

The evaluation of public health in South Eastern Europe: from transition to progress

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Abstract

Background: The public health services project of the South-eastern Europe health network has undertaken an evaluation of public health services in its nine member countries. The purpose of the evaluation of public health services provision in the South-eastern European (SEE) countries is to understand where these countries now stand in public health, the institutional, organisational, legislative and service delivery developments that are taking place and to identify strengths and weaknesses in their public health systems and services in order to inform decision making about investment and future reform.

Methods: The evaluation was orientated around “essential public health operations” that are deemed to form the core of public health activities and services and to be indispensable to the delivery of modern public health services in any country. The evaluation analysed these activities and services within the structure of the health system functions of stewardship, resource generation, financing and service delivery, as developed by WHO.

Results: The results demonstrate a mixed picture of strengths and weaknesses within the context of significant social, economic and political challenges in the region. Among the many visible and significant strengths in public health services in the region are well developed networks of public health institutes with well defined surveillance systems, highly experienced and well educated public health professionals as well as many positive examples of service delivery. But there are also many concerns and challenges, not the least of which is political focus, direction and support for modern public health services, as well as funding. Collaboration and partnership among sectors is weak and information and communication systems are inadequate and not sufficiently integrated.

Conclusions: Having emphasized the main weak and challengeable points in the Public Health systems and services in the SEE countries, the evaluation is also a first step to defining a way forward in the SEE countries to ensure that the turmoil of ‘transition’ is only a prelude to the comprehensive modernisation of public health services.

