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REVIEW ARTICLE

The international community and the reconstruction of health care in South Eastern Europe

Sanja Matović Miljanović · Svetlana Janković

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Abstract Today, with the aid of the international community [European Union (EU), World Bank (WB), World Health Organisation (WHO), United Nations Children's Fund (UNICEF), nongovernmental organisations (NGOs), Global Fund (GF), Stability Pact, etc.] the ministries of health in transitional countries in the South Eastern Europe (SEE) region are in the process of expanding the capacities and skills of the health workforce in order to achieve successful health care reform and accomplish necessary steps for EU integration. The aim of this paper is to review international community support to reconstruction of the health care in SEE countries, with main focus on the EU and WB donors and projects. Review was done on the basis of existing donor reports, Internet search (search of official Web sites and electronic databases, check of references from selected documents, and use of a generic Internet search engine) and authors' experience from different health projects. The governments of SEE countries, in order to create an effective and efficient health system, overcame a period of transition and soon or later became ready for the process of EU integration, and began working on the following issues: rehabilitation, reconstruction and equipping of health facilities; developing a health strategy and policy documents; legislation and financing framework; building institutional, human resource and management capacity; health care sector reform; support to public health development and restructuring of the pharmaceutical sector. In many SEE countries, the capacity of the Ministry of Health and Health Insurance Fund was strengthened, and policy and strategy documents were drafted to guide reorganisation and reorientation of health care services. The public health system was strengthened. A family medicine model was introduced and developed in most countries. Development of enabling legislation mostly followed proposed changes in the health system. Although progress on several important fronts in achieving transition and progress in the rehabilitation health sector in SEE countries is significant, a lot remains to be done. Experience in some countries can be used to stimulate, motivate and encourage professionals throughout the civil service to grasp with both hands the opportunities for positive change.

Keywords SEE countries · International community · Health care reform · Projects · EU integration

S. Matović Miljanović (✉)
Institute of Public Health of Serbia "Dr Milan Jovanovic Batut",
5 Dr. Subotica st.,
11000 Belgrade, Serbia and Montenegro
e-mail: smmiljan@sezampro.yu

S. Janković
Institute of Public Health Belgrade,
54a Despota Stefana st.,
11000 Belgrade, Serbia and Montenegro
e-mail: cecasvet@hotmail.com

Introduction

As a result of the political and economic transition in last two decades, central and eastern Europe has faced major social changes. A central focus was the change from centralised (state) planning to the market-oriented economic system. Some countries, such as Slovenia, Romania and Bulgaria, faced the process of transition earlier (from 1989 to 2001) while some countries of former Yugoslavia (such as Serbia and Montenegro) entered the transition very late (in 2000). Economic and political instability in the process of transition in the South Eastern Europe (SEE) region correlates with changes in the population's health. Especially in countries of former Yugoslavia, large-scale

population displacement affected the overall health of the population by determining the societal and economic status of the new nations and by influencing the structure of populations as reflected in statistical data. As health care was not one of the public financing priorities in SEE countries (Bara et al. 2002), the overall result was a drop in life expectancy during the 1980s in most of these countries.

According to data from 2003, life expectancy is lowest in Romania (70.1) while in Slovenia it is 6 years higher (76.1) (Fig. 1).

The process of reforming the health care systems in SEE countries had to deal with many obstacles, predominantly control of health care expenditure, balancing the development of different segments of health care services, stabilisation of effectiveness and quality of care, transition from a one-party system to a pluralistic democracy, introduction of a free market economy, war devastation etc. (Kovačić and Šošić 1998). Policy makers struggled with profound structural changes coupled with reduced budgets, lack of appropriately trained staff, and rising poverty levels. In addition to the marked deterioration of the health of their citizens, health systems in the region had to respond to a variety of economic and political pressures as well as to long-standing health care problems, including a low quality of services characterised by poor responsiveness to citizens and outdated clinical practices (Figueras et al. 2004).

Before SEE countries entered the period of the transition, the health system was highly centralised in most of them and was based on public-sector provision and tax financing. Privatisation in the health care sector was limited and covered mainly the fields of dentistry and pharmacy while in primary and secondary health care, the percentage of private practices was very low. Changes that the health system underwent included the adoption of laws that enabled decentralisation and increased local autonomy and laws to permit private health services through establishment of medical associations (chambers). Reform health care systems were evidence based and oriented towards primary health care (Orešković 1998).

European Union integration process

The European Union (EU) integration process for all SEE countries has begun. While Slovenia joined the EU in 2005, some countries, such as Romania and Bulgaria, are in the stage of acceding countries (scheduled to join the EU on 1 January 2007). Croatia, Turkey and Macedonia are currently in the status of candidate countries while Serbia and Montenegro, Bosnia and Herzegovina and Albania are potential candidates, considering the fact that the Stabilisation and Association process commenced prior to negotiations on accession to the EU. All countries are committed to fulfil a set of criteria as laid out by the Copenhagen meeting of the European Council (EC). This implies that they will need to approximate the policies and rules of the EU, the *acquis communautaire*, a term that refers to EU law. The *acquis* is, for the purpose of the EU enlargement process, divided into 31 chapters (for negotiations with Turkey and Croatia into 35 chapters). Only one of these chapters relates directly with the Health Sector (Consumer and Health Protection). However, several other chapters are in close relations with Health Sector issues (free movement of persons, food safety, economic and monetary policy, taxation, science and research, environment, etc.).

