Psychiatric disorders clearly impose a substantial burden in Central and Eastern Europe and Central Asia."

Context: approaches to the study of mental health economics

A formula for allocating resources among the various competing health care sectors is necessary because of limited health care budgets and a seamless demand for resources. Economic evaluation allows politicians, policy makers, managers and clinicians to make choices by guiding optimal use of limited resources. It provides data on the most efficient way of meeting a stated objective by assessing the costs and benefits of different methods.

Thus, economic evaluation can inform choices between different treatments, treatment settings and illnesses. Methods of economic evaluation include: cost minimisation analysis (CMA); cost-effectiveness analysis (CEA); cost-utility analysis (CUA); cost-benefit analysis (CBA); and, cost of illness analysis (COI).

CMA concentrates on costs and thus are helpful only when the outcome of two or more interventions is similar.

CEA compares the efficiency of alternative methods of treatment or delivery of services by establishing the monetary cost of implementation of treatment or service delivery and their clinical effectiveness on appropriate outcome measures.

CUA compares the efficiency of alternative methods of treatment or service delivery by establishing the monetary costs of treatment strategies or service provision and outcome, using a composite measure of health gain such as Quality-Adjusted Life Years (QUALY).

CBA involves complete evaluation of all sectors of society and measuring both costs and benefits in monetary units.

COI measures the economic burden of resources used to treat and care for a disorder from all sectors of society. Modern studies have developed methods for evaluating a range of factors (clinical, social, demographic, patient characteristics, service characteristics etc.) that predict costs. Such predictions can help more appropriate targeting of scarce resources.

This brief paper offers a general consideration – in order to generate debate – of the value of such studies to the mental health field in the Central and East European (CEE) countries and Central Asian Republics (CAR).

Reasons for paucity of studies

There are a number of reasons for the absence of mental health economic studies in psychiatry for the CEE and CAR. First, mental health has traditionally been a low priority health issue; second, mental health services have traditionally been less well developed than other health sectors; third, economic analysis and justification were previously not always needed; fourth, data sets needed for economic analysis were not always readily available; and finally, there has been a lack of health economists and absence of training in this emerging discipline.

Consequently, there are no formally published mental health economic studies from these countries. Nevertheless, a small number of CEA and COI studies have emerged from Yugoslavia, Serbia and Russia, but these have only been presented at scientific meetings (Table 1 over leaf).

Is there a need for mental health studies in the CEE and CAR?

The World Bank has developed an elegant method of measuring the burden of diseases in a common currency. This concept of global burden of disease (GBD) provides a composite measure of the loss of healthy

Table 1 Mental health economic studies from Central and Eastern European and Central Asian countries

Reference	*Country*	*Disorder*	*Type of study*
Skavysh, 1997	Russia	Suicide	Cost of illness
Solokhina et al., 1997	Russia	All	Cost of illness
Crnobaric et al., 1997	Serbia	Schizophrenia	Cost-effectiveness of drug treatment
Munjiza & Velickovic, 1997	Yugoslavia	Alcohol	Cost-effectiveness of family therapy
Munjiza et al., 1997	Yugoslavia	Drug misuse	Cost-effectiveness of prevention program

life from premature death and from disability. This is measured quantitatively by disability adjusted life years (DALYs). The GBD, as measured by DALYs, was estimated as 6.8 per cent for the world in 1990 and has since been revised to 10.5 per cent. Across the world this figure is as follows: sub-Saharan Africa, 4 per cent; India, 7 per cent; China, 14.2 per cent; Latin America and the Caribbean, 15.9 per cent; Middle East, 8.7 per cent; other Asia and Islands, 10.8 per cent; formerly socialist economies of Europe, 17.2 per cent; and, established modern economies, 25.1 per cent.

Psychiatric disorders account for five of the ten leading causes of disability and include unipolar depression, alcohol use, bipolar affective disorder, schizophrenia and obsessive compulsive neurosis. Psychiatric disorders clearly impose a substantial burden in Central and Eastern Europe and Central Asia. Thus, there is a clear and pressing need to develop psychiatric services for these heavy burden disorders.

Economic analysis can serve to highlight the need for such developments and facilitate a coherent and systematic strategy for service development. Moreover, monetary organisations like the World Bank will consider sound evidence of economic evaluation in the equation for funding projects.

Extrapolation of economic analysis from one country to another may not always be possible. This may be due to differing local health and social service characteristics, cultures, family life-styles, religions, levels of stigma attached to mental illness, local demography, local epidemiology of mental disorders, and local epidemiology of other medical disorders. These factors also influence the uptake and efficacy of any new treatment and new service development. As such, precisely because extrapolation may not always be possible, there is a need for local studies.

The methodologies for economic evaluations have been well established in many western countries and can be adapted for use in the CEE and CAR countries with appropriate local modification. Furthermore, many of the varied data sources required for economic analysis are now beginning to emerge from these countries. As services are also being newly developed, economic evaluative studies can be built into the new service development and be conducted as 'companion studies' to normal clinical practice. This would only require modest increases in research resources - often a problem in these countries.

Conclusions

New service developments are likely to emerge in parallel with the increasing burden. This will provide a unique opportunity to incorporate models of economic evaluation in the development of new services.

Moreover, the methodologies and the availability of the necessary data sets make economic evaluations more feasible than ever. Unless such activity is undertaken, psychiatry will be left behind other health care sectors. And, as competition for scarce resources is fierce, perhaps it will be left behind other societal sectors as well. CEE and CAR policymakers need to invest in such evaluations in psychiatry in order to ensure that this does not occur.

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Reform of mental health in Eastern Europe

Robert van Voren

Harvey Whiteford

A decade after fall of the Berlin Wall, the health sector in Eastern Europe is undergoing considerable reform..[1] Work on the global burden of disease has emphasised the significant burden associated with mental disorders, with five of the ten leading causes of disability world-wide being neuropsychiatric disorders. These in turn accounted for a quarter of total disability and 10 per cent of total burden in 1990.[2] The burden was estimated at 11.5 per cent in 1998[3] and is expected to rise to 15 per cent by the year 2020, with the rise being particularly sharp in developing countries.

