

Précis



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Supporting Health Reform in Eastern Europe

As they undertook the difficult transition to a market economy, the countries of Eastern Europe found that they needed to radically reform their health sectors. The scope, pace, and outcome of the reforms eventually undertaken varied. But they shared many characteristics. Most sought to decentralize care, increase private sector involvement in service delivery, rationalize or downsize hospital services, and strengthen the role of family practice physicians. Many introduced forms of national health insurance. Some took steps to strengthen public health programs and regulations (such as controls on public smoking and tobacco advertisement). Others sought to improve reproductive health services for women.

The World Bank encouraged these reforms through its early investment activities in the region and support to regional initiatives funded by grants. The Bank's strategy for the health, nutrition, and population (HNP) sector in the region, articulated in 1998, identified major reform challenges, summarized emerging lessons, and identified priorities to improve the effectiveness of Bank support.

The Bank's HNP portfolio in the region is relatively young. Seven projects (in Albania, Croatia, Estonia, Hungary, Kyrgyz Republic, Romania, and Turkey) were completed by the end of fiscal 2002 and reviewed by the Bank's Operations Evaluation Department (OED). Five of these—Albania Health Services Rehabilitation, Croatia Health Project, Estonia Health Project, Hungary Health Services and Management, and Romania Health Services Rehabilitation—faced similar challenges and became the basis for a broader

OED review of the Bank's reform experience in Eastern Europe. OED also conducted in-depth field assessments of completed projects in Estonia, Hungary, and Romania.

Health reform is a slow and contentious process. Reform in transition countries has been especially difficult because most have had to reform inefficient systems with excessive hospital capacity. This required downsizing resisted by health workers, consumers, and local politicians. Furthermore, many countries lacked the knowledge and capacity needed for health policymaking, planning, and management. A long tradition of specialist medical training contributed to resistance to family medicine, and to cost-effective treatment protocols. Finally, economic transition itself impeded reforms when GDP and health sector budgets were stagnant or declining—as experienced by most transition countries, particularly in the early 1990s.





Although the Bank is often among the most important international agencies operating in a country, its financial contribution is typically small relative to total health financing. The Bank plays only a peripheral role in domestic political bargaining and coalition building around health reforms. Under these constraints, the Bank's influence depends on catalyzing wider reforms, which it tries to achieve through policy dialogue, investments in training and capacity-building, and policy conditions associated with lending.

Bank Support in Context

The health projects in Estonia, Hungary, and Romania illustrate the range of difficulties that have been encountered when attempting to reform the health sector in transition countries. The projects shared many objectives and characteristics, but the evolution of health reform differed. Estonia has been among the most advanced in the region in reforming both its economy and its health sector, while Romania has lagged on both. Hungary has progressed in economic reform and is positioning itself for accession to the European Union, but it has been slow to tackle the sector.

Outcomes of completed projects also varied, from highly satisfactory in Estonia, to moderately satisfactory in Romania, and moderately unsatisfactory in Hungary. In Estonia, the Bank-sponsored Health Project effectively integrated investment and reform activities, and served as an overall framework for the government's reform program. The Romania Health Sector Rehabilitation Project made important contributions to rehabilitation of health infrastructure and to catalyzing health reforms, but the outcome of project investment activities varied considerably. The Hungary project had low government ownership and, although several project components were successful, most project investments had limited sector impact and their sustainability is uncertain.

Determinants of Project and Sector Reform Outcomes

Most of the early Bank-financed health projects in the region underestimated the political and institutional diffi-

culties of reforms, and were unduly optimistic regarding the pace and prospects for reform. Several other major factors were found to influence the outcome of these early projects.

First, the design and sequencing of sector reforms—as well as the Bank's strategy, policy advice, and project design—must be matched to the political and sectoral context of the country, particularly the degree of consensus for reform, and capacity for design and implementation of projects and reform programs.

Second, the outcome of structural reforms—including introduction of compulsory national health insurance or privatization of family doctors—depends on progress in complementary reforms, as well training and capacity development for health managers and providers.