The overall process of EU integration in SEE countries, especially for the Health Sector, depends much on the capacity for change. The endeavour to accomplish change is

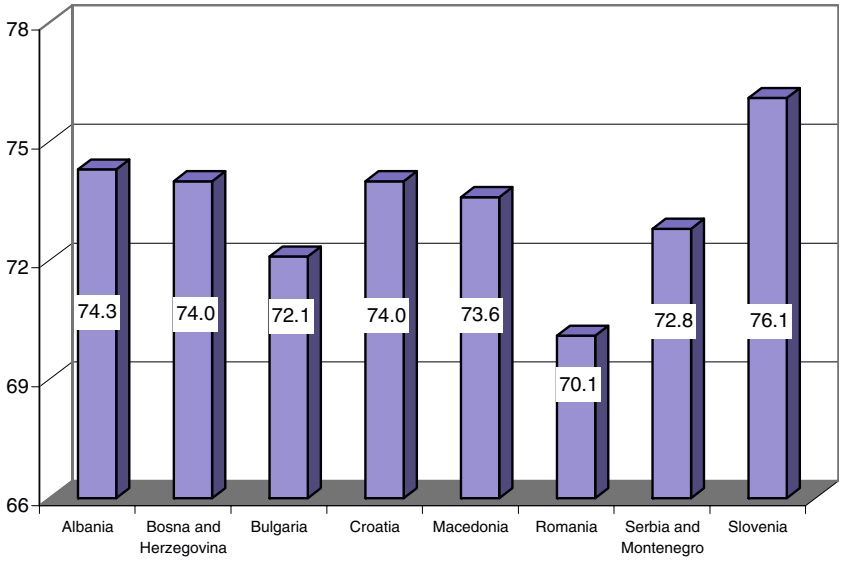

Fig. 1 Life expectancy at birth (year 2003). Source: World Bank (WB) country data – http://web.worldbank.org

putting high demands to the governments of all countries. It is clear that change management must play the most important role in the process of integration, but many countries are still faced with the lack of overall management skills and uninformed and decentralised decision making. Also, the public administration in health sectors still have insufficient capacity for implementation of necessary programmes and activities requested for EU integration. In some countries (e.g. Bosnia and Herzegovina), even general state-level functions are not fully performed or have been severely compromised since there is a lack of management capacity and human resources for strategy development, planning, monitoring, evaluation (The European Union's CARDS Programme for Bosnia and Herzegovina 2004). In response to the rapidly changing international development landscape, donor and multilateral institutions have become increasingly aware of the value of partnerships.

International community support to SEE countries

In last two decades in the SEE region, government commitment and technical and financial support from the international community, through a number of nongovernmental organisations (NGOs), bilateral donors, and international development agencies, has resulted in significant progress in rehabilitating its health sectors. With the aid of EU, World Bank (WB), World Health Organisation (WHO), Global Fund (GF), European Investment Bank (EIB), United Nations Children's Fund (UNICEF), different NGOs, etc., the Ministries of Health in transition countries in the SEE region are in the process of expanding the capacities and skills of the health care workforce in order to achieve successful health care reform and to provide the necessary steps for EU integration. The authors of this paper mainly review the support of two main donors—EU and WB—to health systems in SEE countries in transition. Some significant projects for the SEE region, such as the Open Society Institute and Association of Schools of Public Healthh in the European Region (OSI ASPHER) project and Public Health SEE (PH-SEE) Stability Pact network are also mentioned.

EU assistance programmes were mainly managed by EU delegations (in Romania, Bulgaria, Bosnia and Herzegovina, Croatia) as well as by the European Agency for Reconstruction (EAR) (for Serbia and Montenegro and the Former Yugoslav Republic of Macedonia). While support through EU delegation started earlier, EAR was established in February 2000 as the EU main reconstruction arm in Kosovo and later expanded to Serbia and Montenegro and the Former Yugoslav Republic of Macedonia. The form of EU support depended upon different needs and circumstances in a particular country. In the beginning, donor support was in the form of aid/postwar emergency programmes focused on reconstruction of infrastructure (especially for former Yugoslav countries such as Bosnia and Herzegovina and Croatia, which were faced with civil war). Later, different development projects started in order to provide technical assistance for health system reconstruction and support health system reform in SEE countries. EU is assisting restoration and development of the health sector through Poland and Hungary: Assistance for Restructuring Their Economies (PHARE) programme (1997 and 1999) and Community Assistance for Reconstruction, Development and Stabilisation (CARDS) 2001, 2003 and 2005 programmes. Side by side with EU aid, the WB has provided significant financial support and technical assistance to help SEE countries establish a health care system that is accessible, affordable and efficient. Besides support to hospital and clinic rehabilitation, reconstruction and equipping of health facilities, development of primary health care systems was supported. National capacity for managing health care services was strengthened by introducing the family medicine model, developing centres for health care management, strengthening public health institutes and, in some countries, establishing accreditation and quality assurance agencies (Ivanovska and Ljuma 1999; Georgieva et al. 2002).