Mental health care in many countries of Central and Eastern Europe and the Newly Independent States (CCEE/NIS) has an unfortunate legacy which makes the reform more complex, but the need for it more imperative. This sector is only slowly emerging from the international isolation which existed for half a century, brought on, in large part, by a legacy of the abuse of psychiatry that so concerned the international mental health community. This has complicated reform in a way that mainstream health has not experienced.

Under the previous totalitarian systems of the CCEE/NIS, mental health care evolved into a closed sector: it became disengaged not only from international mental health development, but so too from other sectors within their own countries, such as general health, social welfare and education. Changes which swept through most other countries with established specialised mental health services systems bypassed Eastern Europe.[4,5] The system of care remained predominantly custodial, hospital-centred and biologically oriented. Multi-disciplinary teamwork was underdeveloped as were clinical data collection systems; and primary health care did not see a role for itself in the treatment of mental disorders in many countries. Studies of service outcome and effectiveness were badly neglected, and consumer/patient rights were largely absent.

A decade of change

In 1989, fundamental changes started in mental health care, with organised psychiatry starting to reform itself. In March 1989, a group of Moscow psychiatrists established the Independent Psychiatric Association, as separate from the Soviet All-Union Society of Psychiatrists and Neuro-pathologists which, until then, had essentially monopolised psychiatry. A year later, new societies had emerged in the Baltic countries and Ukraine, as well as in Romania and Bulgaria, and today most countries have one or more psychiatric associations.

The non-governmental mental health sector also started to develop. Relatives' groups sprouted, psychiatric nurses formed representative bodies and, within ten years, at least a hundred mental health NGOs had emerged in the region. In many countries, Leagues for Mental Health or Mental Health Associations now exist (e.g. in Azerbaijan, Bulgaria, Georgia, Moldova and Romania). However, consumers have been slower in organising themselves, especially in the NIS.

By 1993 it had become clear that a more cohesive approach to the mental health reform movement was needed. Quite a number of reform initiatives had been undertaken throughout the region and a growing number of people had acquired new skills and knowledge. However, no links existed between these budding reformers and disunity often prevailed. In September 1993, with financial support from the Soros Foundation, the first meeting of a group called the Reformers in Psychiatry was organised in the Slovak capital of Bratislava. About sixty mental health reformers from a dozen countries in the region plus a group of Western experts and supporters met in an empty theatre in one of the suburbs of Bratislava. Despite initial pessimism, the three-day session saw the creation of a Network of Reformers in Psychiatry which exists today.

Since that initial gathering, there have been more than fifteen meetings of this Network and it has grown into a think-tank for mental health reform in the CCEE/NIS and a communication channel between mental health reformers. The Network unites some 500 mental health reformers in 25 countries and is multi-disciplinary. Membership consists of psychiatrists, psychologists, psychiatric nurses, social workers, sociologists, relatives of the mentally ill as well as a growing number of consumers. More than

fifty non-governmental mental health organisations in the CCEE/NIS are linked to the Network.

Also, in recent years, the nursing profession in the CCEE/NIS has consolidated its own reform, and many associations of psychiatric nurses have been established (e.g. in Belarus, Ukraine and Bulgaria). Professional psychiatric nursing can offer a perspective on mental illness, which is independent of but complements that of psychiatry. These developments are potentially innovative in reducing the dependence on services which consumers acquired within the authoritarian psychiatric model. In 1993, a training programme for psychiatric nursing was initiated in Ukraine with financial support from the Dutch Ministry of Foreign Affairs. In 1996, it was decided to further enlarge the project into a Ukrainian-Bulgarian initiative to develop a standard Russian language curriculum in multi-disciplinary teamwork. By 1999, the training programme had expanded to Moldova and the Kyrgyz Republic.

The professional reform has been assisted by the translation of dozens of books and articles from western languages, and has helped to close the information gap. In countries such Albania, Bulgaria, Lithuania, Romania and Ukraine, national publication programmes now exist. Effort is being directed toward translations of the International Classification of (Mental) Diseases (ICD-10) into CCEE/NIS languages. Both a Lithuanian and a Romanian edition of ICD-10 have been released. In the former USSR, the process of developing a Russian Glossary for Mental Health Terminology, in collaboration with the World Health Organization, will provide more uniformity of terminology and clinical language.

Reform of service delivery systems is also underway. Since the early 1990s, an increasing number of alternatives to custodial care in psychiatric institutions have been developed. In the Czech and Slovak Republics, community psychiatric services have become an integral part of the mental health care system, while the first steps in that direction are now under way in Bulgaria, Georgia and Ukraine. The community psychiatric centres in Prague, Bratislava and Michalovce (Slovak Republic) have agreed to become training centres in community psychiatric services for the whole CCEE/NIS region.

"Despite the historical and current difficulties faced by mental health care in Eastern Europe, some of the reform initiatives in the CCEE have much to teach the rest of the world."

Legislative reform of mental health acts has also been part of the changing landscape. By the summer of 1999, thirteen countries in the region had enacted new legislation and several more were considering new drafts. To supplement this, a number of the new psychiatric associations have begun to establish stronger ethical foundations for their work. In April 1998, at a meeting of the Network of Reformers, a model ethical code, 'The Ethical Duties of Psychiatrists', was officially adopted and plans are being developed to create guidelines for psychiatric bodies on how to disseminate the code. Increasingly, attention is being directed at how a more humane, patient-centred system of mental health care in the CCEE/NIS can be ensured. However, the usefulness of legal advocacy and ethical guidelines, as a tool of reform, depends on factors such as the maturity of legal institutions, the sophistication of the legal culture, and the level and pace of reform activity in other sectors within each particular country.

Future Prospects

In the coming decade, further change is necessary and desirable. This will occur in an evolving political climate. By 2010, a number of CCEE countries are expected to have either joined the European Union (EU) or to be in the pre-accession phase. Currently, Estonia, Poland, the Czech Republic, Hungary and Slovenia have entered the pre-accession phase, while Slovakia, Romania, Bulgaria and the remaining two Baltic countries are likely to be considered early in the new millennium. Per capita health expenditure in EU candidate countries is only one-fifth that of EU countries[6] and, without further economic growth and continued political reform, the potential for stagnation in those countries who are not part of the change is of concern.[5].