Third, the Bank's most successful project investments—and most significant contributions to the sector reform process—resulted from lending and nonlending support for strengthening capacity and building consensus for reform. These activities typically represented a small proportion of total lending.

Fourth, capital investments can complement and reinforce the reform process, if used properly. But for most of the completed projects, capital investments were only modestly successful in bringing about reforms or significant improvements in health service quality or efficiency. Outcomes were better when investments were carefully linked with institutional reforms and complementary support for capacity development.

Fifth, project investment activities were more likely to be successful when carried out in partnership with other donors, nongovernmental organizations, or research institutes. Many governments are reluctant to borrow for technical assistance, and other organizations have a comparative advantage in technical areas or capacity building.

Sixth, despite more than 10 years of reform experience, there is remarkably little evidence regarding the impact of various reforms on service quality and efficiency, health behaviors, or health outcomes. Lack of priority to monitoring and evaluation has reduced the Bank's contribution to consensus building and social learning.

Design and Implementation of Sector Reforms

The health sector reform agenda has been remarkably similar across the region. Experience with three areas—national health insurance, strengthening of family medicine and privatization of general practitioners, and strengthening health promotion and public health programs—illustrates some of the challenges.

National health insurance—great expectations, mixed results: Most countries in Eastern Europe have established some form of compulsory national health insurance, financed through a payroll tax. The reforms were expected both to increase resources available to health and to catalyze improvements in system efficiency and quality. But

outcomes have been mixed. In advanced reformers, such as Estonia, the new insurance system is well established and beginning to yield benefits. In Hungary cost containment remains a challenge. In countries like Romania, where the economic and institutional context is weak, the reforms remain fragile, with continued shortcomings in the legal framework.

Experience in Estonia, Hungary, and Romania shows that insurance and payment reform alone are insufficient to significantly rationalize or improve the efficiency of the hospital sector. The Bank's ability to influence the development of national health insurance has been limited, largely because the decision to implement social insurance has been driven by political considerations. Thus the Bank's role has been limited to encouraging refinements in the system and strengthening management systems, as it has done in Croatia and Estonia.

The Bank remains engaged in national health insurance issues in many countries in the region and in the future will need to attend to several important questions: Do the benefits of compulsory national insurance outweigh the opportunity cost of establishing these new institutions, particularly in low-capacity settings? Even if compulsory national health insurance is not ideal, how can countries that have made a political commitment to national health insurance best adapt to this system? Should governments introduce competition among public and private insurance providers—along with the even greater regulatory burden required by this approach? Should payroll taxes continue to be the primary source of revenue for national health insurance—given their potential to increase labor costs and tax evasion? If not, what mix of revenue sources might reduce negative side effects for the economy? Countries themselves will make these decisions, but increasing knowledge and advising client governments on such questions is an important priority for the Bank and its partners.

Strengthening family practice—importance of sequencing training and reforms. To strengthen primary care, countries throughout the region have either piloted or implemented reforms to establish family medicine as a distinct specialty and to contract family doctors as independent practitioners. Estonia, a leader in these reforms, established a Department of Family Medicine at its medical school in the early 1990s (and expanded it with project support). By the time the reforms were fully implemented in 1997, a critical mass of well-qualified family doctors had been trained, increasing acceptance among the public and medical community. In Romania, a project-sponsored pilot tested family doctor reforms in eight districts. The pilot built support and helped refine legislation, but reforms were implemented nationally before family doctors had been trained in their new roles. The reforms created the potential for improving primary care, but further refinements are needed. For example, the recently established health insurance fund has limited ability to monitor the quantity (billing) or quality of care.

The contrasting Estonia and Romania experiences point to several lessons. First, changes in the employment and payment systems should be accompanied or preceded by intensive training for family doctors, to allow them to adapt to their new roles and to increase credibility for reforms among patients and the medical profession. Second, general practice reforms should be implemented in phases, with the “gatekeeper” function (for specialist care) the last to implement—after credibility is established. Third, the success of reforms depends not only on establishing appropriate incentives in the payment system, but also on developing adequate capacity within the purchasing authority for regulation and monitoring of general practitioners and effective mechanisms to protect budgetary allocations for primary care. Finally, establishing family doctors as independent practitioners requires clarification in the regulatory framework for primary care, including clarifying ownership of primary care facilities (usually previously owned by government), employment for nurses, and accreditation for private or independent practitioners.