In order to establish better coordination and implementation of all WB projects, in each country, a project coordination and implementation unit (PCU/PIU) was established by the Ministry of Health. Together with EU and WB, financial and technical support was also provided by the WHO, GF, EIB, International Committee of the Red Cross, UNICEF, different NGOs etc. OSI ASPHER, as well as the PH-SEE Stability Pact network provide significant support to health care in the region, particularly in building institutional, human resources and management capacity. The Ministry of Health, Health Insurance Fund and other stakeholders, with the help and support of the international community and above-mentioned donor agencies, were mainly working on the following issues in order to create an effective and efficient health system, overcome the period of transition and sooner or later become ready for the process of EU integration:

a. Rehabilitation, reconstruction and equipping of health facilities (hospitals, clinics, etc)
b. Developing health strategy and policy documents, legislation and financing framework
c. Building institutional, human resources and management capacity
d. Health care sector reform (primary, secondary and tertiary health care)
e. Support to public health development
f. Restructuring the pharmaceutical sector

Rehabilitation, reconstruction and equipping of health facilities (hospitals, clinics, etc)

As mentioned above, in almost all SEE countries, early international projects mostly focused on reconstruction of infrastructure. A lot of donor funds were spent on civil works, renovation of buildings [primary health care (PHC) centres, hospitals, clinics, etc.], equipment delivery and pharmaceutical supplies. The primary objective of the WB project Essential Hospital Services (1997–2002) in Bosnia and Herzegovina was physical rehabilitation and reconstruction of essential hospital facilities. This rehabilitation and restoration was set in a broader and longer-term context of contributing to moving the hospital sector towards a more modern and ultimately cost-effective system. Repair and reconstruction focused on priority structural, electrical, mechanical and heating systems. The selected hospitals were provided with their most urgent needs in diagnostic and therapeutic equipment for secondary-level care and essential medical supplies (World Bank 2002a). Within the Basic Health Project in Bosnia and Herzegovina in 2001, health centre facilities were rehabilitated and provided with medical and office equipment for family medicine services (World Bank 2004a). Also in Bulgaria adaptation works in PHCs were carried out, and medical equipment was purchased during implementation (1996–2001) of the WB-funded Health Sector Restructuring project (World Bank 2002b). In Serbia, physical rehabilitation of PHC centres was completed through the Basic Health Services Pilot Project, funded mainly by the International Committee of the Red Cross. During this project, PHC centres were supplied with medical equipment as well as computer hardware and technical equipment (Kraljevo Municipality). In Kosovo, with help from the EU, in 2001, renovation works at Pristina University Hospital, the Centre for Family Medicine Development at Pristina University, and at eight Family Medicine Training Centres across Kosovo were successfully completed.

Developing health strategy and policy documents, legislation and financing framework

It is clear that in order to have successful health reform, governments in every country must provide a clear policy vision that 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 (Figueras et al. 2004). Many projects conducted in recent years in SEE countries were designed to support development of policies and strategies in the health sector. Within the support of the WB-funded project Health Sector Restructuring in Bulgaria (1996–2001), the National Health Strategy and Action Plan was developed (World Bank 2002a,b). In Albania, the following strategic documents were produced in 2003 and 2004 with the support of the Health Systems Recovery and Development Project: National HIV/AIDS Strategy completed; Health Sector Strategy developed and adopted; Hospital Strategy for National Hospital Management Capacity completed and National Health Promotion Strategy developed and adopted (World Bank 2005).

The Tobacco Control Strategy and Action Plan were developed in Bosnia and Herzegovina in 2003 (within the WB Project Public Health and Disease Control), as well as in Serbia in 2005 (in the framework of the Support of the Public Health Development in Serbia project funded by EU and managed by the European Agency for Reconstruction). Serbia and Montenegro also took a further significant step in tobacco control by signing the WHO Framework Convention on Tobacco Control in 2004 and later by ratification of this document in 2005. In the framework of the same project, Serbian Public Health Strategy and Action Plan was developed (European Agency for Reconstruction 2005a,b).

Development of enabling legislation is another necessary task for reform implementation, which needs to follow proposed changes in the health system. Very often, as the result of the minority or short-term coalition governments and political uncertainly, in many countries in the region, enactment of appropriate legislation has failed. The need for enabling legislation is recognised by the international community, and many donors supported countries in the region in this matter. For example, in Serbia, a new Medicine Law has been finalised and agreed upon by the government within the EU project "Support to the Regulatory Framework of the Pharmaceutical Sector".

Anti-smoking legislation was developed in 2003 in Bosnia and Herzegovina with assistance from the Public Health and Disease Control project. During the Health Sector Restructuring Project in Bulgaria from 1996–2001, legal conditions were developed for the operation of the blood transfusion system (World Bank 2002a,b).

Review and revision of relevant extant Romanian legislation to strengthen the framework of the National Structure for Communicable Disease Surveillance, Control and Prevention and to monitor compliance with EU legislation were done in 2003 during the "Improvement of the Efficiency of the Romanian System for Epidemiological Surveillance and Control of Communicable Disease" project.

Much of the initial reform effort in the region has also focused on the key theme of health system financing. In most countries, the intention of the reform was to shift away from the centralised and integrated tax-based state model of Semashko to decentralised, contract-based social

health insurance reflecting the core features of the western European Bismarck model (Figueras et al. 2004). Implementation of effective health insurance systems, defining a more realistic benefits package and addressing informal payments were priorities in many countries. In the ongoing EU project Capacity Building of the Health Insurance Fund in Serbia, some objectives are to support the health reform process and health care purchasing, contract for and operate financing approaches, as well as improve the operation of basic financing and financial management systems. 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. Through the WB loan in Bosnia and Herzegovina, capitation-based payments for primary care (design and development of payment mechanisms for family medicine teams) were piloted with the help of the Development and Payment Mechanisms component of the Basic Health Project. Implementation of new budgeting formula often dictates conducting surveys to get realistic data about financial flows. In Albania, the Budget Tracking Survey and the National Health Accounts Study were completed with the help of the Health Systems Recovery and Development Project (World Bank 2005).

