Ten years of health sector reform in CEE and NIS:

An Overview

A background paper prepared for USAID Conference, Washington, DC
29–31 July 2002
Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia

Josep Figueras
European Observatory on Health Care Systems
WHO Regional Office for Europe

Martin McKee
European Observatory on Health Care Systems, London
School of Hygiene and Tropical Medicine

Suszy Lessof
European Observatory on Health Care Systems
WHO Regional Office for Europe

This draft paper is part of a series commissioned by USAID to provide a conceptual framework and overview of the main thematic topics of the USAID conference "Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia." Following the conference, each team of authors will revise the papers, compiling the final versions in a book by the European Observatory on Health Care Systems, which will be made available to conference participants in early 2003.

1. Introduction

The decade since the break up of the Soviet bloc has brought enormous political and socio-economic change. The health sector has not been spared the effects of transition and the countries emerging from the process have each engaged in varying degrees of health system reform. It is at last possible to reach some judgement about how this process has unfolded, and to identify successes and failures, and to understand better the scale and nature of the remaining challenges. It is now timely to take stock of these experiences and to draw lessons for the future development of health systems in this complex and dynamic region.

In all countries one of the greatest challenges facing those undertaking health systems reform is how to develop an overall 'health system perspective'. In practice, policy-makers tend to focus their attention on individual initiatives that all too often are perceived as 'magic bullets' that they will cure all of the health sector's ills. We begin instead from the position that the need is for a better understanding of the intricacies and complexities of health systems as a whole, and the nature of the interrelationships between their different elements.

This introductory paper aims to provide such a perspective, offering an integrated conceptual framework that brings together a series of themes that encompass health system reforms in the region. For each theme it highlights a number of priority areas, and outlines key successes, failures and future challenges. It provides a map for policy-makers that is embedded in a systematic approach to the evidence on health system reform.

The themes are: facing the challenges of health care financing; improving the continuum of care; improving the quality of health services; linking with the community; and advancing public health. Each is examined in much more detail in the accompanying papers. Finally, the paper looks at the process of reform to identify which factors (whether contextual or linked to capacity) begin to explain why some reforms are implemented successfully and others are not.

2. Facing the challenges of health care financing

Much of the initial reform effort in the region has focused on the key theme - financing of health systems. Financing includes funding i.e. the collection and pooling of financial resources, and the allocation of these resources to providers i.e. the purchasing of services. In most countries the intention of the reform was to shift away from the centralized and integrated tax-based state model of Shemasko to decentralized, contract-based social health insurance reflecting the core features of the western European Bismark model. The shift has changed the way money is collected and pooled, and created a new relationship between purchasers and providers of care. It was intended to earmark or protect health funds, prompt greater efficiency and responsiveness and signal a move away from the perceived shortcomings of the past. It often took place however, against a backdrop of socio-economic and institutional upheaval. The countries of central and eastern Europe (CEE)

and the newly independent states (NIS) therefore face a new and challenging environment, in terms of the total funding of health care and also of the effectiveness with which they collect and pool resources and purchase services.

On the funding side three important areas demand consideration. First, the implementation of effective health insurance systems, which has been central to financing reform in a large number of countries, has proved problematic. General government revenues often continue to play a significant funding role despite the switch to social health insurance contributions. There is now a substantial body of evidence that helps to explain this and other experiences of implementing insurance. Where social insurance has been seen to fail, failure can be attributed to the weak macroeconomic context; the reliance of poorer countries on out-of-pocket payments and general taxation; low levels of employment and formal activity within labour markets; poor compliance and high levels of corruption; and lack of transfers from tax or social security funds to health insurance. Tackling these issues will not be simple. Wider economic recovery and institutional capacity building may go some way towards increasing the revenue collected through payroll taxes but further efforts to ensure compliance will also be necessary including dealing with corruption.

Second, defining a more realistic benefit packages will be a key strategy in ensuring financial sustainability. The commitment to fund both universal coverage and a truly comprehensive benefits package is unrealistic and unsustainable in many countries in the region. Despite political and technical difficulties and concerns about equity, countries may need to consider explicitly defining more limited entitlements to ensure that public revenues are targeted at the most cost effective interventions and the poorest segments of society and protect public health.

Finally, addressing informal payments must be a major priority in many countries. Data on their extent in a range of eastern European countries suggest they are widespread in both ambulatory and hospital care and that in a small number of NIS countries they form the largest source of funding. Informal payments are a response of the health care system, particularly providers, to the lack of financial resources and a system that is unable to provide adequate access to basic services. Cultural and historical factors also help determine the response of patients although the implications for access, equity and indeed efficiency are highly problematic. Formalizing payments and establishing systems of pre-payment (or insurance) is nonetheless, extremely difficult and requires considerable government and technical capacity and the explicit recognition of external constraints.