Reforms will also be challenged by the potential loss of some of the funding sources which have supported the reform process in the CCEE/NIS (e.g. the Open Society Institute of George Soros). Funding is likely to be increasingly dependent on local sources, both governmental (thereby making mental health reform projects dependent on either the State budget or health insurance sources) and private (local foundations and charities which are getting off the ground). Also, funding from sources such as the World Bank, UN institutions and Ministries of Development Aid are often provided through governmental channels which will challenge the developing NGO movement. The current economic difficulties in Eastern Europe make the dependence on this aid even more important.

For agencies such as the World Bank to become involved, the evidence for a social and economic return on the investment must be seen. There is substantial evidence that most of the now commonly-used mental health interventions are efficacious, that is, they work better than placebo in randomised controlled trials.[7] The review by Shah and Jenkins[8] analysed 114 cost-

effectiveness studies (10 from developing countries) and 14 cost benefit studies (one from a developing country) of specific mental health interventions and modes of service delivery. Despite the difficulties with design and analysis identified by Evers et al,[9] these studies have helped refine the interventions, albeit primarily for developed countries, which can produce the best outcomes at lowest cost. However, as these studies compare one psychiatric intervention or mode of service delivery with another, they provide limited information on the cost and health gain of interventions for mental disorders compared to other health conditions.

Little work has been done comparing cost and outcome in a common dimension such as Disability Adjusted Life Years (DALYs),[2] for interventions with mental disorders and other common health conditions. The limited work which has been done, however, suggests that interventions for serious mental disorders, such as schizophrenia and bipolar disorder, can result in equivalent or more savings in terms of DALYs averted than interventions for conditions such as diabetes, cancer and coronary heart disease.[10]

Despite the historical and current difficulties faced by mental health care in Eastern Europe, some of the reform initiatives in the CCEE have much to teach the rest of the world. With very limited resources, reform is, necessarily, being pursued flexibly, with many developing innovate strategies to meet patient needs, involve relatives and achieve better outcomes. The opportunity and potential to achieve quality, cost-effective care because of the enormous change being undertaken is starting to be recognised. Perhaps regions such as the CCEE will become a breeding ground for innovation, and Western European institutions and services may be able to learn from these experiences.

The opinions contained in this article are those of the authors and do not necessarily represent the views of the World Bank, members of its Board of Executive Directors or the countries they represent.

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Reforming the Pharmaceutical Sector in Croatia[1]

Panos Kanavos

"There is currently an acute problem with the payment of pharmacists, who are reimbursed by the Croatian Institute of Health Insurance as late as 6 months after submitting a claim. This has bankrupted several pharmacies some of which have subsequently been taken over by wholesalers."

Croatia has undergone a tremendous transition in recent years, one that involved war in the early 1990s and resulted in much destruction. The combined result of war and transition on the economy has been recession and stark hyperinflation between 1990-1994. The economy has only begun to register positive growth since 1994 (Table 1). In the context of such transition, the health sector in Croatia has been especially hard hit, with the reform process proving a challenging one. This brief paper looks at the pharmaceutical sector in Croatia, and considers the means necessary to reforming it such that it serves as a vital component of the wider health care reform process.

In an environment of rising health care expenditure, pharmaceutical spending has retained its high stake in total health care costs, ranging from 22 per cent (1997) to 28 per cent (1994) (Table 2). Per capita pharmaceutical spending has increased between 1994-99 along with the cost per prescription and, indeed, the number of prescriptions per capita. This indicates that more expensive products enter the Croatian marketplace, more expensive products are prescribed, that demand-side controls may be loose, or a combination of all these.

Table 1 Growth and inflation in the Croatian economy, 1990—97

Indicator	GDP growth (% change)	Annual inflation rate (%)
1990	-6.9	610
1991	-19.8	123
1992	-11.1	666
1993	-0.9	1518
1994	0.6	98
1995	1.7	2.0
1996	4.2	3.5
1997	5.0	3.7

Rising pharmaceutical expenditure requires an analysis of what drives drug costs up and whether resources are allocated efficiently, particularly in an environment characterised by economic downturn and resource scarcity. At the same time, the review of the chain of production, distribution, pricing, reimbursement, and consumption of pharmaceuticals and the application of reforms, where necessary, becomes a policy priority.

Issues in pharmaceutical sector reform

As in other countries, several agents are involved in the Croatian pharmaceutical sector, including the pharmaceutical industry, government bodies (Ministries of Finance, Health, Trade), wholesalers, retailers, doctors and consumers. Controlling the action of these agents requires multi-faceted and flexible policies that can be divided into three categories, focusing on: (i) the supply side and targeting pharmaceutical manufacturers; (ii) the proxy demand side targeting doctors and pharmacists; and (iii) the demand side and targeting patients. Successful and balanced policies that lead to an improvement in resource allocation for pharmaceuticals contain elements of both supply and demand.[1]

Macroeconomic factors

In addition to the above, other, more general factors may impact on the pharmaceutical sector. For instance, continuous growth is a necessary condition for sustainable financing of the health sector and the likely increase in the resources that are available to it. The issue of insurance contributions and the extent to which they are adequate to meet health policy objectives is also critical. Croatia currently faces problems with the collection of insurance contributions, and revenue consistently falls short of expenditure. Revenue shortages can destabilise the provision and delivery of health services, as well as payments to different providers. Indeed, there is currently an acute problem with the payment of pharmacists, who are reimbursed by the Croatian Institute of Health Insurance (IHI) as late as 6 months after submitting a claim. This has bankrupted several pharmacies some of which have subsequently been taken over by wholesalers.

Solving the problem of insurance contributions in a transition economy is certainly not easy. Action on

1. Much of the data in this article is based on an interview carried out at the Croatian Institute of Health Insurance in December 1999.