Building institutional, human resources and management capacity

Building institutional, human resources and management capacity is crucial for 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 many SEE countries. With the financial and technical support of the EU and WB, capacity building of the Ministry of Health was supported in many SEE countries. In Serbia, the Memorandum of Understanding was signed between the EAR and the Ministry of Health in 2002 outlining an agreed upon framework for implementation of the capacity-building support project within the ministry. In Albania, the Ministry of Health was supported by the "Health Systems Recovery and Development" project in order to strength capacities in the field of human resource planning and management in the health sector. In Romania, a number of staff from the Ministry of Health were trained and supported in health services planning through the "Health Sector Reform" project (World Bank 2004a).

Lack of proper health planning was recognised by the international community as one of the main problems in the process of health reform in SEE countries. In order to support health planning and strengthen national and regional capacities, many projects were designed. In Albania, the Regional Health Care Master Plan was completed with support from the Health Systems Recovery and Development project while in Romania, local health services plans were developed with the assistance of the "Health Sector Reform" project.

A surplus of doctors, the strict line between professional groups and a lack of team work were present in the centrally planned approach before transition. In order to develop and strengthen human resources and management capacity, much training in the country and abroad, including study tours, were organised for health professionals throughout different projects in SEE countries. For example, the "Basic Health Project" in Bosnia supported the establishment of Centres for Health Management and development of a curriculum for health management. About 100 PHC managers were trained through short courses. In addition, the project supported development of the curriculum for a masters degree programme on health management (World Bank 2004b).

In Serbia, an EU project supported establishment of the Centre School of Public Health (C-SPH), with main goal being to prepare new generations of public health professionals capable of analysing health problems in the twenty-first century and determining priorities for interventions. A curriculum for a master of public health was developed, and the first generation of students started in February 2005. Additionally, more than 500 health professionals were trained during the summer and winter campus and in different courses in the previous 2 years.

Building institutional, human resources and management capacity in the SEE region is also supported by OSI ASPHER. This programme is aimed at developing quality in public health teaching programmes by drawing upon the experience, expertise and networks of Association of Schools of Public Health in the European Region (ASPHER 2006). To achieve the aims involved in quality development, ASPHER and OSI have designed a two-tiered approach. The programme consists of two parts: "Strengthening and deepening public health education and training" [concentrates on developing quality by use of the Public Health Education European Review (PEER)] and "Building Public Health Education and Training Capacity" (development of partnerships between the applicant schools and members of the ASPHER network).

Significant support in the SEE region is also seen throughout PH SEE Stability Pact network. Stability Pact for South Eastern Europe is a broad-based international political initiative aimed at enhancing cooperation between SEE countries and is based on the definition of "security" in a broader sense, with the objective to ensure human security that will comprise not only the traditional security-and-defence point of view but also social and economic security and welfare. With the Programme for Training and

Research in Public Health, it significantly contributes to the institutional, human and management capacity building in the SEE region. This programme intends to improve and support collaboration of teaching and research institutions in public health training and research programmes related to regional specificities and needs. Besides development of postgraduate and continuing training materials in public health and implementation and evaluation of training programmes through common workshops, one of the main objectives of this programme is identification of priorities and stimulation of national and joint public health research projects. Establishment of the public health professionals' network builds a strong human resource and management capacity and a good basis for the further reform and reconfiguration of the health care system.

From 2001 to date, activities of the PH SEE network programme were mainly organised through courses and summer and winter schools, with the following topics: Planning and Management of Public Health, Minimum Indicator Set for SEE Countries, Strategies for Public Health Policy, and Evidence-Based Public Health. Summer schools took place in the different countries (e.g. Croatia in 2001, Slovenia in 2002, Serbia and Montenegro in 2003 and 2005). Moreover, several meetings and conferences were organised in order to establish sustainable collaboration and strongly supported further activities (PH SEE 2006).

Health care sector reform (primary, secondary and tertiary health care)

In health policy and strategy documents, primary health care is intended to achieve some significant reforms. It is well known that in almost all SEE countries, specialists played the main role in the health care system. Nowadays, a consensus exists about the future main role of family physicians. The international community supported such an idea through different projects to develop effective strategies for strengthening and modernising primary care and establishing a family medicine model. Very often, before being extended nationally, models were tested locally and through pilot projects. There are many successful examples of pilot projects linked to successful national reforms. In Bosnia and Herzegovina, a primary health care system based on cost-effective interventions was established in pilot areas with the assistance of the "Basic Health Project". In Serbia, the "Basic Health Services Pilot" Project from 2001 to 2005 dealt with planning, development and operationalisation of an integrated basic health services package to meet the primary health care needs of the population in the pilot site (Kraljevo Municipality). With EC assistance, the Centre for Family Medicine Development was established and developed in Kosovo (at the University of Pristina) for the training of family doctors. One of the main achievements of the WB-funded Health Sector Transition Project in the Former Yugoslav Republic of Macedonia was the success of the continuous medical education programme for primary care practitioners (World Bank 2003). Financial and technical support was also provided to secondary and tertiary care, and was mainly focused on effective improvement of hospital performance, hospital restructuring strategies and shifting boundaries between primary care and hospitals. Reform programmes have consistently underestimated the complexities involved in introducing new skills and genuinely changing practice, but reforms of provider organisations can only improve outcomes if they change the quality of clinical practice. 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-analyses.

