Progress and strategy paper

Health

Series : PHARG

Progress and strategy paper

Health

Lead Author Hélène Bourgade
Editors Vittoria Alliata, Jonathan Hatwell

Foreword

This paper is part of a series which will cover each of the main areas of Phare activity. It describes the nature of the problems faced in Phare's partner countries during their transition from planned to market economies. It goes on to examine actions undertaken to date, and to assess their impact on the transformation process.

There is clearly a need to ensure that the approach being taken in any given sector is relevant to the longer-term goals of economic transformation. For this reason, these papers also contain the thinking of those responsible for operating Phare on actions for the future and how Phare should contribute to the next phase of the transition.

The papers do not reflect any official position of the European Commission. They have been written by the Phare Operational Units and are intended as a stimulus to discussion for all those involved in the debate on economic transformation in central and eastern Europe.

Alan Mayhew

Relations with central and east European countries

The Phare Programme

The Phare Programme is a European Union initiative which supports the development of a larger democratic family of nations within a prosperous and stable Europe. Its aim is to help the countries of central and eastern Europe rejoin the mainstream of European development and build closer political and economic ties with the European Union.

Phare does this by providing grant finance to support the process of economic transformation and to strengthen newly created democratic societies. Phare also provides grant finance to help countries with Europe Agreements integrate with the European Union.

In its first five years of operation to 1994, Phare has made available ECU 4,283 million to 11 partner countries, making Phare the largest assistance programme of its kind.

Phare works in close cooperation with its partner countries to decide how funds are to be spent, within a framework agreed with the European Union. This ensures that Phare funding is relevant to each government's own reform policies and priorities. Each country takes the responsibility for running its own programmes.

Phare provides know-how from a wide range of non-commercial, public and private organisations to its partner countries. It acts as a multiplier by stimulating investment and responding to needs that cannot be met by others. Phare acts as a powerful catalyst by unlocking funds for important projects from other donors through studies, capital grants, guarantee schemes and credit lines. It also invests directly in infrastructure, which will account for more Phare funds as the restructuring process progresses.

The main priorities for Phare funding are common to all countries, although everyone is at a different stage of transformation. The key areas include restructuring of state enterprises including agriculture, private sector development, reform of institutions and public administration, reform of social services, employment, education and health, development of energy, transport and telecommunications infrastructure, and environment and nuclear safety. Under the Europe Agreements, Phare funding is being used to make laws compatible with European Union norms and standards, and to align practices.

Table of contents

Executive summary 7

Introduction 8

Section 1 - The health sector in the central and eastern European countries 9

Main trends 9
Priority reform needs 14

Section 2 - Phare activity in the health sector 17

The rationale for Phare involvement 17
Overview 18
Initial assistance 19
Current forms of support 19

Section 3 - Assessment and future orientations 21

Assessment 21
Future orientations 22

Annex I - Programme summary sheets 23

Annex II - Health indicators for central and Eastern European countries, the European Union and OECD 26

Annex III - Main areas of activity in the health sector 27

Executive summary

This paper is concerned with the reforms and restructuring necessary in the central and eastern European countries to render their health services economically viable and socially acceptable. In particular, it focuses on how Phare can support this difficult transformation.

It begins with an analysis of the serious problems existing in the health sector at the outset of the wider transition in which these countries are engaged. The main trends in terms of people's health status in the central and eastern European countries are an increasingly dependent population, rising mortality rates and the spread of non-infectious diseases, particularly those linked to lifestyle and environment. These problems are accentuated by structural imbalances in the health services, which are too hospital-centred and give insufficient attention to community-based services which have been shown in western industrialised countries to be a more appropriate and cost-effective way of responding to many health care needs. Preventive services have been cut back at the expense of curative services. Resource allocation was conducted in an inefficient and inequitable way and the resulting problems have been compounded by a decline in the economy's financing capacity. Further difficulties are found in terms of human resources, with over-specialisation of staff, the concept of the general practitioner being almost non-existent at the outset of the reforms. The management function is also gravely underdeveloped. Privatisation and liberalisation in the pharmaceutical sector have proceeded outside any clear legal framework and developed in an uncontrolled way, with the result that many medicines are no longer widely affordable.

In the light of this analysis, this paper identifies the key reform and restructuring needs, which are the reorganisation of the health services, in particular to make them less based around hospital care and to develop community care, the reform of the financing systems, the elaboration of a pharmaceutical policy, meeting the training and retraining needs found in the new health service environment and the development of disease prevention and health promotion activities.

Phare's contribution towards meeting these needs is then discussed. Over ECU 100 million has been made available for health sector reform in the period 1990-1993, excluding humanitarian assistance. After initial interventions geared to supporting the maintenance of a number of basic services in the opening phase of the central and eastern European countries' transition, through delivery of emergency supplies, Phare is now concerned almost exclusively with resolving the structural imbalances identified above. A framework for intervention is set out identifying priority reforms in the areas of health service reorganisation and financing, pharmaceutical policy, human resources, and preventive medicine/health promotion.

The paper concludes with an assessment of progress in meeting the objectives of the Phare programme in the health sector, together with a discussion of strategic orientation for future actions. By definition, it is too early at this stage to measure the impact of structural reforms currently being pursued, such as the overhaul of the university medical curriculum in a given country, or assistance in devising a new health insurance system. The objectives of such interventions are medium-term ones and a full evaluation will only be possible later. However, a number of pertinent remarks of a general nature can be made. The paper stresses the importance of the partner countries' commitment to reform if a viable health service is to be created for the long term. In a number of cases, this has not always been forthcoming, seriously limiting the contribution Phare and other international forms of assistance can make to resolving structural problems. Experience has also shown the importance of close coordination between donors, which allows them to complement, rather than duplicate, their respective programmes in support of any given country's reforms.