Table 2 The importance of pharmaceutical consumption in the health economy

	1994	1995	1996	1997	1998	1999 (est)
Total health care expenditure per capita (in Kuna)	854.9	1,087.1	1,156.7	1,323.9	1,874.6	1,570.8
Pharmaceutical expenditure as a % of total health care costs	27.91	26.07	25.14	21.93	23.97	19.95
Pharmaceutical expenditure per capita (in Kuna)	238.62	283.40	290.80	290.34	449.34	313.38
Cost per prescription (in Kuna)	53.19	62.58	58.14	53.08	75.39	80.46
Prescriptions per capita	4.49	4.53	5.01	5.41	5.99	6.82

Source: Croatian Institute of Health Insurance, December 1999.

several fronts is essential, particularly in what concerns: (i) the level of contributions, bearing in mind what the economy can afford to pay; (ii) the issue of who pays and how much, bearing in mind that there exists an extensive primary sector and a large proportion of the working population are self-employed; (iii) the size and extent of the parallel economy and how those employed in this sector pay for health services (accurate data is difficult to come by); and (iv) the choice between different methods of financing health services, including social insurance and voluntary (private) insurance on the basis of affordability.

Pharmaceutical sector reform focus: the main problems

Supply side

Two key elements underpin the focus on the supply side: pricing methodology and the reimbursement list. In Croatia, pharmaceutical prices are calculated on the basis of *external* referencing, i.e. taking the average of France, Italy and Spain. According to one source, the target price in Croatia is 90 per cent of the derived average. The average prices obtained are revised annually and the body responsible for the monitoring of the system and the setting up of the average prices is a committee in the IHI.

For a country like Croatia, the system of average pricing may be unsatisfactory for a number of reasons. Firstly, it requires continuous monitoring of prices in the target countries and may be expensive in terms of acquiring data on a frequent basis. Secondly, it may be unsatisfactory for many companies, since inflation differentials may change the cost of inputs, or even the final product. Thirdly, this methodology leads to price-fixing, but has no actual implications for volume sold. Finally, and most importantly, the average of French, Italian and Spanish prices reflects the ability and/or willingness to pay in these three countries, where the standard of living is currently much higher than in Croatia. In order for such prices to reflect current standards of living in Croatia, a higher wealth adjustment may be necessary, particularly for imported pharmaceuticals, for which little or no value is added locally. An alternative for the short-term might be the introduction of a cost-plus methodology for in-patent medicines and *internal* reference pricing for multisource drugs. And, in the longer term, a methodology more geared towards economic criteria, on the assumption that sufficient competence and infrastructure exists in health economics.

With regards to the reimbursement list, there are two positive lists, one for primary care containing about 250 drugs and drug combinations (a total of 613 different dosage forms or products) and one for hospitals, which includes all drugs on the primary care list, in addition to a further 615 products. The Committee responsible for deciding on which drugs are to be listed has two major failings which may lead to inconsistencies in what is included in the list. First, it includes neither a general practitioner nor a pharmacist; and second, as the experts are all based in Zagreb, other parts of the country are not represented properly. The committee generally meets monthly, and considers 10–20 drugs at each meeting. Presumably it may also consider deletions of unnecessary old drugs. The committee asks for the 5 best clinical trial reports, a clinical pharmacology report and a pharmacoeconomic analysis. It subsequently makes a recommendation to the Board of the IHI. The Board nearly always accepts this, but takes up to a year to do so. Although several documents are in principle requested for submission, these may not be reviewed adequately or not at all; particularly the pharmacoeconomic analysis. Furthermore, the time it takes for the Board to decide is far too long, and certainly this could be shortened.

Because generic names signal the therapeutic class to which a drug belongs, and underline the relationships between drugs in the same class, rational therapy would be helped if drugs were primarily referred to and prescribed by generic names. Brand names should be used only where there is a medical/pharmaceutical reason for identifying a particular brand. Special provisions would be appropriate for expensive products, especially those intended and perhaps needed for long-term use. It is especially important for such products to be used in accordance with guidelines that: (i) specify the indications in detail; (ii) describe the sort of supervision that the treatment requires; (iii) outline what qualifications are required for that supervision; and (v) indicate at what intervals the patient should be reviewed. The use of individual expensive therapies should be monitored in a regular system of clinical audit.

Proxy demand side

Little is done to monitor and evaluate prescribing, and data on dispensing collected by the IHI from community pharmacists are either under-utilised or, due to personnel shortages, not utilised at all. Physicians in Croatia continue to

write prescriptions manually, and there is effectively no control over what is prescribed – at least not until the prescription is dispensed at a pharmacy, where the pharmacist will enter the relevant data into a computerised spreadsheet and will eventually submit this to IHI.

An integrated system of monitoring and evaluation that would provide accurate information on prescribing patterns and dispensing, and would guarantee a continuous flow of information between prescribers, dispensers and health insurance, needs to be put in place. It would also be required to provide detailed information on diagnosis, prescribing and consumption. Health insurance can use this information in four ways. Firstly, to scrutinise pricing and payments to contractors for the dispensing of prescriptions. Secondly, to provide prescribing and dispensing information to the entire health service. Thirdly, to manage the Croatian Institute of Health Insurance's income availability. And, finally, to prevent prescribing and dispensing fraud within the health service.

Another major area where work needs to be done is rational drug use. Rational drug use encompasses a set of policy actions targeting mainly prescribers, but also consumers/patients. Policies on rational drug use have a long-term horizon, combined with an element of continuity. They comprise changes in national education curricula of medical, dental and pharmacy students; improved and objective sources of information for prescribers; continuing education for practitioners; monitoring and evaluation of prescribing patterns at the national level; and promoting consumer/patient awareness of public health issues.

On the issue of information, it is perceived that independent drug information as it currently stands is inadequate. There exist two publications in Croatia offering information sources: *Pharmaca* (published since 1963) and *The Hospital Drug Bulletin of the University Hospital Rebro* in Zagreb (published since 1976). While it is understood that both journals are distributed to subscribers only, it would be very important for relevant non-subscribers to receive copies. For instance, the independent drug bulletin published in Zagreb goes to all 600 doctors in 2 hospitals in Zagreb, and to 1,200 subscribers: a total of 1,800. The total number of doctors in Croatia is 10,000. Consequently, over 80 per cent of doctors get no independent information. This should be improved and the IHI could play a major role in the dissemination of information and ensuring its easy access to prescribers.