International assistance was provided in many countries, with the main focus on initiating and establishing an operative system for development and management of treatment protocols in the health service and to improve diagnostic, treatment and referral practices for different diseases. These protocols are to be based on the principles of evidence-based medicine and methodology and developed in such a way as to ensure involvement of clinicians at different levels of practice, namely, tertiary specialists, generalists and primary care physicians. Clinical guidelines for prevention and management of common conditions were developed in Romania with assistance of the Health Sector Reform Project (World Bank 2004a). In Serbia, continuous development of clinical guidelines was done (2003–2005) in the frame of the Improving Medicine Management in Serbia project.

Support to public health development

In September 2002, the EC and European Parliament (EP) meeting of the Conciliation Committee adopted a decision on a 6-year programme (2003–2008) of Community Action on Public Health (Watson 2001). The programme came into existence on 1 January 2003 with a total budget of eur 312. The programme promotes an integrated health strategy through three major objectives: improving information and knowledge relating to public health; enhancing the capacity of public authorities and health systems to respond rapidly to health threats and promoting health and the prevention of disease by addressing health determinants across all policies and activities (Watson 2001). In addition to the 25 member states of the EU, the call for project proposals was open for participation of candidate countries: Bulgaria, Romania and Turkey. In 2004, eur 1.3 million for the three

candidate countries were allocated within the programme. The importance the commission attaches to public health in EU policies was reflected in efforts to ensure a global, coherent, EU health strategy, close links between public health measures, and health-related initiatives in other policy areas. Such links were supported by new mechanisms and instruments, e.g. health impact assessment of other policies, joint measures with various policies and mechanisms strengthening the coordination of health-related activities.

Some projects in 2004 in which candidate countries participated as a partners with EU countries were: Network for Communicable Diseases Control in South Europe and Mediterranean (Romania); Vaccine European New Integrated Collaboration Effort (Romania); A European Platform for Mental Health Promotion and Mental Disorder Prevention: Indicators, Interventions and Policies (Bulgaria); Health Impact Assessment in Accession and Pre-Accession Countries (Bulgaria and Turkey). In 2005 the following projects began: Vaccine Safety—Attitudes, Training and Communication (Bulgaria, Romania and Turkey); Preparation of the Global Report on the Health Status of the EU (Bulgaria); Developing Public Health Indicators for Reporting Environmental/Occupational Risks (Romania), EU Core Indicators in Diabetes Mellitus (Romania), etc.

Beside projects funded from EC Programme for Community Action, some significant additional funds (such as Structural and Cohesion Funds) are expected to be available in forthcoming years. Structural and Cohesion Funds are the EU's main instruments for supporting social and economic restructuring across the EU. They are used to tackle regional disparities and support regional development through actions in a variety of sectors, including health-sector development. Most Structural Funds projects are assessed and approved by relevant local and regional authorities. These funds are used to assist candidate countries in preparation for accession.

In parallel to the EU initiatives the strong motivation among health professionals from SEE countries to update knowledge and skills in public health and health promotion and the willingness and motivation of the various stakeholders to accept and adopt new approaches in public health work placed public health in the vanguard of the health reform process in many SEE countries. With the aid of numerous partners, ministries of health in many countries are in the process of expanding capacities and skills of the public health workforce in order to achieve the "new" public health.

Public health services underwent a series of changes during the 1990s, with decentralisation of powers to local authorities, fragmentation and blurring of responsibility. But in some countries (such as Bosnia and Herzegovina and Serbia and Montenegro), the process of restructuring public health services is ongoing. In Bosnia and Herzegovina in 2003, institutional support to the Institutes of Public Health was the main component in the "Public Health and Disease Control" project. The Strategic and Business Plan, developed during the project, defined the aims of the Institutes of Public Health and helped establish short-term plans of action coherent with the long-term vision and aimed at meeting overall targets. In Serbia, at the end of 2005, the "Support to Public Health Development in Serbia" project was working on improving performance of the network of Institutes of Public Health in Serbia as well as on enhancing professional training in public health by establishing a National School of Public Health. The project also supported a national expert group in developing the Public Health Strategy and Action Plan for Serbia. Development of Public Health Strategy for Romania was supported by the Public Health and Disease Control Component within the Health Sector Reform Project in Romania. Besides strategy, provision of the health promotion training for key staff as well as procurement of equipment for the reference public health laboratories were also results of that project (World Bank 2004a). The authors of that paper argue that reform of the public health sector in SEE countries should be placed within the context of the overall reform of public administration within the country. In this respect, much of the journey lies ahead.