As regards future orientation, Phare will continue to press for government commitment to elaborating the detailed reform and restructuring measures each country requires. This may entail in some cases a new emphasis on communication issues to ensure that the message gets across that the reforms are crucial if the health service is to remain viable in the long term. Where reform measures have been identified, Phare will direct its assistance towards testing viability through pilot projects, as it has already started to do in a number of cases. Once a positive assessment of viability has been made, Phare will seek to help governments with nationwide extension, through provision of whatever training and organisational know-how is needed. It will also cooperate with governments to help ensure loan-financing from the relevant international financial institutions.

Another important factor is the importance attached to integration between the European Union and the central and eastern European countries. In this context, while continuing to pursue the priorities identified in the structural reform framework, Phare will also, where appropriate in future programme design, incorporate central and eastern European countries' methods and models of management, organisation and training with those found in the European Union. In this way, the wider objective of integration can be served while pursuing the specific objectives of health sector reform.

Introduction

The spectacular improvement in health over the last fifty years, whilst it is unevenly distributed around the world, is essentially attributable to better nutrition, hygiene and sanitation, the spread of literacy, the control of infectious diseases, and to family planning. Whilst it is not the principal factor in determining the health status of a population, improvement in health services is seen by people, by health professionals and by policy makers as one of the key factors in improving health. In the very difficult social and economic transition in which the central and eastern European countries are currently engaged, their health services appear to be particularly under threat.

From its inception, Phare has been involved in the health sector. Its initial interventions were geared to ensuring the maintenance of a number of basic services through assistance not dissimilar in character to humanitarian aid. Today the aim of its activity in the sector is primarily to support structural reform and the definition of new policies, with a view to establishing health services which are viable in a market-economic context, socially acceptable and financially sustainable.

Section 1 - The health sector in the central and eastern European countries

Main trends

Demographic and public health factors

Growth in the dependent population: Certain central and eastern European countries have a relatively low birth rate and an ageing population. In others demographic problems derive from considerable emigration of adult males towards western countries. Economic reconstruction is bringing with it a rapid rise in unemployment and in poverty. Growth in the dependent population is therefore a characteristic of most of these countries. This growth will have important consequences for health costs.

- in common with western industrialised countries, some of the central and eastern European countries, such as Hungary and Bulgaria, have a declining population while in others, such as Poland and the former Czechoslovakia, the population is growing slightly. Others again have a higher level of growth. This is so in the Baltic States and Albania. Considerable emigration of adult males to western countries such as Germany, Italy, Greece and the USA, which started in the early 1990s, has had a marked demographic impact, for example in Albania. The urban population represents more than two-thirds of the total in most countries, 75 per cent in former Czechoslovakia, about 70 per cent in Estonia, Latvia and Lithuania and about 68 per cent in Bulgaria. In other countries the majority of the population is rural, such as in Albania and Slovenia. Urban populations appear to be more exposed to risk factors linked to the quality of the environment, working conditions, the state of housing and individual lifestyle. The rural population is still a long way from health services.

Increasing trends in mortality: The most recent figures show that infant mortality has been on the increase in the past few years. In most countries maternal mortality remains high. High mortality among male adults is a particular trend in the central and eastern European countries.

- infant mortality declined steadily during the 1970s, then stabilised in the 1980s at different levels in different countries. From 1990 the situation deteriorated steadily and infant mortality rates have risen in recent times in most central and eastern European countries.
- this rise can be put down mainly to a higher incidence of premature births and perinatal illness, reflecting poorer access to health services and lower quality of care. Despite a steady decline in maternal mortality in the central and eastern European countries over the past thirty years, in most cases the rate is still higher than that in western Europe (the former Czechoslovakia is a notable exception). In Romania, Poland and Bulgaria, the use of legal and illegal abortion practices as the principal means of birth control has had a significant impact on the maternal mortality rate. As in Poland and Bulgaria, a high rate of mortality among adult males is typical of the central and eastern European countries, although Albania is an exception. Overall, but with significant differences between countries, life expectancy at birth is on average four to seven years lower than in the European Union.

Decline in health status: Most central and eastern European countries experienced a decline in their health status in the 1980s. The decline gathered pace in the early 1990s. There is no sign of the trend being reversed over the next few years.

- although infectious diseases have been kept fairly well under control (they remain the principal cause of death in children), poverty in wider sections of the population, bad housing conditions, a decline in the quantity and quality of food, alcoholism and excessive smoking, ailments related to pollution and a deteriorating environment, accidents and suicide are the main causes of declining health status in the central and eastern European countries. Major health problems, deriving from respiratory and cardiovascular diseases, cancer, accidents and intoxication, can mainly be attributed to lifestyle and a steadily worsening environment.

A deteriorating environment

The impact of the environment on health has still not received sufficient attention in the central and eastern European countries. In some cases the environment has become so bad that it represents a major impediment to better health.

- people's physical and mental health hinges to a great extent on the environment in which they live and on their income, on the amount and quality of their food, on drinking water, on heating and on housing. But it also depends on their level of safety, especially road safety, the extent to which they use drugs, such as tobacco, alcohol and intoxicants, and pollution (waste disposal, toxic waste and radiation hazards). These latter factors have been widely neglected in the central and eastern

European countries, as governments have opted to maintain curative services at the expense of preventive ones, despite the fact that the latter represent a very productive investment in terms of costs and benefits.

Worsening health services

Institutions poorly geared to essential needs: In most central and eastern European countries the number of health service institutions is comparable to that of OECD countries. But the irrational use of hospital beds has contributed to a considerable rise in health expenditure without satisfactorily meeting demand. The lack of a policy on maintenance has resulted in a deterioration in the state of buildings and equipment and hence in the quality of services.