On the purchasing side two areas of reform have been particularly important. First are efforts to enhance the cost effective purchasing of services through the separation of purchaser and provider functions; ascribing purchasing functions to insurance funds; and employing contracts as the main tool for resource allocation. The introduction of these new models in CEE and NIS has been challenging for a number of reasons including the inadequacy of funding and the unpredictability of funding flows; low provider autonomy; the absence of routine information systems; a lack of timely information; and sparse technical

capacity and information management skills. Second, the introduction of performance related payment systems for providers is a widespread strategy for enhancing efficiency. Capitation has been introduced for primary care services in many countries and it is common for new hospital payment systems to be developed that link payment to a defined unit of hospital output. The results have been mixed to date. This is due to a number of issues including the fragmentation of public sector pooling and purchasing; poor design of payment systems which do not dovetail or complement each other; institutional impediments and vested interests; the financial deficits of public providers; and limited capability to monitor inputs or outcomes.

In order to move towards fulfilling the aims underpinning the reforms of health financing both funding and resource allocation need further attention. Mechanisms for pooling resources need to be strengthened with other sources of public expenditure included with social health insurance contributions to ensure the most cost-effective use of funding. The technical and administrative capacity of purchasers also need to be strengthened to exert maximum pressure for provider efficiency. This requires the development of information and monitoring systems, which can deliver timely and accurate data on provision and the training of personnel to use this information effectively. Similarly, government regulation and stewardship will be vital in ensuring that purchasers act in the best interests of the population.

Regardless of how well the collection and pooling of funding is organized and the extent to which resource allocation is enhanced, these can only be means to an end. The ultimate end point is an improved impact on health outcomes, which depends in turn on the quality and cost effectiveness of the services provided. Arguably, the initial focus of much of the reform effort in CEE and NIS on creating a structure of financial incentives has been at the expense of the reform of health care delivery itself. Clearly, the incentives created have not proved sufficient to prompt the 'spontaneous' improvements in the delivery systems. Indeed it now emerges that for these financial reforms to succeed in their overarching objectives they need to be accompanied by an independent, in-depth but articulated reform of the provision of care.

3. Improving the continuum of care

The nature of health care provision has changed almost beyond recognition over the past fifty years, in terms of the diseases being treated and the opportunities to diagnose and treat them. Many once common diseases, especially childhood infections, have been significantly reduced or eliminated. Ageing populations now experience multiple chronic diseases. Innovative treatments have turned many diseases that were once fatal into lifelong conditions that people die with rather than from. Collectively these changes can be characterised as a shift from simplicity to complexity. They have transpired in the east of Europe as well as the west and demand new responses from health systems region wide.

The classic Soviet model provided basic care, including immunisations and first aid to dispersed populations. It may have been suited to previous, more straightforward conditions but is no longer adequate. There now needs to be a more complex interaction of health professionals with a range of skills, each intervening when necessary. The management of diabetes is a case in point. While most care will be self-managed in conjunction with a primary care team there should always be allowance for recourse to a range of different specialists. Each element must be in place and, as importantly, there must be clear guidance to ensure the patient's way through this complexity is signposted and facilitated.

The policy-makers of CEE / NIS are only beginning to address this, not least because of their focus on financing and the absolute shortage of finances experienced. If they are to bring about the changes in health care delivery that will meet the complex needs of patients they face four main dilemmas. They must improve the performance of hospitals; restructure health care facilities; shift the boundaries between primary secondary and tertiary care; and strengthen and modernise primary care. These issues cannot be considered in isolation but as part of a single integrated delivery structure or 'continuum of care' and within the broader health system context.

First, the effective improvement of hospital performance includes upgrading the organization of hospital services and increasing efficiency and appropriateness of services. Decentralization of management in combination with shifts in payment mechanisms have been pursued as the key strategies in delivering better performance. There has not however, been sufficient investment to ensure that the information systems needed to measure performance are in place or that staff have the appropriate skills to review their actions or to act on evidence. Nor are there the funds to ensure that facilities are appropriately designed and equipped. Health professionals and managers will require adequate tools to deliver appropriate services. This implies the replacement of obsolete facilities and equipment, new training programmes and clear standard setting with access to monitoring and feedback and the wherewithal to take steps to enhance performance. These needs are of course linked with the efforts to improve quality (see below) but must also be seen as fundamental to improving the continuum of care.

Second, hospital restructuring strategies are needed to address the oversupply of beds and the inefficiencies of secondary and tertiary services. Hospital capacity in many countries of the region is excessive with basic indicators, such as the ratio of hospital beds to population, suggesting that levels of provision in some countries are about 50% higher than in the west. There have been cuts in bed numbers but these have been patchy across the region. Moreover, the concept that restructuring revolves around bed closures is far too simplistic. It fails to recognize the very different role of hospitals in this region or to acknowledge that in many cases they are still the main providers of social care. While, this is rarely the most cost-effective means of service provision, patients have few other options. Closures will certainly be desirable at some stage but they can only follow on the provision of alternative, and more appropriate, facilities and the creation of social support systems.