Restructuring the pharmaceutical sector

In many SEE countries, international support was provided for the restructuring of the pharmaceutical sector in order to improve availability of and access to pharmaceuticals, to alleviate the shortages of health supplies in hospitals and health centres and to support the pharmaceutical industry. Several similar projects were conducted in many countries. For example, in Macedonia, the Technical Assistance for Pharmaceutical Project I from 1996–1998 and in Romania, the project on Harmonisation and Application of Legislation in Pharmaceutical Sector from 1998–2001. In Serbia, EC support was provided through the projects Support to the Regulatory Framework of the Pharmaceutical Sector and Support to the Serbian Pharmaceutical Sector Through the Supply of Drugs and Medical Devices, Training and Capacity Building. Projects supported the regulatory framework of the pharmaceutical sector and helped establish and equipthe Medical Products Agency. Development of a National Drug Policy Document was also initiated, and a training programme for more than 200 people developed. In Kosovo, A Sustainable Pharmaceutical Sector project focused on the following activities: Support to KFK (Kosovo Community Pharmacies): financially sound and sustainable business plans, reporting procedures, audit trails, warehouse premises being up to acceptable hygiene

Table 1 List of selected ongoing and implemented World Bank (WB) and European Union (EU) projects

	Country / Project name/ Time frame	Funded by / Project costs	Project objectives	Project components
1	Albania **Health Systems Recovery and Development Project** 1998 - 2005	WB US$28.0 mil	• Establish/strengthen institutional and human resource capacities for an effective and sustainable health sector • Improve the accessibility, quality and efficiency of essential health services in fulfilment of a precondition for sustained improvements in health status	• National Capacity Building • Governance and Management of the Health System in the Tirana Region • Upgrading of Tirana Health Care Delivery System • Project Management
2	Bosnia and Herzegovina **Essential Hospital Services Project** 1997 – 2002	WB US$15.0 mil	• Rehabilitate hospital services • Commence health financing reforms	• Physical Rehabilitation and Reconstruction of Essential Hospital Facilities • Physical Repairs at the Institute of Public Health • Medical Equipment and Supplies • Clinical Skills Upgrading • Health Finance Reform • Project Implementation Support
3	Bosnia and Herzegovina **PHARE 1997**	EU € 5.7 million	• Reducing dependence of BIH on humanitarian assistance and rebuilding sustainable reform of health sector	• Support to primary health care and Manpower Development • TA in Health Financing and Information system • Support to Pharmaceutical Sector development • Technical assistance to the Department of health in Brčko district
4	Bosnia and Herzegovina **CARDS 2001**	(EU/WHO) € 2.5 million	• Elevated costs, inefficiency and ineffectiveness and achievements of modern Health Care standards	• Technical assistance in health care reform
5	Bosnia and Herzegovina **CARDS 2003**	EU € 0.5 million	• Comprehensive PA Reform	• Functional Review of Health Sector
6	Bosnia and Herzegovina **Basic Health** 1999- 2004	WB US$12mil	• Establish a primary health care system based on cost-effective interventions • Reduce lost productivity due to preventable illnesses, disabilities and premature deaths • Improve local and national capacities for managing the health sector	• Primary Health Care • Public Health and Disease Control • Accreditation and Quality Assurance • Project Management
7	Bosnia and Herzegovina **Health Sector Enhancement Project** 2005 - 2010	WB US$43.8 mil	• Enhance health system efficiency through restructuring and strengthening of primary health care along the family medicine model • Strengthen the policy making process through the development and implementation of a system for monitoring and evaluating health sector performance	• Primary Health Care Restructuring • Improvement of Health Sector Management Capacity • Health Policy Formulation and Project Support
8	Bulgaria **Health Sector Restructuring Project** 1996 - 2001	WB US$47.1 mil	• Improve the efficiency of the health care delivery system and facilitate the restructuring of the health sector by strengthening the policy analysis and management capacity in the sector • Protect the population by ensuring continuing provision of essential health care services during the transition period and beyond	• Policy Analysis and Management • Primary Health Care • Emergency Medical Services • Blood Transfusion
9	Bulgaria **PHARE** 1996 -1998	EU € 1.6 million	• Technical Assistance within the Framework for Private Medical Practice	• Implementation of the framework of a private health system based upon a family practice organisation • Technical assistance, setting-up of equipment, organisation of study tours
10	Bulgaria **Health Sector Reform Project** 2000 - 2007	WB US$86.96 mil	• Support the Government of Bulgaria in implementing fundamental reform of its health sector, designed to improve access to quality health services and ensure financial and operational sustainability	• Primary and Ambulatory Care Reform • Hospital Care Reform • Health Care Financing • Capacity Building and Project Management • NHIF Infrastructure Development • Technical Assistance
11	Romania **Health Rehabilitation Project** 1992 – 1999	WB US$ 207.5 mil	• Rehabilitate and upgrade the primary health care delivery system • Support the first steps of a major restructuring of health sector financing and management to ensure a sustainable, cost-effective health care system in the medium term	• Upgrading rural dispensaries; • Improving reproductive health care services; • Strengthening training for nurses and physicians; • Introducing a health promotion program; • Ensuring the supply of essential drugs; • Upgrading the communication/transport system for emergencies
12	Romania **Health Sector Reform APL 1** 2000 – 2004	WB US$ 59.82 mil.	• Improve the capacity for policy, planning and regulation, finance and management in the health sector • Improve quality, cost-effectiveness and technical efficiency in selected poor and remote areas, essential hospital and ambulatory health care services and emergency medical services • Modernize public health services	• Planning and Regulation of Healthcare Delivery System • Essential Upgrade of District Hospitals • Primary Health Care • Emergency Medical Services • Public Health and Disease Control • Project Management
13	Romania **Improvement of the efficiency of the Romanian system for epidemiological surveillance** 2003 – 2004	EU € 1.4 million	• Supporting the Ministry of Health and other key stakeholders to improve the function, organisational structure and financing of the epidemiological surveillance and communicable disease reporting system in Romania. In particular, the programme serves to create the foundations for the integration of the Romanian surveillance system into the European Union (EU) surveillance network in order to comply with the EU framework Decision 2119/98/EC, and subsequent EU legislation.	• Epidemiological surveillance and control system of communicable diseases • Health laboratories technology and infrastructure • Communication technology and infrastructure

and security standards, regular distribution of medicine, appropriate stock levels in warehouses and pharmacies; Support to KDRA (Kosovo Drug Regulatory Agency): equitable access to essential drugs throughout Kosovo, availability of low-cost nonessential drugs, network of licensed premises staffed by trained pharmacists; Training: undergraduate pharmacy and medical training linked to a postgraduate educational programme.