Monitoring the implementation of policies on rational drug use is also a key policy element. Currently, there is no systematic monitoring of consumption determinants, although efforts are under way to do so in the future.

Prescribing guidelines are a means of indirectly controlling prescribing patterns through recommended action by physicians. Such guidelines can either be positive or negative. Priorities for draft guidelines could be given to conditions where prescribing and, therefore, spending, is highest. According to the IHI, the five most expensive health (pharmaceutical) problems in Croatia are infections, gastrointestinal disorders, psychic disorders, hypertension and musculosceletal diseases. Guidelines could be developed in these areas with the consensus of the medical profession. The drafting of guidelines is a key focal point in the process of evaluating the clinical cost-effectiveness of new technologies and the extent to which the most recent innovations do provide therapeutic benefit at a reasonable cost. The uptake of cost-effectiveness analysis should be done over the long term, and must be preceded by training and education of the relevant stakeholders (insurance, doctors, industry). This must focus on the principles of cost-effectiveness and its implementation in pharmaceutical policy-making.

Physicians are currently prescribing by brandname and should be educated and encouraged to prescribe generically wherever this is possible. As a short-term measure, the Ministry of Health and/or the IHI might wish to request that physicians ensure that a proportion of the total value of their prescriptions (e.g. 20 per cent) is for cheaper products, including generics. Generic prescribing would be further facilitated if prescribing physicians were given prescribing budgets to manage within their practices. Prescribing budgets might be set on a historical basis and take into account the population mix that each practice serves. They could also be fixed and subject to penalties if exceeded. Prior to the implementation of such a measure, however, the training of doctors may be necessary. Generic substitution should be encouraged and practised by pharmacists wherever possible. If this becomes the case, then due consideration should be given to the incentive structure of pharmacists' payment methods, which is currently a flat fee per prescription.

Demand side

Patient co-payments currently amount to less than 1 per cent of the total cost of medicines. They are fixed at 1 Kuna per prescription. The elderly, children, and war veterans are currently exempt from co-payments. The current level of co-payments does not serve as a means of raising patient awareness of the cost of medicines. Nor is it a significant source of revenue for the health service. Higher flat rate co-payments could be used as a means of raising additional finance. Alternatively, they could be used to raise both patient awareness and funds for the health service. In this case, the option would be to decide their level depending on the condition treated. For example, life-saving drugs would be fully reimbursed, whereas less essential drugs would have high co-payment rates. The government also needs to actively promote self-medication and take action towards delisting old medicines by offering them over-the-counter (OTC).

Industrial policy

The pharmaceutical industry is an asset for the Republic of Croatia. The domestic industry is strong and, with several subsidiaries of foreign multinationals, provides employment, contributes to manufacturing value-added, and links the clinical

side with the commercial sector through clinical trials. Alongside health policy, ensuring safe, efficacious and affordable drugs, industrial policy should focus on the type of activities that the industry is pursuing locally, favouring particularly any R&D conducted in the country as well as manufacturing activities. This should be distinguished from protectionist and discriminatory policies that apply to the foreign industry at large, or some of its components.

Concluding remark

Pharmaceutical sector reform is not an easy task under the circumstances that Croatia currently faces. Clearly, the key elements of such reform should give emphasis to the demand side, whilst also addressing gaps on the supply side. While the latter are a relatively short-term matter, the former would require investment in infrastructure and long-term commitment. Action on the supply-side should also take into account industrial policy issues.

Protection of pharmaceutical inventions in the Czech Republic

Ludmila Sterbova

The Czech Republic attaches great importance to the protection of intellectual property rights, as confirmed in the 1998 Programme Declaration of the Czech government. The Czech Republic is well aware that the legal protection of intellectual property rights as applicable to the development of new pharmaceutical products and their introduction onto the market is very important, not only to all researchers and manufacturers of medicaments, but also with respect to attracting foreign direct investment and boosting local research and development.

Under the present system of Czech public law, the protection of pharmaceutical intellectual property rights is in line with the standards prevailing in many developed countries. Owners of a new invention and production process have their intellectual property protected against misuse by third-parties, although the degree and manner of this protection is not always the same. The Czech Republic fulfils all obligations under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) regarding pharmaceuticals. And although the Czech measures guarantee a certain degree of protection for pharmaceutical discoveries, in view of the country's aim to join the European Union (EU), some will nonetheless require amendment to make them compatible with EU legislation.

Patent protection

Obtaining a patent for a new idea (product patent), or a patent for a production process based on the new idea (process patent), are among the basic intellectual property rights available for pharmaceutical products in the Czech Republic. The aim of such protection is to prevent unauthorised third persons from making and using the patented idea and production process, and from either selling or importing it, else offering products obtained through this process for sale.

As mentioned, Czech patent arrangements are in harmony with the TRIPS agreement. Pharmaceutical products have been patentable in the Czech Republic since 1991 under Act No. 527/1990, Coll. on inventions, innovations, and industrial designs (in the wording of Act No. 519/1991, Coll.). The conditions and manner of patent protection for medicaments in the Czech Republic are identical with those in EU Member States (some of which in fact introduced medicaments patenting later than the Czech Republic). The Czech Republic provides protection to the first person to have filed a patent application for a given product or process. The period of protection is for 20 years from the moment the application is filed, providing that the invention has not already been published or introduced onto the market.

Since medicaments and pharmaceutical products could not be patented in the Czech Republic before the 1991 Act took effect, the law allowed the additional registration (from 1st January 1991 to 31st December 1991) of inventions which had already been protected by a patent in other countries – known as 'pipeline protection'. To some extent, this compensated owners of valid patents on products already on the Czech market. Until 1991 it had only been possible to protect, by patent, the production procedure of medicaments. The idea was not protected, though the expression of idea was protected under copyright law. Under this 'retroactive' provision of Czech patent law, 218 applications have been filed: 145 of them were declined and to date, only 16 have been granted. For the remaining applications, the applicants have not yet fulfilled all their obligations as required under Czech patent law.