- the central and eastern European countries boast a number of establishments (hospitals, clinics and health centres) comparable to those in OECD countries, but the construction of new health service buildings declined in the 1980s as a result of lower capital budgets. In most countries the number of hospital beds per capita is comparable to and sometimes greater than in OECD countries. Bed occupancy began falling towards the end of the 1980s. By 1990 it was 80 per cent in Hungary and 77 per cent in Bulgaria, for example. This fall has become greater in recent years and indicates a general under-use of services
- in countries such as Albania, Romania and Bulgaria, the poor quality of consumables and the lack of medical and surgical equipment further contributes to inefficiency. The average age of medical and surgical equipment in the central and eastern European countries is often greater than 20 years, whilst it is less than ten years on average in western Europe. The almost total absence of maintenance policy has led to a progressive deterioration of buildings and equipment which contributes to the decline in the quality of services
- the absence of alternatives to hospital care and the inefficient use of a large proportion of hospital beds for social cases rather than for medical care has been a major factor in the growth of health expenditure. Moreover, health services are expensively organised on the basis of curative specialties, and the absence of community health care arrangements - comprising general practitioners backed up by nurses, social workers, decentralised laboratories and day surgery - exacerbates an already precarious situation by giving unnecessary precedence to hospital care. Such arrangements, to be found in western countries, are an appropriate response to the population's essential needs, in particular for patients suffering from chronic conditions such as diabetes, cardiovascular diseases, certain cancers and physical handicaps for which hospital care is not usually necessary.

Inadequate prevention services: Already underdeveloped because of the primacy of curative over preventive services and the absence of an adequate legislative framework, resources for preventive services have been progressively cut, particularly in the area of family planning and tackling non-communicable disease.

- prevention activities have suffered budget restrictions in fields as fundamental as vaccination and prenatal care. In the workplace, occupational health services are geared more to curative services than employee health protection. Most central and eastern European countries lack sufficient resources for undertaking prevention programmes against non-communicable diseases linked to changes in lifestyle.
- nicotine addiction, alcohol abuse, and drug addiction are constantly increasing and have become social epidemics against which few appropriate measures are taken at present. HIV infection is quickly taking hold in Poland and Romania and in the medium term the health services may have difficulty coping with the problem of AIDS.

An ailing pharmaceutical sector: The liberalisation of the pharmaceutical market and the privatisation of the means of production and distribution have resulted in a rapid growth in the price of drugs, which have now become too expensive for most people. Except in the Czech and Slovak Republics and Hungary, the pharmaceutical industry is generally outdated and has difficulties obtaining essential materials and equipment, owing to the shortage of foreign exchange. The absence of a regulatory framework for the industry comparable to that in western countries presents an obstacle to the reorganisation of the pharmaceutical sector in the central and eastern European countries.

- in some central and eastern European countries, such as Hungary and the Czech and Slovak Republics, the pharmaceutical industry is relatively advanced and competitive on the international market. Other countries have industries that are generally antiquated but in most cases able to provide the bulk or all of national drug requirements. However, the standards of quality enforced in western Europe are not always respected. Moreover, the fact that the raw materials

needed for production often have to be imported and that foreign exchange is scarce has considerably weakened the industry. Bulgaria, for example, whose productive capacity is greater than its own national needs, exported more than 90 per cent of its production in 1991 to obtain hard currency at a time when there was a severe drugs shortage

- because liberalisation of the pharmaceutical market and privatisation of supply and distribution networks were undertaken too rapidly and often with insufficient oversight, it has not achieved the desired result. In some countries, the supply network is now primarily serving the interests of private importers rather than of the health service. Wholesalers and private pharmacies have been established without any effective system of consumer protection having been put in place. The absence of management of the process of reform in the pharmaceutical sector has led in many of the central and eastern European countries to a situation where medicines have become too expensive for the majority of people and are of a quality which is not always controlled.

Insufficient coordination on health issues at government level: As in all the sectors that emerge from a highly centralised system of planning and management, health services are most often organised vertically without any real links to other sectors whose activities affect public health.

- although health problems are often multisectoral, there is frequently inadequate machinery for coordination with other relevant ministries. Within the health system the approaches to problem-solving are often vertical and there is frequent duplication of effort, which wastes resources. There are also other systems for providing health services, organised in parallel to the general state systems, such as by the army, civil service and by enterprises. These operate without an overall view of needs and without any realistic measure of the costs and benefits of the choices made. The coordinating role of the Ministry of Health in such matters has not for the most part been defined
- action against the causes of certain health problems involving pollution, other environmental threats and accidents, for example, is rarely the subject of effective inter-sector management, with very limited impact as a result.

Human resource problems

Over-specialisation: The present arrangements in the central and eastern European countries favour specialists and not general practitioners, and this has adverse consequences both for the quality of care and the medical-care management of patients. It also has the effect of increasing costs without responding appropriately to basic health problems.

- numbers of doctors, pharmacists, dentists and nurses are at OECD levels but the distribution of health personnel is often uneven, favouring towns at the expense of rural areas. The percentage of medical staff who are specialised is high, for example: 72 per cent in Poland; 75 per cent in Hungary; and 79 per cent in Bulgaria. Generally speaking, there was no specific training of general practitioners in the central and eastern European countries. Most of them are experiencing the problem of over-supply of medical staff. The very low standard of salaries of health professionals and in particular of doctors plays an important role in their lack of motivation and contributes to the undermining of the quality of health services. The focus on specialisation has led to the development of a costly system poorly geared to needs
- at a time when faced with uncontrolled growth in costs, the western industrialised countries are seeking to strengthen or develop systems based upon a network of effective primary care, and to put social health problems under community responsibility, the central and eastern European countries lack the human resources relevant to their needs. University programmes do not focus on community care. No special effort has been made to set up continuous training and retraining schemes to ensure that general practice is given an enhanced status in relation to specialisation, and is matched by a more attractive pay policy
- in the same way, the creation of medico-social professions capable of providing care within the community has not yet been seen as a priority despite the wealth of experience gained in western Europe. To be effective and efficient, health services need to be organised at community level, operating close to the home, coping with patients in their family setting, using a multi-disciplinary team built around general practitioners. Such community medicine is also based on a network of community support capable of ensuring the welfare of patients outside hospital and the provision of preventive services within the community.

The weakness of the management function: At a particularly critical time, when health systems are being subjected to great pressure to expand, and when financial

resources are declining, the weakness of the management function is a major obstacle to a more rational and effective use of resources.