At the end of this selected list of different methods of support provided by the international community, it is important to mention that in achieving successful implementation, supportive social and political circumstances in the country are necessary. According to some authors (Figueras et al. 2004), to be sustainable and effective in the long term, two prerequisites are crucial: a degree of technical "certainty" as regards the reform model to be

Table 1 (continued)

14	Romania **Health Sector Reform APL II** 2005 -2009	WB US$ 207 mil	• Improve efficiency and equity in the planning and regulation of the health service delivery system • Reduce preventable deaths among emergency medical cases • Improve access and quality in primary health care in poor and remote areas • Help the Romanian health sector to better focus on priority public health problems, by reducing preventable illness and deaths	• Maternity and Neonatal Care • Emergency Care Services • Primary Health Care and Rural Medical Services • Policy and Planning • Project Management
15	Croatia **Health Project** 1995 - 1999	WB US$ 54 mil	• Improve the operational and financial management system of the Health Insurance Institute • Improve the quality of the health care delivery system • Improve the health status of the population by supporting health promotion programs	• Health Insurance Administration • Primary Care and Health Promotion Services • Essential Hospital and Emergency Services
16	Croatia **Health System Project** 2000 - 2004	WB US$39.88 mil	• Strengthening institutional capacity within the health sector • Introducing pilot delivery system improvements and a national heart disease program • Strengthening public health activities • Developing policy options that will increase the sector's financial sustainability • Improving and expanding the health information system • Disposing of outdated and unusable pharmaceuticals	• Health Services Delivery • Public Health • Pharmaceutical Waste Disposal • System -Wide Initiatives • Project Management
17	Macedonia **Health Sector Transition Project** 1996 - 2002	WB US$ 17.1 mil	• Build capacity for policy-making and health system management • Strengthen primary health care and health promotion, particularly in rural areas • Help reduce the cost of essential drugs through reforms creating a more competitive pharmaceutical market.	• Health Finance and Management • Basic Health Services • Supply and Distribution of Pharmaceuticals • Project Management – International Project Unit
18	Macedonia **Health Sector Management Project** 2004 -2008	WB US$ 11.34 mil	• Upgrade MOH and HIF capacity to formulate and effectively implement health policies, health insurance, financial management and contracting of providers • Develop and implement an efficient scheme of restructuring of hospital services with emphasis on developing day-care services and shifting to primary care	• Policy Formulation and Implementation • Strengthening HIF Governance and Management • Improving Service Delivery • Project Management, Monitoring and Evaluation
19	Montenegro **Health Care System Improvement Project** 2004-2009	WB US$ 9.89 mil	• Support improvement in financial sustainability of the health care • Improve quality, efficiency and access to primary health care services • Support a project management network of the Ministry of Health and a central Technical Services Unit	• Support for Health Reform Program • Phased Implementation of Primary Health Care Development • Project Management
20	Serbia **Support to the Serbian Pharmaceutical Sector** 2000 - 2003	EAR € 23.7 million	• To improve the availability of essential drugs throughout Serbia and introduce related sector reforms, such as establishing treatment protocols and the rationalisation and restructuring of the pharmaceutical industry	• Supply of essential drugs, reagents and medical consumables and medical equipment • Provision of training and technical assistance
21	Serbia **Reorganisation of the Blood Transfusion Services** 2002 - 2005	EAR € 2.2 million	• Support the re-organisation of blood transfusion services through the provision of technical assistance towards re-organisation and upgrading of blood transfusion services into national blood transfusion service and their harmonization with EU regulation and standards.	• Implementing a new organization of the National Blood Transfusion Services • Establishing an Agency for regulation of blood transfusion in Serbia • Supplying and/or upgrading relevant equipment •
22	Serbia **Improving Medicine Management in Serbia** 2003 - 2005	EAR € 2.5 million	• Improving medicine management in Serbia, introduction of new prescribing and dispensing of medicines at primary level.	• Improvement of medicine utilization in hospitals • Computerization of hospital pharmacies • Support to the medicine agency • Continuous development of clinical guidelines
23	Serbia **Support to Public health development in Serbia** 2003 - 2005	EAR € 2 million	• Contribute to the improvement of the health of the population in Serbia through development of public health policies, strategies, human resources and practices.	• Improving PH policy, legislation and financing • Improving the performance of the IPH network • Enhancing professional training in PH • Strengthening health data collection and utilization • Assessing preventive services in country
24	Serbia **Health Project** 2003 - 2008	WB US$ 23.48 mil	• Build capacity to develop a sustainable, performance oriented health care system	• Health Services Restructuring • Health Finance, Policy and Management • Project Management, Monitoring and Evaluation
25	Kosovo **A Sustainable Pharmaceutical Sector** 2000 - 2002	EAR € 0.7 million	• To set up a drug procurement and distribution system capable of approaching an optimal balance of efficiency, effectiveness, accessibility, equity, user acceptability and relevance to need, within its resource constraints and regional context.	• Support to KFK (Kosovo Community Pharmacies): • Support to KDRA (Kosovo Drug Regulatory Agency): • Training: undergraduate pharmacy and medical training.