Third, shifting the boundaries between primary care and hospitals will be key to any successful reform process. It raises the issue of how and when patients are admitted to hospital and how and when they are discharged. There is clear evidence that many patients who could be more appropriately managed in a non-hospital setting are admitted to hospital. It is also the case that patients who could be discharged are kept in even after they have ceased to receive treatment. Both these problems have a common solution. This is the provision of alternative and more appropriate and cost-effective care settings with a simple and uncomplicated interface between them.

Finally then and central to the above there must be effective strategies for strengthening and modernising primary care. In Soviet influenced systems, primary care was the poor relation of the hospital sector. Staff were poorly paid and of low status, and the inadequacy of their training, facilities and equipment meant that their role was limited to little more than referring patients for specialist care or regulating sickness absence. Almost all countries have accepted the need for reform and they have achieved varying degrees of progress. Reforms have tended to centre on the development of a conception of family medicine with all that implies about continuity of care, capitation payments and physician responsibility. These need to be pushed forward with organizational reforms, to give primary care professionals or institutions more control over levels of care, allowing them to steer patients to the most appropriate care setting, whether it be in hospital, nursing home or a patient's own home. There also needs to be an expansion of the range of services and functions primary care delivers, including new or enhanced services currently seen as 'secondary', provided that the primary care context can be shown to be appropriate in terms of effectiveness and efficiency. This requires that a full range of primary care professionals are furnished with the necessary skills and that effective communication between levels can be established to allow primary care to successfully lead the process of the "virtual integration" of the different modalities of care.

Reforming delivery is complex and the problems are compounded by the multiple demands placed on health ministries which are expected to manage change. Their capacities are already stretched by the day-to-day operation of the health care system and few therefore have been able to step back to exercise oversight and address how to promote health rather than just keeping facilities open. Even given additional capacity though, there are no simple rubrics for achieving a seamless continuum of care that balances affordability, equity and efficiency in a complex environment. Nonetheless it is the role of policy-makers to take a whole system perspective and develop a clear health strategy with established rules within which various health care providers can work. This will depend on prerequisites like effective regulatory systems and mechanisms to promote participation. It will also require that the quality of services at all levels of the health care system can be monitored effectively.

4. Improving the quality of health services

Reform programmes have consistently underestimated the complexities involved in introducing new skills and genuinely changing practice but reforms of provider organizations can only improve outcomes if they change the quality of clinical practice. Many commentators have argued therefore that for reform to be effective it must be "bottom up" and start with improvements in clinical practice and with the training and standards of health professionals. These will depend on measures that include a range of accreditation, evidence based medicine and quality assurance mechanisms and on appropriate human resource policies. These systems and human resource development aspects are addressed in turn.

Strengthening quality improvement systems is dependent on the existing clinical context and the legacy of the past. At the outset it must be conceded that promotion of high quality care in CEE and NIS is made difficult by the lack of resources, the failing infrastructure and inappropriate management structures inherited from the Soviet models of the past. However, even allowing for these constraints it is apparent that the quality of care provided is often much worse than it need be. This is particularly striking when seen in contrast to western European and north American preoccupations with quality over the last three decades.

Many of the ideas underlying the increased emphasis on quality in the west had their origins in manufacturing and service industries and reflected concerns with efficiency and with consumer responses that did not feature in command economies. They saw management systems develop to streamline production (for example in car manufacturing), to ensure customer satisfaction (the hotel industry), and reduce errors (the aviation industry). Organisational theories on concepts of quality management have also become increasingly influential in health care. In line with work in the wider economy the emphasis in health has shifted from structures, standards and norms to outcomes and process linked to outcomes by scientific evidence. This "outcomes movement" underpinned the approach of the American Institute of Medicine in generating a definition of quality in health care. The definition is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." It allows the concept of quality to be operationalized and raises many important issues, including the meaning of professional knowledge and the definition of outcomes and there is now an extensive literature on these issues.

It is clear that clinical guidelines should no longer be based on the opinions or instincts of senior physicians but must stem from systematic reviews that critically appraise the evidence of relevant research and combine the results using explicit techniques such as meta-analysis. It is also clear that the production of clinical guidelines is not in itself, sufficient to change clinical practice. A central challenge therefore, is how to put evidence-based guidelines into routine clinical practice and how to change in reality the two key components that constitute care - its technical content and the organisation of its delivery.

It might be supposed that this would be more difficult in the west, with its traditions of physician independence and the historical role of anecdote and opinion in determining clinical practice. It might also be supposed that the Soviet inspired traditions of standards and norms would provided a strong basis for applying guidelines to enhance the quality of care. In reality the west has experienced a revolution in its approach to evidence, albeit a gradual one, while CEE and NIS has been characterised by a failure to develop a culture of evidence-based medicine and the continuing and widespread use of ineffective treatments.