- emerging from a rigid and bureaucratic planning system, health service management is not yet sufficiently effective. Decision-makers, managers and health professionals do not have the benefit of the training, the means, nor the information they need to manage efficiently on the basis of comparative cost-effectiveness and cost-benefit analysis. Most of those responsible for the management of health services are physicians without training in the management and administration of health services. Such training is moreover not to be found in most of the university courses.

A dire financial situation

Inequitable and inefficient financial management: Until recently health service allocations were decided without reference either to actual levels of service activity, or to service performance or cost-effectiveness. This approach has progressively reinforced existing inequalities between regions, services and social groups, making for long-term inefficiency in the provision of services.

- faced with this waste of resources, new resource allocation policies have been set up in several countries such as Poland, Hungary, Latvia and Estonia. These policies take account of factors such as the size of the population served, the volume and quality of services provided, and set store by disease prevention and health promotion. These reforms also seek to merge the separate parallel systems (such as those for civil servants and for large undertakings) into a single system, in order to achieve a more rational and equitable use of resources.

Misdirected expenditure: The present organisation of health systems in the central and eastern European countries favours curative hospital services with their high costs rather than decentralised curative services and prevention, which are more cost-effective.

- whilst the steady increase in the incidence of certain diseases, in particular non-communicable diseases, could be curbed by an effective prevention policy, the central and eastern European countries continue to prefer curative services, often based around the specialist, which give rise to expenditure out of proportion to the limited resources of these countries. Moreover, the emphasis on hospital medicine entails major expenditure on those diseases which in the majority of cases could be treated in the community at much lower cost.

Uncontrolled health service costs: Health service expenditure in the central and eastern European countries steadily declined in real terms in the 1980s, albeit less rapidly than gross domestic product, and is now far below average expenditure on health in OECD countries. There has thus been growth of health expenditure as a share of gross domestic product. The problem of uncontrolled growth of expenditure is nowadays a central question for the new health insurance systems which are being developed. It must be resolved if the central and eastern European countries wish to avoid the state being obliged to take on the responsibility for that part of the growth in expenditure that cannot be covered by health insurance contributions, which themselves will probably fall as these countries enter a period of economic recession.

- the present organisation of health services is a major obstacle to the establishment of an effective policy for controlling costs and to the development of a system of modern finance based upon health insurance. In fact, the surplus of medical staff will engender a steep rise in costs if their salaries are increased without any corresponding reduction in their number. The excessive number of hospital beds and the increasing demand for care comparable to western standards, carrying with it greater costs of drugs and of medical and surgical equipment and supplies, will equally result in a rise in costs which cannot be contained without a sizeable reduction in the number of beds. At present the central and eastern European countries' health service expenditure is below five per cent of gross domestic product, as against seven per cent in European Union Member States. This level of expenditure could double in a few years if an effective policy for containing health service expenditure is not put in place.

Declining financing capacity: The economic recession which has coincided with the transition to a market economy is reducing the state's capacity to ensure that health services are adequately financed. This decline in resources cannot in the short and medium term be offset by a transfer of costs to households whose incomes are steadily declining.

- economic reconstruction measures in the central and eastern European countries have been accompanied by an overall reduction in financial capacity. It will therefore be very difficult in the short term to find additional resources to cover health expenditure, whether

in the public or private sector. In order to deal with this situation, cost-containment measures have been introduced in Estonia, Latvia and Lithuania, Hungary and Poland. However, they are not of themselves sufficient to match health expenditure with financial capacity and ensure adequate services for the population.

Difficulties in transforming the financing system: Most of the countries wish to adopt a health services model more akin to a health insurance system than that of the former Soviet Union, which they inherited from central planning. The transition from one system to another is going to prove very difficult against a backdrop of recession and rising unemployment.

- financing of the health systems in central and eastern European countries was initially modelled on that of the former Soviet Union introduced in the 1920s. This 'Semashko' model is based on direct financing of expenditure from the state budget. Planning and management are centralised. Health service staff are paid by the state, generally at a rate below the average working wage. There is no private provision, but often within the public sector there are parallel health services, in particular for certain privileged classes of the population. There are no special methods for motivating the professionals, who have no way of influencing the key decisions involving the health sector.
- the European Union Members States have developed two different systems: a tax-financed health care system currently existing in seven Member States and a health insurance one in the other five. The health financing challenge in all western European countries is obviously more linked to the type of relations established between health care providers and the financing bodies than to the question of whether there should be a national health system or an insurance based one. The key problem is in the management of three basic elements: quality of care, equal access without consideration of incomes and cost containment.
- the health insurance system found in various forms in Germany, the Netherlands, Austria, Belgium and France, is decentralised and financed by compulsory insurance based upon social contributions from employees and employers. The state often provides complementary finance for particularly vulnerable sections of the population such as retired people, children and the unemployed. The financing institutions are non-governmental. Health professionals are generally paid on the basis of the services they provide, also usually the case in tax financed systems, and play an important role in negotiations with the public authorities and the financing institutions.
- whichever kind of system the central and eastern European countries develop, it will have to cope with their current economic and social realities and will need specific deep adaptations. The attraction of a health insurance system could respond to the political will to move away from a state-based system while making contributions more visible. If such a development occurs, special attention should be given to administrative costs, the risk of favouring high-technology medicine at the expense of primary care and health promotion, the difficulty in containing costs because of the dominant role of the medical profession, and the absence of consumer participation.
- many of the central and eastern European countries have already started to reform their health finance systems, but have encountered difficulties, with the state having to intervene to an increasing extent to make up the deficit arising from the financing arrangements. In Latvia and Estonia the steep fall in financial resources has led the authorities to take drastic steps to reduce health services and staff. Whilst health insurance and private practice have been established in most central and eastern European countries, they do not seem able to offer a real alternative outside the large towns at a time of recession and high inflation. Whatever their future economic position, these countries must make swingeing staff and service cuts. Hungary, Poland and Estonia have already done so. Such decisions are going to be difficult because they risk generating huge inequalities in access to care and excluding large sections of the population from the health care system.