Health promotion—limited progress: Strengthening health promotion and prevention of noncommunicable diseases—including reducing tobacco and alcohol consumption and improving diets—requires efforts to influence individual behavior (through information, education, and communication), as well as changes in policies, laws, and taxes. But progress has been limited because most governments in the region initially assigned health promotion a low priority. Project-sponsored health promotion components were relatively successful in Estonia and Croatia (where governments were generally supportive), but unsatisfactory in Romania and Hungary (where support was weak). The Bank needs to give greater emphasis to building capacity and commitment for health promotion activities in project design, supervision, and policy dialogue, particularly when government commitment is weak.

The experience in Croatia, Estonia, Hungary, and Romania suggests several lessons for future Bank work in this area: First, changing long-established patterns of individual and social behavior is a long-term process, as is building institutional capacity and national commitment for health promotion—particularly given the low starting point of most of the countries. Second, the Bank can contribute to building capacity and consensus for health promotion through policy dialogue (with ministries of health, ministries of finance, and nongovernmental stakeholders) and through targeted project support (such as establishing or strengthening health promotion organizations). But these activities require consistent attention during project design and supervision, despite the modest size of investments. Third, monitoring and evaluation of health behaviors was weak in all completed projects—and in most countries—both in tracking behavior trends at the national level (which typically require survey instruments) and in evaluations of the effectiveness of specific health promotion interventions. Projects tended to set unrealistic targets for

changes in health indicators for chronic diseases (cancer, heart disease); intermediate behavioral indicators are more appropriate (smoking prevalence).

Strengthening Capacity and Consensus for Reform

How can the Bank use its lending and nonlending activities to help strengthen local capacity and to build consensus for reform among stakeholders?

Strengthening capacity for design and implementation of reforms: Project support for establishing or strengthening health management institutes in Hungary and Romania, schools of public health in Estonia and Hungary, and a department of family medicine in Estonia has helped increase the credibility of these “new” disciplines, built national capacity in skills critical for reform, and strengthened constituencies for sector reform. Their direct impact on policy depended on relations with government, however. Reforming existing organizations—such as ministries of health or Soviet-era sanitary-epidemiological agencies—has proven more difficult than establishing new ones in Estonia and Hungary. But long-term dialogue and support for training can pay off. Despite contributions to training and capacity by a variety of donors, the demands of sector reforms on both managers and health providers continues to outstrip the supply of training and technical support in many countries. And, based on experience in Albania, Hungary, and Romania, training programs need to be adapted to the busy schedules of providers and hospital managers.

Building consensus for reform: Given regular turnover of governments and ministers, engagement with a wide range of stakeholders, including Parliament and opposition parties, is essential. Pilot projects can contribute to refining and building consensus for reforms, but need to be well-designed, evaluated, and relevant to government priorities. Bank studies and analyses were often influential, as in Albania, Hungary, and Romania, but the impact depended

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on the extent of local involvement and dissemination, and on the government’s absorptive capacity for technical analysis. Although project conditions cannot force governments to take actions, the Bank can use targeted policy conditionality to strengthen the hand of reformers and help “lock in” reforms—as in Estonia and Romania.

Recommendations

The Bank can enhance its contribution to sector reform by:

- *Strengthening the knowledge base for sector reform*, through improving monitoring and evaluation at both the project and sector levels, and by sponsoring analytic work on how to best adapt reforms to local circumstances, particularly differing institutional and political contexts.
- *Strengthen focus on neglected priorities*, including health promotion, reducing under-the-table payments, and equity (including for ethnic minorities).
- *Continue to experiment with new lending instruments*, including Adaptable Program Loans, Learning and Innovation Loans, and Sector Adjustment Loans—and selectively incorporating health sector-related conditions into macroeconomic adjustment loans.
- *Further strengthen partnerships with donors, non-governmental organizations*, and research institutes, within the region as well as at the country level.



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