Exhaustion of rights

Under the above-mentioned Act No. 527/1990, Coll., the principle of the national exhaustion of rights in the Czech Republic applies to patented pharmaceutical products. When the owner of the rights decides to intro-

duce the product involving the protected idea onto the Czech market, its further movement (sale) within this market cannot be prevented, as the rights are thus exhausted on the national market. When the Czech Republic accedes to the EU it will adopt the principle of the communitary exhaustion of rights. Under this principle, the EU territory is taken as a single market, and so the rights are exhausted in all Member States when the product appears on the market of one of them. There are some indications that EU manufacturers are worried about the application of this principle to the markets of the applicant countries because it can deepen the problem of parallel imports. But as Czech legislation will be fully harmonised with EU legislation a long time before the country's accession, the danger of parallel imports from the Czech Republic will not pose any more of a threat than results from the communitary exhaustion of rights in another EU member countries. The regulations pertaining to the parallel importation of medicines are currently under evaluation in the EU, and the Czech Republic will be watching such debates very carefully.

Supplementary protection certificates

A large section of the protective term guaranteed by the patent, 10 to 12 years on average, expires in the period between the invention of the medicament and its commercial use. For this reason, many advanced states (but not all of them) provide the legal possibility of acquiring supplementary protection certificates for medicaments, which in fact prolong protection for more than 20 years. This legal arrangement is made possible (but not obligatory) by the TRIPS Agreement. The Czech Republic is preparing an amendment to Act No. 527/1990, Coll. to enable – in harmony with EU practice – the issuing of Supplementary Protection Certificates for medicaments introduced and patented on the Czech market. This amendment has been accepted by the Czech Chamber of Deputies of the Parliament in the beginning of March this year, and should take effect sometime during year.

Supplementary protection certificates will be issued for a maximum of five years. However, this period can be shorter, as it is derived from the period which elapses between the patent application and the day of the first registration allowing commercial use of the product: a potential shortening by some five years. Application for a supplementary protection certificate must be submitted within six months from the issue of the first license to introduce the product on the market.

Experimental use

Experimental use of an invention – while this is protected by law – is a very sensitive matter in connection with the protection of medicament inventions and with supplementary protection certificates. Experiments and tests needed for the registration of medicaments will not be allowed in the Czech Republic during the period of validity of patents and supplementary protection certificates, not even by the amendment to Act No. 527/1990, Coll. The amendment will only allow the experimental use of the result of the invention, which is in conformity with EU legislation.

Although the amendment will secure harmony between the Czech and EU legislation, its practical implementation does not need to guarantee – at least not initially – an identical degree of protection in the EU and the Czech Republic for all holders of intellectual property rights regarding pharmaceutical products. Difference in the degree of protection can have several causes. One of them could be the possibility of acquiring supplementary protection certificates only for products introduced on the market after the amended law becomes valid. Products registered in the Czech Republic for commercial use before this date do not get supplementary protection and their protection expires together with the protected patent period. Neither will supplementary protection certificates apply to products for which patents were not awarded in the Czech Republic, even if they are introduced on the Czech market after the amended Act No. 527/1990, Coll. takes effect.

Despite the Czech Republic's interest in harmonising its practice of granting legal protection to intellectual property rights with that of the EU, it is very difficult to find a systematic arrangement. It is unfortunately impossible to legally accept the principle of granting the same supplementary protection to all owners of patents and of supplementary protection certificates valid in the EU as they enjoy on the EU market. This would discriminate against other patent owners according to the criterion of territorial pertinence. Harm could also be done to EU owners of inventions registered in the Czech Republic and against those who made no investment into obtaining patent protection in the Czech Republic. In the short-term, therefore, the protection of rights holders will not be identical. But, since relevant Czech legislation will be brought in line with EU standards prior to accession, these differences will be soon eradicated.

Protection of undisclosed information

In the Czech Republic, the introduction of a pharmaceutical product onto the market first requires a state license. The application for registration must be accompanied by a number of documents, primarily those confirming the results of clinical tests. Most of the data contained in these documents are secret, belonging to the category of so-called 'undisclosed information'. As a member of the World Trade Organization, the Czech Republic is duty-bound to protect this data against publication, and thus against unfair commercial use; although the TRIPS Agreement does not directly stipulate the period of such protection.

In keeping with the TRIPS Agreement, however, the Czech Republic provides six year protection to undisclosed information acquired in connection with application for the registration of a pharmaceutical product. This protection is provided under Act No. 79/1997, Coll. on medicaments. The six year protection term commences with the submission of the application for a license to introduce preparation onto the Czech market, and covers

data on pharmaceutical products irrespective of whether they are protected by a patent in the Czech Republic or not.

Trademarks

Finally, mention must be made of the protection of trademarks under which medicaments are introduced onto the market, and the protection of the trade name of the manufacturer and the distributor. Relevant legislation in the Czech Republic has a high standard (the country is member of the Paris Convention, the Madrid Treaty and the Protocol to the Madrid Treaty). Trademark legislation will be fully harmonised with EU provisions during 2000, and will meet all requirements and obligations of the TRIPS Agreement.

Conclusion

To conclude this summary of the legal provisions pertaining to pharmaceutical patent protection in the Czech Republic, some additional notes regarding particularly sensitive areas – and recent occurrences – are provided.

As a signatory to the TRIPS Agreement and being an accession state to the EU, the Czech government is dedicated to achieving a high level of protection and enforcement of the intellectual property rights for medicaments. This task is, however, complicated by various pharmaceutical industry lobbies representing contradictory attitudes with respect to: the Supplementary Protection Certificate; the experimental use of patented inventions; and the protection of undisclosed information. These differing inter-industry positions arise from different economic interests, and reflect the division in orientation between the research-intensive manufacturers on one side and the producers of generics on the other. Both positions are reinforced by the government's interest in fulfilling all obligations under the accession documents and by the ambition to create favourable conditions for the domestic industry.