The emergence of an uncontrolled private sector: A private sector has emerged in each of the central and eastern European countries. It is limited for now to towns and cities and is developing in the absence of any framework, whether legal or financial, for its activity. This unregulated development has led to a situation where medicines are too expensive for the majority of the population.

Central and eastern European countries falling further behind

Over the last twenty years, the health services and the health status of people in the central and eastern European countries have been slowly deteriorating.

For the most part, these countries are now at the bottom of the European league table, lagging far behind their European Union counterparts. The following examples show the position of central and eastern European countries compared with European Union countries.

- life expectancy for males is significantly lower (five to seven years in places such as the Baltic States and Hungary)
- children have three or four times less chance of surviving their first year of life in Albania and Romania
- non-communicable diseases, such as cardiovascular diseases, are on the increase but could be controlled by prevention programmes
- the dependent population (children, people who are elderly or unemployed) is growing whilst resources decline
- diseases linked to environmental degradation are having an increasing impact on general sickness levels
- in some central and eastern European countries, women are two or three times more likely to die from the consequences of pregnancy, because abortion is the main form of birth control.

Priority reform needs

The key objective of health reform in central and eastern European countries is to restructure the health care system whilst guaranteeing the whole of the population a basic minimum level of access to quality services. These reforms have to be undertaken under the political, economic, social, demographic and health conditions specific to each country. They also have to be integrated into general economic development.

Despite their differences, the central and eastern European countries shared to varying degrees a number of common problems related to the nature of the centralised planning system they inherited. To resolve these problems, and improve the quality and efficiency of the health services, governments must identify priority objectives and strategies relevant to the detailed features of their own circumstances and the means at their disposal. The strategic objectives and strategies include:

- reform of planning and management methods
- decentralisation of health services
- development of primary and community care
- maintenance of the widest possible access to health services
- improvement in the qualifications of health personnel
- development of preventive activities and action directed against the causes of illness.

These are discussed in more detail below.

A reform of planning and management methods

This is a fundamental area on which the success of the health service reforms depend. There is all the more reason to reform planning and management as it does not entail the mobilisation of sizeable financial resources. The reforms can draw on the experience of western European countries and on the rapid improvement of the management capacities of local staff.

To have the best chance of success the reform of planning methods and resource management should embrace:

- a definition of health policy which responds to the essential health needs of the population, for example through the development of an overall plan for the health sector or the introduction of a list of service targets to overcome existing gaps in the volume or performance of services
- the reorganisation of health services in accordance with health policy priorities

- the improvement of budget planning to assist the implementation of health policy priorities
- the redeployment of personnel in accordance with the decentralisation and reorganisation of the health services
- the establishment of mechanisms to promote greater staff productivity, through for example financial and material incentives, reorganisation of working methods
- the development of new financing systems additional to state funding, for example health insurance, direct payment for certain services
- the establishment of methods of managing health services based on better cost-effectiveness
- the establishment of methods for monitoring and controlling growth in health service expenditure
- the establishment of systems for the maintenance of buildings and equipment, and a policy for standards of medical and surgical equipment and supplies incorporating performance and compatibility.

Decentralisation of health services

Bringing decision-making centres and management nearer to the populations involved will enhance the effectiveness of all the health services. The transfer of responsibilities from centralized to decentralised systems involves major changes in working methods and behaviour. Considerable effort is therefore needed in the field of training and retraining.

The decentralisation of health services has to embrace the following strategies:

- the creation of a legislative framework for organizing the decentralisation of the health services
- the transfer of the organisation and the management of the health system to the regional and local level
- the redefinition of the role of the hospital within a system of decentralised health services, and the reorganisation of its activities in accordance with the new health policy priorities
- the establishment of structures for coordination between the administration, local government, health professionals and consumers, for example through the creation of regional and local committees for the definition, monitoring and evaluation of services.

Development of primary and community health services

The rationalisation of health systems and the pursuit of greater cost-effectiveness in the organisation of services will enable the central and eastern European countries to give greater priority to the development of community care. Such restructuring will entail considerable human and material investment that can only be undertaken if secondary and tertiary health services are also cut.

These reforms should be based on the following strategies:

- putting increased value on the health professionals working at community level, such as general practitioners, nurses and social workers
- the development of alternatives to hospitalisation, for example looking after sick and elderly people at home
- the establishment of a system of social support at community level, for example home-helps and special support for socially deprived groups
- improvement in the quality of basic facilities, for example establishing rehabilitation and maintenance programmes for buildings and equipment and providing incentives for staff.

Maintaining the widest possible access to health services

How far people believe in the value of the health service reforms depends chiefly on how far the new services meet their real needs, especially those of the most disadvantaged groups. One of the keys to the success of the reforms is whether people can afford to use the new health services, in particular whether they can obtain the medicines they need.

The principal strategies to be adopted are

- Establishing a legal and regulatory framework for controlling the liberalisation of prices for services and drugs and the privatisation of certain parts of the health system
- Setting up a pharmaceutical policy which provides for a minimum level of financial access to essential quality drugs, for example by improving supply, storage and distribution systems, with a view to possible privatisation or even development and introduction of a price policy for essential drugs
- The restructuring of the national pharmaceutical industry and the development of part of the production to meet the essential needs of the countries themselves
- The creation, when economic conditions permit, of a system of health insurance which allows the community to provide a number of essential health services for the population.

Improvement in the qualifications of health personnel

The restructuring of the health system will entail a need for new professional qualifications which health personnel cannot at present meet. A considerable effort will have to be made in the field of initial training and retraining to allow a better use of human resources to meet the needs of the health sector, and to harmonise the health personnel standards with those of western European countries.

In this field, the principal strategies to be pursued are

- the definition of a training and management policy for human resources which responds to the new needs of the health system
- the revision of courses and the creation of new types of training for health professionals which respond to the new needs of the health system, in particular to develop community health care, for example setting up specific training for general practitioners
- the development of basic training programmes and retraining in administration and management of health services which should be open to all health professions so as to make optimum use of management potential and human resources
- the establishment of specific courses for the training of non-medical personnel essential for the development of community health services.