EAR European Agency for Reconstruction, *MOH* Ministry of Health, *NHIF* national health insurance fund, *HIF* health insurance fund, *IPH* Institutes of Public Health

introduced, and a broad social consensus behind the chosen model. In that science, some projects are designed to support the public in acceptance of changes and suggested reform. One example is a health-sector reform project in Bulgaria, Technical Assistance to Design and Develop a Public Information Programme for the New Hospital System in Bulgaria, which was designed to develop a multimedia programme focusing on improving public acceptance of the new hospital system in Bulgaria.

The list of selected EU and WB ongoing or implemented projects, reviewed by the authors of this paper, is enclosed as Table 1.

Discussion

An efficient and well-managed health care system is critical for the economic and social development of a country. In most transition countries, health care and public service systems are in a process of dramatic change, often referred to as reform. These reforms have for the most part been stimulated by external forces due to macroeconomic conditions (WHO 2000). Restructuring of the economies of countries as a condition of loans from international donors has had a profound impact on public and health services of individual countries. In last decade, progress has been made

on several important fronts in achieving transition. With the help of different donors in many countries, policy documents and legislative instruments have been drafted to guide the reorganisation and reorientation of health care services. The public health system was strengthened, and a family medicine model was introduced and developed in most countries. Development of enabling legislation followed proposed changes in the health system. Countries in the SEE region reached a different stage of transition. However, much more remains to be done. Attention in this discussion is given to the strengths and weakness of international support to health system reform and the sustainability of changes made during the projects in SEE countries.

International funds and technical assistance provided at the right time are crucial factors for reform implementation. The main benefit of donor assistance is financial support, provision of international experience and multisectoral involvement. Provision of financial support through the different projects is enabling governments to undertake important reform in the health sector. Without such support, reforms would be far more modest and spread out over a longer period. Providing high-quality technical advice on health-sector reform from a broad, international experience is very valuable in creating changes in different health systems. International donors can also create pressure to make tough decisions when necessary based on economic and social analysis. Donor agencies are very often involved in different sectors providing significant technical assistance (multisector involvement). Work across sectors of the economy is particularly helpful in the health sector. Involvement in a country's overall policy dialogue on economic development, public sector management and poverty reduction strategies provides an added advantage.

International support throughout projects has been more or less successful depending on different factors that influenced results. The authors of this paper are point to the following possible weak points of technical assistance provided throughout projects and possible constraints:

- Limitation of project duration (average 1–2 years in EU projects while WB projects are mostly longer) can result in drafted documents and strategies but actual implementation or acceptance of the documents (by the government or public) is not followed up or further supported. It is obvious that implementation is mostly the task and the responsibility of the each country government, but experience shows that further support for implementation and assurance of sustainability is needed.
- Political and economic instability in some SEE countries, often changes of government and staff in the ministries, which can result even in periods without an appointed minister (e.g. Serbia), makes practice difficult, and there are assumptions about the standards of practice made at a range of different levels. Changes of leading decision makers in the Ministry of Health or other agencies might disrupt policy decisions and implementation.
- There is often lack of information and cooperation among different departments and stakeholders in a country. An effective internal communications system must be developed for sharing information about forthcoming events and issues between the Ministry of Health, National Health Insurance Fund, regional structures and other public institutions.
- There is often overlap between projects and insufficient coordination on the country level. Often, there is also lack of overall coordination among projects, which prevents everyone from being informed about the activities of related projects. This can result in overlapping of project activities.
- Unrealistic planning of activities during the project can lead to additional expenditures and changes in outcomes.
- Sufficient staff and strengthening capacity is essential to ensure that there is a sufficient number of local staff to implement projects. It is also essential that donor agencies provide sufficient support through training and provision of consulting services, which should occur at the beginning of the project rather than later.
- Lack of professional and public support to some aspects of reform, as well as staff resistance to institutional reforms and taking on wider responsibilities can hinder progress.
- Lack of counterpart funds can cause delays in project activities and put in jeopardy sustainability of project achievements.

It is clear that sustainability of project achievements is one of the main issues. To address this issue, some activities have been tested in pilot regions before implementation on the national level. The purpose of large-scale pilot projects is not experimental; rather, it is to field test fundamentally sound, proven and agreed-upon reforms prior to their wider implementation in a given country and allow a period of experience for tailoring reforms to the local context. Pilot activities should therefore be designed and implemented with a view to scaling up from the outset. It is important that the basic gist of reforms is shared and consistent with the government's strategic direction (World Bank 2004a).

Conclusion

Over the last decades, the international community, through many organisations and donors, is supporting and will

continue to support the process of health care reform in the SEE region and is working toward EU integration of these countries. Although significant progress has been made, much remains to be done. Follow-up activities are required in order to maintain the momentum of improving the capacity of Ministry of Health and National Health Insurance Funds and better informing the public about reforms in health care in all SEE countries. Existing and forthcoming funds (e.g. structural funds) are seen as a great support and help to countries in the SEE region toward achieving health system reform and ensuring sustainability of the changes, as well as assisting candidate countries in the preparation for EU accession. However, as the right to health is laid down in the constitution of each of these countries, responsibility for sustainability and securing it belongs to the governments as a whole, working with and on behalf of their citizens.

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