This is not to say that there has been no progress in the region. Since transition individuals in many countries have formed professional associations to promote quality in health care. It has also proved possible to introduce systems to enhance quality of care with beneficial effects on effectiveness, efficiency and humanity of care in some areas. Yet there have been many problems. The command and control nature of Soviet inspired systems, which might have eased implementation has actually prevented change, in large part because of an initial reluctance by those in positions of leadership to delegate decision making to more junior staff. It is only gradually, and in limited areas, that leaders have became more open to this quality focused way of working, and have been able to identify new and often more satisfying roles for themselves in improving services. One of the greatest challenges has been and continues to be the empowerment of those involved so that the message that change is possible is conveyed and so that practitioners can develop a real sense of ownership of quality initiatives.

This touches on the second dimension inherent in achieving quality care that is improving the quality of health professionals. This requires that the staff in place have the appropriate and necessary diagnostic, technical and caring skills and that the right mix of professionals is in place. The centrally planned approach before transition saw the over supply of doctors, rigid demarcation between professional groups, the under development of the nursing role and an inappropriate skill mix. Priority areas are therefore, the reform of human resource planning to address the new balance of staff required and to ensure production of more family practice specialists, public health professionals (doctors, nurses and others) and managers; training programmes, including continuing education which will develop and maintain the right skills; and strengthening professional standards and accreditation.

It will also be crucial to enable and motivate staff so that they are in a position to deliver quality care and contribute to the ongoing improvement of services. This implies addressing the levels of pay, employment security and conditions under which all groups of staff work. Certainly, staff who are expected to rely on under-the-table payments, who fear losing their job or who have to work without access to the equipment needed to treat patients adequately cannot be expected to deliver quality care or to respond appropriately to patients' needs in the long-term.

Improving the quality of health services will depend therefore on the expansion of evidence-based medicine and the application of modern quality improvement methods,

including the appropriate treatment of staff. These are critical issues that must be explored over the next ten years of health reform if there are to be real improvements in the quality of care. Certainly, as long as there is widespread use of ineffective treatments, increasing the level of funding for health care will increase waste rather than bringing about substantial improvements in health. If the goal is to improve the health of the population, interventions funded from scarce resources must be based on scientific evidence of their effectiveness and carried out by suitably qualified staff applying best practice and monitoring and responding to outcomes.

5. Linking with the community

In many respects total quality of health care and health care services implies appropriate treatment of individuals and the involvement of their communities. Certainly empowering the citizen and strengthening community participation have been referred to extensively in reform programmes that seek to respond to consumers needs, decentralize power and become increasingly democratic. However, the legacy in CEE and even more so in the NIS have not made this easy. The countries of the region have a recent history of highly formalized, state-centred systems, with only a limited presence of civil society and formulaic approaches to participation in social and public life. The nineteenth century traditions of central Europe were subsumed by communist state monopolies and civil society gave way to quasi social organizations in sports, culture and education, which were dominated by the state. Individual participation in the running of the health system was virtually non-existent, with no choice of providers and low consumer responsiveness. Many countries in transition have sought to address this although this often involves only lip service as in the broad participatory strategies described in their reform programmes. It has often been difficult however, to overcome resource constraints, cultural blocks and professional resistance either in linking with the individual or the community.

Empowering the citizen has been seen as an important reform focus not least as a means of prompting system changes and increased responsiveness. Four major sets of strategies are included here; allowing consumers a choice of providers and/or insurers; encouraging patient participation in clinical decision making (as co-producers of care); promoting citizen participation in the running of the services at various levels (for example in agreeing the basic package of care); and introducing patient rights legislation. These strategies are included in many reform programmes, yet so far progress has been mostly at the level of good will or rhetoric and only limited change has actually taken place. The most positive evidence of action has been in the areas of patient choice and patient rights legislation.

An increase in choice of provider by patients is a relatively common goal of reforms and the introduction of health insurance and of contracting with providers has in some cases allowed consumers to select general practitioners, specialists and hospitals. However, in reality, choice is inevitably constrained by difficulties of access exacerbated by the short supply of certain services and the widespread use of informal payments. In some cases it exists on paper only. Nonetheless, the issue is at least recognised. Similarly, in a small number of

countries consumers are also allowed to choose between competing insurers. This however, has proven to be difficult to regulate and has had an unintended negative impact on efficiency and solidarity.

The introduction of patient rights legislation and patient charters is the other main area of progress and charters have become a common feature in a number of countries, particularly in CEE. These set out a series of patient rights; outline standards covering issues like access to care or waiting times, and establish complaints procedures. The main challenge is that in most cases there are no effective mechanisms in place to ensure implementation. Without any legal or financial sanctions to promote compliance with standards they often dwindle to formal statements of principle with few real consequences.