The development of preventive activities and action directed against the causes of illneses

Economic difficulties have led most central and eastern European countries to abandon part of their preventive programmes in favour of maintaining a number of treatment services. Preventive activities and health promotion should be considered as priorities in health policy, since they represent a productive investment in terms of costs and benefits. This is particularly important in the current difficult economic and social circumstances in which the countries find themselves.

The principal strategies to be followed are

- the development of legislation and measures which provide greater protection for public health - this includes controls on alcohol abuse, nicotine addiction, road accidents, health and safety at work and environmental protection
- establishing national programmes for the promotion of health and the fight against communicable (in particular by vaccination) and non-communicable diseases
- the development of family planning policies to improve the health of mothers and children
- further development of the prevention of occupational diseases and accidents at work.

Section 2 - Phare activity in the health sector

The rationale for Phare involvement

As the Phare programme was set up to support the structural reforms necessary for stable economic development and sustainable growth in the recipient countries, there are a number of reasons which justify its support for the efforts of the central and eastern European countries' governments to reform their health sectors.

The health sector is one of the essential sectors for economic development, and is one of the most important sectors of the national economy, employing in most countries on average, directly or indirectly, up to five per cent of the economically active population and absorbing between five per cent and 13 per cent of gross domestic product. Poor management of the health system therefore involves a waste of national resources, whether directly by unnecessary growth in health service expenditure, or indirectly, by increased social and economic costs through avoidable sickness and its consequences. In the central and eastern European countries, like other sectors, the health sector has been experiencing considerable deterioration and a very low level of efficiency. Without fundamental reforms, the health services in the central and eastern European countries will be unable to meet the challenges of economic reconstruction.

All the essential sectors of the economy are interdependent. Structural imbalance between the sectors of the economy which are essential to economic development can cause grave economic and social problems. In the central and eastern European countries, where the transition to a market economy requires mobilisation of all available resources for major investment in the economy, the health sector is one which should not be neglected. Any economic reconstruction process which failed to take account of a sector as important and costly as health might be unable to ensure sustainable growth.

Health status is a major factor in the social and economic development of countries. Modern economies need efficient health sectors to help keep the health of their productive capacity at a level sufficient to ensure continued competitiveness. They need to recognise that the community as a whole has to bear most of the costs of illness amongst the dependent section of the population, children, elderly people and those who are not in work. The standard of health of the population, and in particular that of vulnerable groups such as children and pregnant women, is considered by the international community as one of the basic indicators of a country's development.

Uncontrolled growth in health service expenditure is an obstacle to social and economic development. Experience from western industrialised countries shows that health service expenditure can grow considerably faster than national income. In some western countries the growth has been 40 per cent greater than growth in gross domestic product. Health care demand is also growing fast in the central and eastern European countries. Runaway growth would have a very negative impact on their development, reducing the scope for investment in the most productive sectors. Experts consider that the uncontrolled growth in expenditure can be overcome and the productivity and efficiency of health services improved without significant increases in cost. Such objectives can be achieved by introducing a rational policy for the health services based on ongoing cost-benefit studies, without ignoring the sector's special human and ethical dimensions.

Health is a sector which is culturally, socially and politically sensitive. Throughout the world the medical lobby is one of the most powerful in the community. It is generally well represented in parliaments, and often in government itself. The pharmaceutical and medical equipment and supplies industries can exert effective pressure on policy-makers by dint of their economic power and multinational character. Consumer dissatisfaction linked to the deterioration of health services can lead to loss of credibility in the whole process of reform. Given the special nature of health problems, discontent among one section of the population, arising from poor health services or a decline in the conditions of employment of the health professions, will be quickly seen at the political level as a major problem.

There is a growing gap between the western countries and central and eastern European countries. Europe Agreements have been signed with six central and eastern European countries (Poland, Hungary, the Czech Republic, Slovakia, Bulgaria and Romania), and will serve as the framework preparing these countries for membership of the European Union. However, the growing gap in terms of health standards and quality of health services is creating additional obstacles to future social and economic convergence between the central and eastern European countries and the European Union. The current social and economic problems caused by the central and eastern European countries' economic reforms are widening this gulf still further.

Health is thus an area in which international aid has a fundamental role to play. It can ensure that essential reforms are undertaken to achieve timely improvement in health services under the most favourable conditions. International aid can help keep the people of the central and eastern European countries from having to endure for too long the social and economic consequences of the transition to a market economy.

Overview

Over ECU 100 million had been made available by Phare to support health-sector reform in the central and eastern European countries by the end of 1993[1]. The following table gives the cumulative totals for the different partner countries.

The specific actions undertaken or planned in each of the partner countries are described in annex II.

Country	Funds made available (thousand ECU) [2]
Albania	6,000
Bulgaria	30,500
Czech Republic	2,700
Estonia	500
Hungary	10,375
Latvia	480
Lithuania	1,300
Poland	20,450
Romania	26,500
Slovak Republic	1,300
Total	**100,105**

1 This covers only assistance within the context of specific programmes for the health sector (including under the General Technical Assistance Facility to some countries). It does not include humanitarian aid provided by Phare to the health sector.

2 Excluding humanitarian aid to the health sector

Initial assistance

The first Phare projects to assist reform of the health sector in the central and eastern European countries were primarily a response to short-term financial needs. They were essentially directed towards:

- reorganisation of the health services within arrangements that were more flexible and more closely linked to needs (reform of the health system in Lithuania, and health management training in Poland and Hungary)
- introduction of private medical practice. The definition of arrangements for private medical practice in Bulgaria
- reform of pharmaceutical policy (introducing new policies in Romania, Bulgaria, Latvia and Lithuania, and the provision of essential drugs in Romania)
- development of new finance systems (support for the creation of a health insurance system and training for those who will manage it in Bulgaria)
- improving the efficiency and effectiveness of health services (training general practitioners in Poland, restructuring blood transfusion services in Romania, and developing emergency medical aid in Bulgaria)
- provision of consumables for the most vulnerable services that have to provide rapid intervention in emergency situations (consumables for emergency hospital services and clinics in Bulgaria and Albania, drugs in Romania and Albania, family planning equipment and supplies in Bulgaria.) This type of support (akin to humanitarian aid) has remained limited.