During both the preparatory stage of the amendment of the patent law and its consideration in Parliament - from the end of 1999 to early 2000 before the amendment was put to the Senate – both industry lobbies were very active. The generics lobby focused on the provisions for SPC and put pressure on the government for the prohibition of experimental use, with the aim of weakening the SPC provisions. Although the generics lobby had the strong support of the European Generic Medicines Association (EGA), the government's proposal aimed at the high level of protection of pharmaceutical inventions was approved and adopted by the Chamber of Deputies in the final reading. The final decision will be made by the Senate in April this year.

The amendment of the patent law is favourable to the principle of pharmaceutical patent protection. It introduces new provisions enabling judicial authorities to order the seizure and destruction of counterfeit goods, including material and equipment used for the production of such goods. Its coming into force represents a further step in establishing a level of industrial property protection in the Czech Republic which is similar to that existing in the EU Member States. This also represents an important step in fulfilling the country's obligations towards EU accession.

Despite the government's success in the achieving such a high level of protection, the research-oriented manufacturers have pointed to other problems concerning parallel importation, compulsory licences, experimental use, and the length of the protection period for undisclosed information.

Parallel importing is not a phenomenon specific to pharmaceutical producers but is connected to marketing, and more especially to pricing policy. As pricing policy for all products is based on the local market and its comparative buying power, parallel importing is bound to occur and cannot be prevented by any other means save economic ones. The use of intellectual property rights legislation is on its own ineffective, as the experience of Australia shows where the prohibition of parallel importation has been adopted under copyright law.

Regarding the experimental use of inventions the anxiety of research-oriented producers is understandable. The legal provisions for experimental use in Canada and the EU, for example, have long been under consideration by the Dispute Settlement Body of the World Trade Organisation. It is a complicated area, and pharmaceutical industries across the world are impatiently waiting on the panel's conclusions. In this area the Czech Republic meets the recommendations of the European Patent Office and meets the provisions of Articles 25 – 27 of the Community Patent Convention concerning the effects of a patent. The interpretation of the experimental use – which is respected in the Czech Republic – clearly states that the manufacture of samples and the conduct of clinical trials on the patented substance, etc. will not be regarded as acts carried out experimentally and for non-commercial purposes. There are no court decisions in the Czech Republic according to which commercial testing would be regarded as non-commercial, or non-economic activity and as not infringing on a patent.

The possibility of granting compulsory licences under specific circumstances, which is a part of existing patent law and will continue under the amendment, should also not be a cause for uneasiness. Czech provisions for granting a compulsory licence meet all requirements of the TRIPS Agreement. But it is worth adding that no compulsory licences, in any field, have been granted in the Czech Republic to-date.

The period of protection for undisclosed information – having been 6 years in the Czech Republic since 1998 - will undoubtedly be extended to 10 years for drugs approved via the centralised procedure according to the EU Directive. But the protection of undisclosed information is a very sensitive issue because it assures the real protection of an invention, which does not fall under legislative patent protection. Last year, it was very difficult to persuade the Chamber of Deputies as to the necessity of confirming the 6 year period in the amendment of the law. The amendment aimed at abolishing the protection of undisclosed infor-

mation was initiated by private sector.

So far the discussion has focused on specific legislation which can protect pharmaceutical inventions. But of equal importance is the wider jurisdiction dedicated to the enforcement of intellectual property rights. In the Czech Republic, the relevant laws are the Civil Code, the Penal Code, the Civil Procedure Code and the Penal Procedure Code. No special law to enforce intellectual property rights per se exists, and no special court has been established. In the field of industrial property rights the Czech Patent Office carries out a declaratory judgement procedure and a revocation procedure. The reversal of the burden of proof in proceedings concerning the infringement of the process patent is regulated by the Patent Law, and in other cases by the Civil Procedure Code. It necessary to point out that very few cases of pharmaceutical patent infringements are solved each year due to the lack of accusation and entries for trial. The more intensive collaboration of the pharmaceutical industry with the Czech police, customs and trade inspection is needed and will be useful for all parties involved in the fight against crime in the field of intellectual property rights.

The Czech pharmaceutical industry is mostly oriented and based around the production of pharmaceuticals for which patent protection has expired. As it is in the interest of society to have access to new medicaments as soon as possible, and at the lowest price possible, the public's support of the generics industry position regarding the enhancement of the level of the patent protection (i.e. to conserve or to lower this level) is not surprising. This support can be easily transformed into strong pressure on the government and the Parliament. Finally, it is highly desirable that Czech producers turn to a system of production under licence, and that the will of foreign research-oriented manufacturers to do so is also cultivated. This is a very prospective step to eliminate the contradictory economic interests in the protection of intellectual property rights.

Recent Publications on Public Health and Health Care

Public Health Policies in the European Union.
Holland WW & Mossialos E (eds) Ashgate: Aldershot, 1999. ISBN 0-7543-2072-7.

The role and status of public health in Europe has again become increasingly recognised. This is not only in individual countries but also in the policies of the European Union as exemplified in the Maastricht and Amsterdam Treaties. This book is a critical account of the present structures and policies of member countries and how policies have evolved within the European Commission. It describes both possible models and needs, and contrasts these with the current supranational and national legislative frameworks.

Preceded by two overview chapters of the public health developments in Europe, and the EU's role specifically, the country chapters focus on developments specific to national circumstances and offer insight into the requirements of each Member State. Written by national authorities in the field of public health, this book provides grounds for comparative analysis between EU states, and thus serves the needs of practitioners, policy makers, policy analysts and students interested in public health and social policy developments.

Managed Health Care: US Evidence and Lessons for the National Health Service.
Robinson R & Steiner A. Open University Press: Buckingham, 1998. ISBN 0-335-19948-8.

In the United States, the concept of managed care has revolutionised the manner in which health services are both financed and delivered. Specific techniques including physician profiling and disease and utilisation management have been developed as a result, and in light of its perceived success, many analysts continue to forward managed care as a general model for bettering health system performance. The book reviews the literature and outlines the fundamentals of managed care in the US, before then exploring its relevance to the British National Health System. In particular, it considers the early research evidence on primary care-based total purchasing pilot projects.