Strengthening community participation might reinforce the rights of the citizen but this dimension goes beyond the individual perspective to consider the role of the community, reflecting the wider democratization of the CEE and the NIS. It is complicated by the fact that while there is good evidence about the positive contribution of social networks to health status much less is known about how best to empower communities as social actors in health systems.

Community participation strategies are generally new to communities in the region, at least as they operate on a formal level and outside government control. They are especially new in the health sector. Health reforms have begun to include stakeholder analysis and this has expanded to address intersectoral partnerships for health reform and health development. However, there is little evidence yet of the creation of sustainable civil society initiatives for health in communities. This is despite the significant role of non-governmental organizations (NGOs) as intermediaries in this respect. The rapid proliferation of NGOs in the region, especially in countries like Hungary and Poland may be encouraging in its broadest terms but only a small percentage of them work with health issues and those that do tend to represent groups of individuals responding to a deterioration of services. They tend not to represent a movement explicitly promoting health or advocating for healthy public policy. Furthermore, many NGOs lack proper technical expertise, management and training in advocacy techniques, and most if not all are poorly funded.

Although the civil society sector for health continues to be weak in many countries, a series of successful programmes launched by the WHO Regional Office for Europe has provided an opportunity to foster the exchange of experiences within and between local communities on health and capacity building issues. Programmes such as WHO's Healthy Cities Project, Safe Communities Initiative and the Health Promoting Schools Project have stimulated the growth of local community action for health and suggest that citizen empowerment and community participation will play an increasing role in the health systems of CEE and the NIS.

6. Advancing public health

The ultimate reform strategy would be to ensure that populations were healthy and that there was no need for health services. Certainly while health services play a significant role in reducing mortality and improving quality of life, much of the health gap between west and east can only be addressed through wide population and intersectoral strategies. In this context, reform debate in the region must shift from 'health care reform' to 'health reform'. Ultimately, and ideally, policy makers should be able to act across the entire spectrum of policies (including personal, population based, and inter-sectoral interventions) on the basis of the contribution that each can make to enhance population health.

The first step in improving population health is to draw on the extensive research available to better understand why health is so much worse in this part of Europe. This is attributable to a range of factors acting at different levels with many of the well-established risk factors linked to chronic disease, premature mortality and morbidity being especially high in the region. Smoking has traditionally been common among men in the region with visible and current consequences. The sustained onslaught of western tobacco companies, often in collusion with senior politicians, promises ongoing problems and the increasing inclusion of women in the mortality and morbidity data. Diet is also a major factor. It is typically high in fat content, and the relative lack of year round fruit and vegetables is now also being recognised as an important cause of chronic disease. Alcohol is an especially important problem in this region, as was apparent from the spectacular reduction in deaths that accompanied the 1985 anti-alcohol campaign in the Soviet Union. Its impact is especially large as it contributes not only to cardiovascular and liver diseases but also plays a major part in the very high death rates from injuries and violence. Finally, infectious diseases are returning with a vengean-ce, but in much more complex guises, as with HIV and drug resistant tuberculosis.

The public health system established in the Soviet Union in the 1920s and 1930s did have many important achievements, in part because of the high political priority given too it. The seriousness with which the threat of disease was regarded is illustrated by Lenin's dictum in respect of typhus that "If communism does not destroy the louse then the louse will destroy communism". However this extensive, but basic system is no longer adequate for the complex challenges faced. Despite the potential contribution that public health services could make, they have received remarkably little attention in the process of reform so far. Any changes that have occurred were often a by-product of wider organisational change. The two priority areas for reform must be; restructuring public health services; and strengthening health promotion.

Restructuring public health services is a necessary response to the outmoded structures in place and the increasing recognition that public health has a strategic role in health systems. Before 1990, public health services in CEE and the NIS were organized in line with the Soviet model.

Responsibility for public health and prevention was vested in the highly centralized Sanitary-Epidemiological (San-Epid) services and focussed on a traditional and limited core of public health activities. Perhaps the most tangible achievement of the San-Epid system was its contribution to vaccination programmes and communicable disease control, which achieved remarkable successes across the region. On the other hand, it was relatively ineffective in combating problems like environmental pollution, occupational diseases and non-communicable disease. Nor was it effective in producing any of the information that might have allowed public health specialists to assess needs or respond effectively to emerging patterns of ill health. Finally, the system was singularly ill equipped to engage with the public to promote health or encourage behaviour change.

Public health services did undergo a series of changes during the 90´s with decentralization of powers to local authorities; fragmentation and blurring of responsibility. These were not purposive reforms and coupled with the decline in funding of the San-Epid system they led to a decline in the quality of those functions that were previously successful (specifically communicable disease control). There has been subsequent under-investment in the development of relevant skills and in the information systems on which modern public health depends. There have been some notable successes, and cohorts of specialists equipped for a more strategic role have been trained but the reform of public health services still has a long way to go.