Current forms of support

It was clear that certain reforms could be accomplished by governments themselves with help from the relevant local professional bodies, while others required support from international aid programmes. On the basis of ongoing analysis of health and health systems in the central and eastern European countries, of the experience gained over the initial two years of support, and of the expertise available in the European Union Member States, Phare was able to formulate a coherent framework for its future assistance, designed to gear projects better to the medium-term needs of structural reform. This focuses on a number of priority areas for intervention, taken from the range of changes essential for undertaking reform of the health sector.

In identifying the key areas, attention was paid to the need to support those reforms which were essential for the medium-term reconstruction of the health sector, and thereby contributed to the objectives of making it viable in a market-economic context, socially acceptable and financially viable. Other important factors were cost-benefit analysis and comparative advantages of different types of intervention, and approximation of management, organisation and training methods to those found in European Union Member States. The resulting priority areas are as follows:

Health service financing

- improving financial management
- creating health insurance systems which bolster the system of basic social protection
- introducing systems of contributions by users with payments for certain services
- developing alternative remuneration models for health service staff
- decentralising financial management and introducing methods of control that take greater account of cost-effectiveness, making for the gradual privatisation of certain services
- implementation of systems for monitoring and controlling growth in health expenditure.

Reorganisation of health services

- developing networks of community and outpatient services
- introducing measures to enhance the status of the health professions working at the level of community-care services, especially general medical practitioners
- redefining the role of the hospital in the health system in the light of new health policy priorities, the development of resource allocation policies and the establishment of health and service targets
- restructuring of hospital services and development of maintenance and standardisation of bio-medical equipment
- establishing a framework which allows the complementary development of public and private medicine
- developing quality assurance methods
- managing human resources

Pharmaceutical policy

- establishing a legislative and regulatory framework and a regulatory official body
- introducing a pricing policy for pharmaceuticals offering the widest possible access to essential drugs
- reorganising supply and distribution of pharmaceuticals both in the public and the private sectors to respond to a country's essential needs.

Training and retraining of health personnel

- developing the curriculum in the context of the changing needs arising from the reform of health services training policy
- improving or creating training courses geared to the development of community medicine, public health, health economics, management and administration
- developing programmes of continuous training and retraining for health professionals to facilitate their redeployment.

Developing disease prevention and health promotion activities

- framing legislation and other measures to provide better protection for public health
- establishing national programmes of health promotion
- developing family planning policies
- approximation of legislation and policies on health and safety at work to those found in the European Union.

Section 3 - Assessment and future orientations

Assessment

Clearly, when seeking to assess the impact that Phare assistance has had in the health sector, a distinction should be drawn between those initial actions where the goal was an immediate one, helping to maintain a number of basic services, and the type of action falling within the framework described in Section 2. Here, Phare is concerned with supporting structural reform to make the health sector viable in the longer term.

As regards the emergency-type aid provided initially, Phare made a contribution in certain central and eastern European countries such as Romania, Bulgaria and Albania to keep the health service running at a particularly difficult time. As regards the structural reforms now being supported, it is too early at this stage to measure the impact of projects such as the overhaul of the university medical curriculum in a given country, or assistance in devising a new health insurance system. The objectives of such interventions are medium-term ones and a full evaluation will only be possible later. However, a number of pertinent remarks of a general nature can be made:

Importance of political commitment in the partner country: If the priority reform needs set out in Section 1 are to be met, Phare support can play a role, as can the support of other international organisations, but more important is the political will of national authorities to undertake genuine structural reform of their health systems. This is demonstrated by the fact that some fundamental measures, for example, the creation of the new legal framework for the health sector, do not entail extra direct expenditure for the state, but are nevertheless not yet in place in all the countries concerned.

In the difficult context of transition to a market economy, a number of constraints militate against maintaining sufficient political commitment to the fundamental reform which is required:

- the weakness within the government structure of the ministries of health, thus limiting their ability to take on the process of reform and oversee projects provided through international aid
- the lack of appetite for radical structural reform within government as a whole. Such reform, despite being vital for long-term viability of the sector, is often unpopular with the medical professions and the wider public
- the power of medical lobbies and, in some central and eastern European countries, the tendency to take decisions on health issues purely according to a medical perspective, and without consideration of questions of viability, have held back new measures for cost-containment and the development of community health. This benefits narrow corporate interests but is detrimental to the wider public interest
- the difficulties of decentralising a centralised and unaccountable system, where the new private health services are insufficiently regulated, and where there are inadequate facilities for coordinating all the changes.

All these factors confirm that Phare should focus an important part of its support on institution-building to develop the local capacity for advancing reform in the most essential areas.

Importance of coordination between the major donors: Financial support to the process of reforming the central and eastern European countries' health sectors comes from a variety of international sources: grants from the Phare programme, from the World Health Organisation and through bilateral sources (including the national aid programmes of European Union Member States) and loans from the World Bank and the European Bank for Reconstruction and Development. To achieve the greatest effectiveness the Phare programme links its activities to those of other international, bilateral and multilateral agencies. All these bodies are concerned with improving the people's health status. The principal organizations with which Phare collaborates in the health sector are WHO, the International Monetary Fund, the World Bank, the EBRD, the International Labour Office and the United Nations Children's Fund. Each international aid organization has its own approach to intervention.

Collaboration between the principal agencies for international aid was, in the early stages of reform, fragmentary and poorly coordinated, without a clear separation of the specific role each donor should be playing. This led to a tendency for each donor to work independently of the others, in terms both of the timetable and of the scope of support offered. Effort may have been duplicated and resources wasted both in the central and eastern European countries concerned and within the institutions themselves.