Essential reading for anyone interested in evidence-based policy-making in this crucial area, the book argues that despite its recent popularity, not enough attention has been paid to the official research evidence on managed care. The authors aim to fill this gap, and the book provides a thorough review of the research evidence on managed care, along with a detailed appraisal of the performance of managed care in relation to areas such as utilisation costs, health promotion and screening, and the quality of care.

Learning from the NHS Internal Market.
Le Grand J, Mays N & Mulligan J (eds). Kings Fund: London, 1998. ISBN 1-85717-215-9.

In light of the Labour Government's proposed changes for the British National Health service, as published in their White Paper, The New NHS, this book asks what can be learned from the internal market reforms instituted in 1991 under the Conservative government of Margaret Thatcher. Specifically, therefore, it explores the impact of the internal or 'quasi'-market.

Relevant to health services researchers, policy analysts, health care managers and anyone interested in the impact of major health care reform, the book raises questions about the effectiveness of the 1991 reforms with regard to the three main changes: health authority purchasing and local commissioning; GP fundholding and total purchasing; and NHS trusts. It examines the available evidence concerning the changes (or lack of them) in efficiency, equity, quality, choice, responsiveness and accountability. It draws out some of the lessons to be learned from the experience, and it investigates whether the next set of NHS reforms – those introduced by the Labour Government in 1997 – show any sign that the lessons have been learnt.

MSc in International Health Policy

Scope and Aim

Health care reform in an international context has created the need for informed choices by practitioners and providers, and the need to assess the impact of reform measures at the micro and macro levels.

The new degree approaches health policy from an international and comparative perspective. The course will enable graduate students to analyse, assess and plan the reform process, evaluate health systems at both micro and macro level, grasp how international organisations operate and understand health policy formation and process in different socioeconomic, political and cultural environments.

Attractive features of the new degree include:

- compulsory (paid) summer internships with major international organisations, private companies, governmental organisations and other leading academic institutions, as part of the overall student assessment; in addition to serving as an opportunity to gain valuable work experience whilst in full- or part-time education, the internship links the academic with the policy-making world and enhances graduate career opportunities;
- students will have the opportunity to take advantage of the international reputation of the School in social sciences in general and health policy in particular; during the course of the MSc, they will meet with senior policy-makers from international organisations, government and industry who will be visiting, teaching or participating in research projects;
- the course is based within LSE Health, a specialist centre within the Department of Social Policy & Administration and students will have access to some of the facilities of the centre comprising databases, an observatory on health reform, and a clearinghouse in pharmaceutical economics;
- new courses focusing on specific aspects of the health care sector, such as assessing health reform, pharmaceutical economics, hospital economics and management;
- emphasis on the policy side, thus enabling students to return to their home countries and understand as well as implement changes in their respective health systems;
- obtain state-of-the-art knowledge on health systems and the process of change from an international perspective and from a number of leading academics, building on networks that LSE Health has established across the OECD, Eastern Europe and the emerging economies in the Far East and Latin America.

About the Programme

Compulsory course: European & Comparative Health Policy

The course analyses aspects in the development of health systems mostly in OECD countries and Eastern Europe from a comparative perspective.

Compulsory dissertation

The MSc degree entails a 10,000 word dissertation on a relevant topic which is compulsory and is undertaken during a summer internship with a governmental, international, private, academic or research organisation/institution.

Optional courses

Candidates will be required to attend and be assessed on two full units or up to four half units from a list normally including the following courses:

- Hospital Economics and Management (half unit)
- Pharmaceutical Economics (half unit)
- Health Economics (two half units)
- Design and Management of Organisations (half unit)
- Public Economics I
- The Economic Organisation of the European Community (full unit)
- Quantitative Analysis in Social Research I (full unit)
- Quantitative Analysis in Social Research II (full unit)
- The Demography of Developed Societies
- Any other relevant graduate level paper (with permission of MSc coordinator and the teacher of the paper)

The Summer Internships

The summer internships are an integral component of the MSc International Health Policy. Their is to provide students with the opportunity of gaining valuable working experience as well as link them up directly with potential employers who may require their skills after they have completed their degree. During the course of the MSc, several of these employers will be visiting the School and interviewing potential candidates for summer internships. Many international organisations, national governments, academic institutions, employers (hospitals) and the private sector have committed themselves to providing one or more internships per year to the course graduates. There is also considerable variety in the location of these institutions and graduates will have a wide choice between UK, Continental European and non-European institutions.

Who should apply

You would need to have a first degree in a relevant academic subject (science, medicine, economics, other social sciences) at a standard equivalent to a British university upper second class honours. Relevant professional experience would be advantageous but not essential.

For further information, please write to :
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European Observatory on Health Care Systems

In June 1998, the European Observatory on Health Care Systems (EOHCS) was founded. It comprises three research hubs – Copenhagen (WHO Regional Office for Europe), London (the London School of Economics & Political Science and the London School of Hygiene & Tropical Medicine) and Madrid (the National School of Public Health).

The Observatory is committed to:

- working in partnership with governments to describe accurately health care systems and the changes they undergo
- utilising experience from across Europe to illuminate policy issues
- bringing together a wide range of academics, policy-makers and practitioners to analyse trends in health care reform
- drawing on the strengths of our partner organisations and networks to provide evidence-based advice to national policy-makers

EOHCS supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The European Observatory on Health Care Systems is a unique project that brings together seven major partners:

- World Health Organization Regional Office for Europe
- Government of Norway
- Government of Spain
- European Investment Bank
- World Bank
- London School of Economics and Political Science (LSE)
- London School of Hygiene and Tropical Medicine (LSH&TM)

The European Observatory on Health Care Systems:

- produces detailed country profiles for each of the countries in WHO's European Region – the forthcoming series of Health Care Systems in Transition reports includes Poland, Croatia, the UK, Germany and Portugal
- compares trends across countries
- analyses key policy issues
- runs a clearing-house for publications on health care reform
- maintains a web site
- offers short-term fellowships for policy-makers
- provides technical guidance for policy-making

If you would like more information about the Observatory please contact:
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