Strengthening health promotion is the second public health dimension that requires priority attention. It was largely ignored in CEE and the NIS before 1990 but has benefited subsequently being recognised as a core public health function in many countries in transition. In general preventive strategies such as those aimed at drug users and HIV prevention have received most attention and have been best linked with emerging civil society. There is however a relative lack of intersectoral action. Blocks to work across sectoral boundaries include; a general attitude that population health is largely a product of medical (curative) services and not a cross-sectoral issue; and territorialism of ministries and difficulties in collaborating between agencies. In addition, there are explicit problems in adopting and enforcing public health legislation which creates conflict with key interest groups so for example the tobacco lobby efforts have often prevented advertising bans or tax increases. Nonethe-less, there are networks and activities that encourage intersectoral action (Healthy Cities, Health Promoting Schools, health impact assessment) and demonstrate that success is possible particularly at the local level.

The challenge facing public health remains considerable but experience to date has helped identify key principles that should underpin change. The first is to preserve the good. The inherited system had successes, especially in immunisation and child health and while these need modernizing they should not be abandoned. The second is to attack the bad. While transition has brought benefits, it also has a downside. Just as open borders can increase access to 'healthy' products (year round fresh fruit and vegetables), so they have increased exposure to risks (cigarettes). The third is to reform the institutions and the fourth to increase the level of skills available. Almost all countries urgently require a restructuring

of public health services to allow them to respond to the complex challenges ahead and almost all have a major shortage of individuals trained in modern public health able to lead the transformation. There are some well-established and very successful Schools of Public Health, (in Hungary, Croatia, and Lithuania), but there is still a great unmet training need for those already working in the field and for the next generation of public health professionals. Fifth, governments must protect the public health budget and recognise that public health services are a public good. If the state does not invest in them then no-one will, with adverse consequences for everyone. Finally, there is a need to think much more widely than before and to adopt new forms of and approaches to interdisciplinary and intersectoral working.

7. Implementing successful reforms

Health reform has been harder to implement than expected, and too often it has had unintended consequences. Many of the difficulties experienced have had more to do with the complexity of changing custom and practice than the actual content of the reform programmes and to a significant extent the success or failure of reform has depended on the ability of policy-makers to implement and manage change.

The reform debate focuses increasingly on those contextual and process factors that enable or obstruct change. The experience of CEE and the NIS to date in implementing health reform signal which are most relevant in this region but nonetheless the key issues group around generic concerns and include; context; stakeholders; effective stewardship; steering implementation processes; and building institutional, human and management capacity.

Understanding the context is fundamental. A key lesson for reform implementation is the importance of mapping and appreciating the impact of the social, political, cultural and economic context within which reforms take place.

The historical experience of countries, their national culture and popular custom all help shape expectations of the health care systems and responses to proposed reforms. The ideological dimensions of national politics and of government policy will clearly shape reform content and will also have an impact on approaches to implementation. Similarly long periods of political change and instability will inevitably affect the political context and tend to undermine the sustainability of reform efforts although they may also represent windows of opportunity. Clearly major political and social transformation creates the possibility of introducing change, and may give new governments the legitimacy to execute policies that is otherwise denied. The seizing of these historic opportunities is amply illustrated across the region where new democratic governments often implemented sweeping reforms. However, in many instances this political 'honeymoon' was short lived.

Another important factor contributing to (and being shaped by) context is the role of external influences in reform development and implementation. Many reform notions have been developed in western countries and transferred across national boundaries to the re-

gion. On occasion countries have been lured into adopting structural health sector arrangements that are incompatible with their health sector traditions, cultures and values and that they have neither the societal interest nor the organizational capacity to sustain. International organizations sometimes contribute to this phenomenon through their activities. In order to make an effective and positive use of these external influences and evidence countries need to develop a stewardship capacity (see below) and to adapt useful reform models to the cultural context, establishing clearly their own health sector objectives and managing donor inputs.

These contextual dimensions are complex to deal with not least because of the difficulties of delineating and defining them. Other more tangible elements of context are easier to measure but no less powerful and economic context is a case in point. The continuing macroeconomic pressures in the region constitute a major obstacle to reform implementation. The deep recession that followed the demise of centrally planned economies led to a significant decline in the financial resources available for health services which inevitably had consequences for health care provision. In some NIS countries these financial cuts were of up to 50 per cent of the health care budget. They created substantial flows of informal payments and can be shown to have slowed or stalled the implementation of health care reforms.