Estonia

ECU 500,000 from GTAF (1993 budget)

Initial assistance is being provided for the following purposes

- to define a health sector policy
- to reform the funding of health care, with a focus on developing a centralized cost accounting and information management system, which will be tested in a pilot district.

Hungary

ECU 375,000 (1990 budget)

Support for development of health-sector management capabilities[1]

ECU 10 million (1993 budget)

This programme will contribute to overall reform of the health sector through support for the establishment of a more efficient primary health care service and through harmonisation of Hungary's health care legislation and practices with those of the European Union Member States. Bridging know-how is currently being funded bilaterally by the Netherlands.

The component dealing with primary health care covers the following

- primary health care policy, strategies and management, including the establishment of an innovation fund and a communications strategy
- on-the-job training, university-level and postgraduate studies, with assistance for training establishments
- establishment of a planning and research unit to work on integrated health care management systems, efficiency and preventive medicine and the promotion of health care.

The "harmonisation" component will cover legislation and services, prevention of workplace accidents and occupational disease, and training and management of health care staff.

Latvia

ECU 300,000 from the General Technical Assistance Facility (1992 budget)

Support for the following key aspects of the health sector reform

- assistance for elaboration of a medicines policy
- design of a training policy for the health sector.

ECU 300,000 from the GTAF (1993 budget)

Forty per cent of the funds made available under the 1993 GTAF for health sector reform have been used in connection with the operations set out above. The remaining ECU 180,000 have been used for assistance relating to financing of the health sector, involving evaluation of

- the system of paying for treatment in a representative pilot area of the country and the funding system for hospitals.

Lithuania

ECU 300,000 (1990 budget)

Assistance in elaboration of health sector policy and of priorities for the restructuring of the sector in the short and medium terms (in partnership with the WHO, and still in progress). Support for the development of management capabilities and dissemination of information on the reform of heath funding.

ECU 1 million from the GTAF (1992 budget)

Three main areas of support

- institutional support to the Ministry of Health, in the form of assistance for a working party responsible for reforms, particularly in connection with the decision-making process
- planning of a new system for health funding eventually leading to a health insurance system
- establishment of a medicines policy, particularly regarding pricing.

1 indicates an action which is already completed

Poland

ECU 450,000 (1990 budget)

Know-how transfer with a view to improving health sector management.[1]

ECU 20 million (1991 budget)

The programme has two components

- development of primary health care, particularly by increasing the numbers of general practitioners (this comprises development of academic staff and training units, training of general practice principals, refurbishing and equipping model practices, support for elaboration of a strategy to develop organisational, legal and financial models for primary care practices)
- resource-management training for the health ministry's executive staff as part of the programme to improve the ministry's management capabilities (prepared with the World Bank).

Romania

ECU 25 million (1991 budget)

This programme has the following aims:

- in conjunction with the World Bank, to improve primary health care, including assistance for elaboration of an overall strategy
- to supply essential medicines, medical consumables and laboratory equipment for over 400 rural dispensaries
- to establish pharmaceutical policy[1]
- to promote eventual self-sufficiency in high-quality blood products through transfer of know-how for restructuring of the national blood transfusion network which has been in place since October 1991 and through delivery of essential equipment
- to improve the capabilities of administrative and medical staff (those already in work or those in training) by helping to establish a training policy and plans for medical and paramedical staff, and by implementing suitable training programmes.

Slovak Republic

ECU 500,000 from the General Technical Assistance Facility (1991 budget)[1]

ECU 1.3 million from the GTAF (1992 budget), part of an allocation of ECU 4 million originally intended for the former Czechoslovakia.

Assistance will focus on three areas:

- health sector funding, with preliminary studies on the current situation and study trips relating to the administration of health insurance
- development of primary health care
- development of health sector management capabilities.

In the case of the last two of these, assistance will take the form of a development and implementation strategy, including a large number of training operations.

1 indicates an action which is already completed

Annex II - Health indicators for central and eastern European countries, European Union and OECD

Indicators/ Countries	Population Size (million)[1]	Life Expectancy[2]	Maternal Mortality[2] per 100,000	Infant Mortality[2] per 1,000	Health per capita[2,3] expend $US
Albania	3.2	72.2	100	31	25[4]
Bulgaria	9.0	72.6	40	17	150
Estonia	1.6	70.0	31	14	-
Hungary	11.0	70.9	21	16	195
Latvia	2.7	69.6	24	16	-
Lithuania	3.8	71.5	-	14	-
Poland	39.0	71.8	15	15	169
Romania	23.0	70.8	180	27	53
Former Czechoslovakia	16.0	71.8	14	11	307
Former Yugoslavia	24.0	72.0	27	21	209
EU	350	75.9	9	7	1,210
OECD	840	76.4	12	8	1,638

1 World Development Report, World Bank, 1992 and 1993.

2 Human Development Report, UNDP, 1993 and 1992.

3 Real GDP at purchasing power parity.

4 Health sector reform in Albania. The World Bank, 1992.

Annex III - Main areas of activity in the health sector 1991 - 1993

	Albania	Bulgaria	Czech Rep.	Estonia	Hungary	Latvia	Lithuania	Poland	Romania	Slovak Rep.
Emergency supplies	■	■							■	
Health service financing		■	■	■		■	■			■
Reorganisation of health services	■	■	■		■		■	■	■	■
Pharmaceutical policy	■	■				■	■		■	
Preventive medicine and health promotion		■			■					
Training and retraining	■	■			■	■		■	■	■

■ **Areas covered by Phare support**

European Commission Phare Information Office Directorate General for External Economic Relations, DG I
Office Address Rue d'Arlon 88 1/26 B-1040 Brussels **Mailing Address** AN 88 1/26 Rue de la Loi 200 B-1049 Brussels
Tel (+32-2) 299 14 00 / 299 13 56 / 299 16 00 **Fax** (+32-2) 299 17 77
Printed July 1994