It is unsurprising that economic retrenchment and decreasing health budgets should have affected the scale of reform and the extent of implementation. Many reforms (like contracting hospitals) require substantial additional investments in management training and information systems in their start up phase. Even when reforms are intended specifically to contain costs or generating savings (like hospital restructuring), initial investments are required before the effects can be felt. This does not however, lead inexorably to the conclusion that reform cannot succeed in the face of major financial constraints. Rather, the main contextual obstacle to implementation of change may be unrealistic expectations about the likely benefits of reform, both from decision-makers and the population at large. For instance, in many NIS countries, market reforms were expected to increase quality while maintaining universality in the face of dwindling financial resources. The demands made of the reforms were unsustainable, early experiences were inevitably deemed failures, which in turn hampered further implementation. Policy-makers may begin to address these dilemmas by acknowledging the full financial implications of reforms proposed and tuning expectations accordingly. This means that implementers may need to be less ambitious, maintain some current structures and focus on affordable areas of reform and on marginal but high priority shifts between areas.

Given that the contextual issues are addressed reform development and implementation will still require that policy-makers are effective in dealing with stakeholders. Health system reform inevitably involves a large number of stakeholders from patients and professionals to politicians. The ability to identify and then deal with them is key to implementation and three strategies play a particularly central role.

First, ensuring the political willingness to support the reform will be key to success. A lack of political will has posed a major obstacle to reform in several countries of the region and explains some of the slowness in introducing change. This is not surprising, particularly since the complex nature of health care reform demands major changes in the status quo and creates benefits felt only in the longer-term, which inevitably clashes with the short-term nature of many political agendas. The difficulties of achieving change in this environment are exacerbated in some CEE and NIS countries by weak coalition governments and political instability. Frequent political changes, not only of governments and ministers but also of high level officials within the relevant Ministries, have often lead to multiple overlapping or competing reform proposals and overall inaction. In contrast, reforms backed by a strong political will within a politically stable setting have sometimes achieved implementation in otherwise unfavourable circumstances. There are no simple ways of securing political commitment to reform, but strategies that have been shown to work include; using comparative analysis to highlight how reform models work; pilot projects to demonstrate the impact of particular reform strategies; decentralizing implementation to local levels; and consensus building from the outset to maximize political support for reform.

Second, setting strategic alliances with key health sector actors is central to implementation efforts. There are numerous examples in the region of pivotal stakeholders such as the medical profession having blocked or enabled reform. In many CEE countries for example, physicians played a central role in the introduction of social health insurance in the expectation that this would increase their income. While there is a good understanding of the importance of stakeholders and of forming strategic alliances with them it is less clear how best to steer diverse interests into policy coalitions to support reform. Every reform effort needs nonetheless to be preceded by a political mapping of key stakeholder interests and to include the development of alliances; and, if possible, the cultivation of policy champions if implementation and sustainability are to be secured.

Finally, public support of reform is becoming increasingly important in much of the region. In the former communist systems the public made little real contribution to the running of the health services but there has been a growth of civil society and the development of health NGOs and consumer groups recently. Furthermore, many new reform strategies give the public a major role in exercising voice and exit powers in areas such as choosing providers. This has largely been an untapped force in the region but must increasingly be an important reference point for policy-makers who want to ensure reform success.

Steering the process or the design and the management of the implementation process itself is also crucial. Inadequate planning and management of implementation has helped to account for numerous reform failures. Key strategies here include; making reform objectives explicit; establishing an appropriate management structure; allocating responsibility clearly; assessing available financial, technical and managerial resources; using a range of mechanisms and tools including legislation and financial incentive; timing and pacing reform appropriately; and putting in place appropriate information and monitoring systems.

Overall the effectiveness of these organizational management techniques is uncontroversial, two strategies though deserve special consideration given the characteristics they take on in this region.

First, the development of enabling legislation has been a major challenge to reform implementation in CEE and the NIS. Many countries in the region have failed to enact appropriate legislation due to the political uncertainty resulting from short-term coalition governments. However, to have legislation in place does not necessarily generate subsequent implementation. In parts of the NIS, legislation typically in the form of inadequately thought through presidential decrees, acts as a formulaic expression of official values to which no one subscribes in practice.

A second strategy in steering the process of reform, selecting the most appropriate timing and pacing of reform, has been the subject of some controversy. Choosing the most appropriate timing, perhaps when there are specific and supportive social or political circumstances, is an important factor in achieving successful implementation. As noted, recent periods of major social transformation have proved to offer windows of opportunity for radical change. Rapid 'big bang' reforms such as in the Czech Republic were effective in bringing about change in a short time. However, experience shows that for this to be sustainable and effective in the long term two prerequisites are crucial; first, a degree of technical 'certainty' as regards the reform model to be introduced is needed; and, second, there must be a broad social consensus behind the chosen model. The lack of either one of these in some countries that underwent a 'big bang' reform has resulted in major reform reversals.

A more incremental approach whereby change is tested locally with pilot projects before being extended nationally may be more effective. This approach yields more evidence about the effectiveness of different models and in the long run may lead to more socially sustainable policies. There are many successful examples of pilot projects linked to successful national reforms such as the introduction of General Practitioner based systems in some CEE countries. This is not to say that all countries undergoing incremental reform have done so by design or following on from the results of pilot experiences. Often incrementalism has taken place by default and is explained by contextual factors including political instability and macroeconomic constraints. Moreover, incrementalist approaches do have drawbacks. A slow pace of reform will allow key groups of stakeholders to organize resistance before change is introduced. Incremental approaches may also flounder when faced with the difficulties of generalising the results of pilot experiences, with factors such as the self selection of human resources in pilot sites or the lack of financial resources available to extend established best practice confounding implementation efforts.

Ultimately, the 'best' approach to implementation in any country will depend on its particular contextual circumstances. However, there seems to be a consensus about the need to combine an incremental and flexible approach to reform with a series of small "bangs"

that can put in place particular reform strategies, particularly in those cases where there is both organizational certainty and social consensus.

Building institutional, human and management capacity is also crucial to the success of reform implementation. Many reform strategies such as the introduction of provider markets require sophisticated information systems as well as substantial technical and managerial skills which have been lacking in much of CEE and the NIS. The absence of these preconditions helps to explain the minimal progress achieved with some reform strategies in a number of countries in the region and remedying these shortfalls will enable implementation.

A related factor in determining reform success is the extent to which there is institutional capacity, particularly in the public sector, to steer the reform process. The introduction of some complex organizational and market reforms together with the decentralization of state functions has highlighted the need to increase the capacity of the State for governance, monitoring and regulating new organizational relationships. A central factor in the failure of reforms in some countries has been the lack of capacity of the Ministries of Health to adopt these new functions. Two key contributory factors to this failure are; the rapid turnover of public sector employees migrating to better paid jobs in the private sector; and the chaotic decentralization of authority to health insurance agencies and/or regions which have left ministries with accountability for implementation but little authority or capacity to drive reforms forward. These issues are further developed as part of the consideration of how to build an effective stewardship role for the State.

WHO's World Health Report 2000 on health systems performance identifies ensuring effective stewardship as fundamental to health systems. Stewardship was defined as having three main components: i) health policy formulation – defining the vision and direction for the health system; ii) regulation - setting fair rules of the game with a level playing field, and iii) intelligence – assessing performance and sharing information. This concept combines many of the elements discussed above and underlines the importance of the State in ensuring effective reform implementation.

Effective government stewardship is key in ensuring the appropriate performance of all health system functions and it becomes particularly important when introducing reform strategies. For instance, the introduction of market incentives together with the loosening of direct managerial control and accountability mechanisms may result in a series of perverse incentives that will require monitoring and regulation.

The analysis of experience in the region shows that the introduction of reforms only succeeds when these are accompanied with strong regulatory, managerial and information capacity, which is often lacking in countries. In other words, if the stewardship role of the government is weak, regardless of the merits or otherwise of particular reform models, these may lead to catastrophic results for the society.

If governments are to succeed, they must provide a clear policy vision which makes health policy goals and trade offs explicit; demarcates the role and functions of the private sector; sets out a level playing field for the public and private sectors; and includes the definition of a basic package of benefits. Second, governments need to put in place appropriate information systems that allow monitoring of results of reforms and support the introduction of quality assurance mechanisms such as accreditation of facilities and auditing. Finally, governments will need to construct a strong and efficient regulatory framework.

These demands highlight the importance of putting in place programmes to strengthen institutional governance aimed at public bodies and in particular Ministries of Health charged with steering health reforms. It will also be particularly important to plan for a new skill mix and to introduce appropriate training programmes for existing and new human resources.

8. Conclusions

The paper has outlined a conceptual framework that integrates the key strategies that must be addressed and linked if policy- makers are to create the kinds of health care systems that citizens of the region ought to be entitled to. It has examined how financing, coordinated service delivery and quality measures matter independently and it has highlighted the need to interweave them effectively with citizen and community participation mechanisms and a far reaching concern for public health. It has also reviewed the complex issues that hinder or help the implementation of reforms and suggested how critical an understanding of context, stakeholders and capacity will be to delivering change. It draws attention to a number of priority areas for further reform and suggests that policy-makers will need to forge alliances, mobilize political will and the public and draw on a range of legal, technical and managerial strategies if they are to steer reform implementation effectively.

Ultimately reform success or failure will depend on the impact of reforms on the societal objectives of health improvement, equity and efficiency and on the extent to which health systems respond to consumers. There are no simple solutions to the challenges faced. It is rather the case that complexity must be an inherent factor in any realistic approach to balancing affordability and effectiveness in what is an immensely complex environment surrounded by powerful interest groups. Policy-makers need therefore to address stewardship and to take a whole system perspective, adopting a clear health strategy and sponsoring effective regulatory systems so as to provide the framework health care purchasers, providers and public health professionals need. This paper gives some indication of the de-gree of complexity and the elements they will need to combine. Subsequent papers examine each individual component in more detail. The extent to which these different elements will combine in any given country context to have an impact on health outcomes remains open to debate and is an area where national policy-makers must bring their expertise to bear.