Key words: South East Europe; Public Health Services; Future Challenges

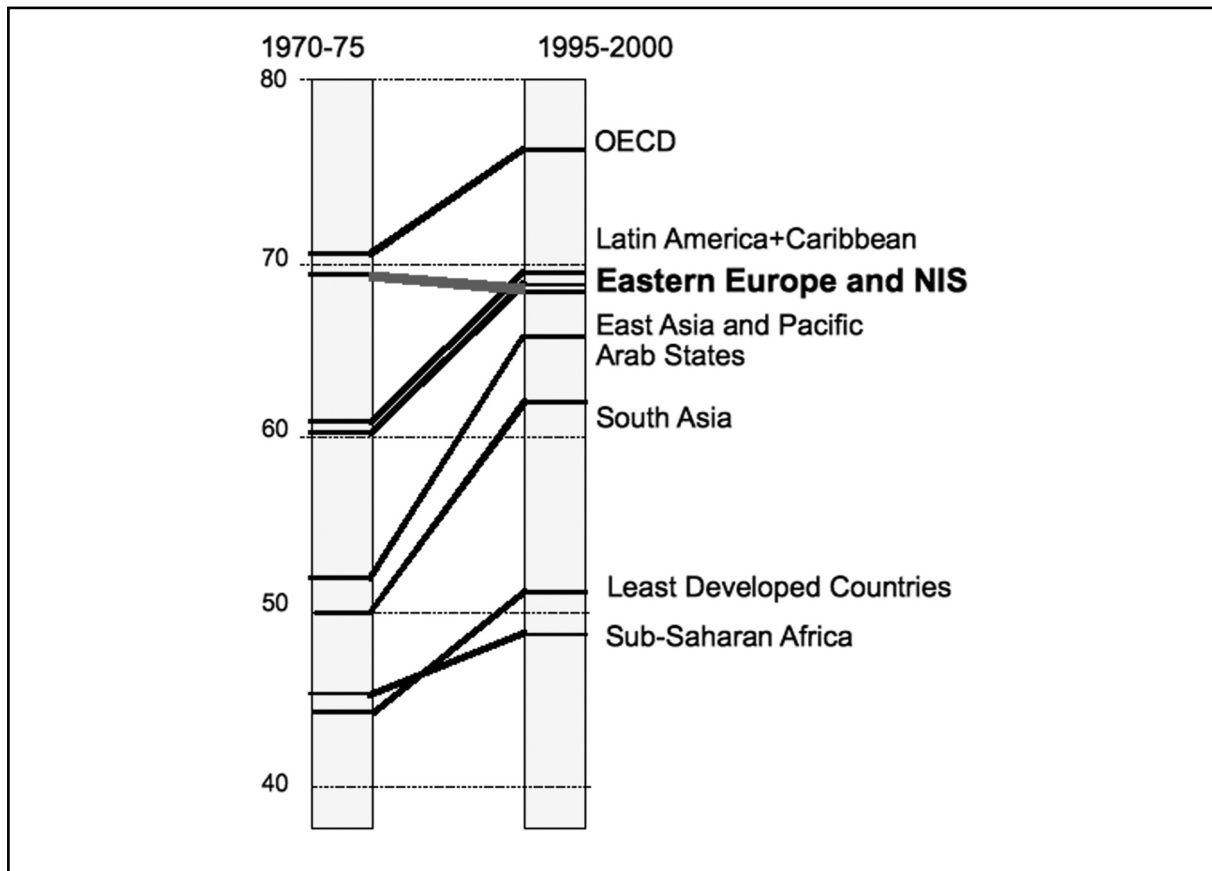
Introduction

In South-eastern Europe (Albania, Bosnia & Herzegovina, Bulgaria, Croatia, Moldova, Montenegro, Romania, Serbia, and The former Yugoslav Republic of Macedonia) the health impact of the economic, social and political dislocation caused by the collapse of communism and the breakup of Yugoslavia has been stark. The challenge to public health has been severe and continues today. The period of “transition” from centrally planned to market economies was followed by a decade of loss in human and social capital, [1] which had many adverse socio-

economic implications, causing the deepening of poverty and inequalities through unemployment and the devaluation of real wages, pensions and social benefits, all of which placed particular pressure on the health system. The health of the population was adversely affected and a rise in death rates, particularly among older men of working age, has been documented.[2] Indeed, the eastern European region as a whole (together with NIS countries) is the only region of the world where overall life expectancy has fallen measured, over a thirty year period (Figure 1).

Indeed, though the period of transition in the

Figure 1. Life expectancy trend in different regions of the world.



Source: Bardehle D. [48]

1990s has provided the most severe challenge to the health status and health systems of the SEE (as well as CEE) countries, a divergence between health status of their populations and those of western European countries can be detected much earlier, from the 1970s and 1980s, suggesting that the failure to address changing patterns of disease and changing priorities is not associated only with the transition period. Mortality from cardiovascular diseases, for example, shows both an earlier divergence and the severity of the impact of transition on the health status of the population (Figure 2).

While each country faces particular challenges, and although reforms of health systems have taken different paths in some respects, the SEE countries continue to have similarities in their social and health systems and the need for better performance and improved population health.

Economic and social context

Most countries of the region showed no or little economic growth through most of the 1990s, although a strong recovery has been under way since the turn of the century (see graph). The

volatility of the region's economies in the 1990s, and in particular the first half of the decade, was reflected in high inflation, high unemployment and falling, stagnating or fluctuating GDP growth. The effects of conflict on economic stability and growth have been particularly severe, with the real GDP of Bosnia & Herzegovina plummeting in the early 1990s. Unemployment has also been affected greatly by economic restructuring and remains a significant macroeconomic problem for the region, hindering the raising of tax revenues and straining social support budgets.

The socioeconomic problems of transition, coupled with the effects of political strife and war, the displacement of people, and the economic and social fracture that resulted, has fed poverty across the region. There are significant inequalities on the basis of socio-economic status in the SEE countries. While most people enjoy adequate housing, many poor households live in unsafe, unhealthy conditions, especially in substandard settlements (Figure 3).

There are some socially marginalized groups (most often the Roma population) and others who suffer disproportionately from poverty such

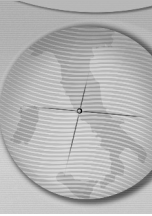
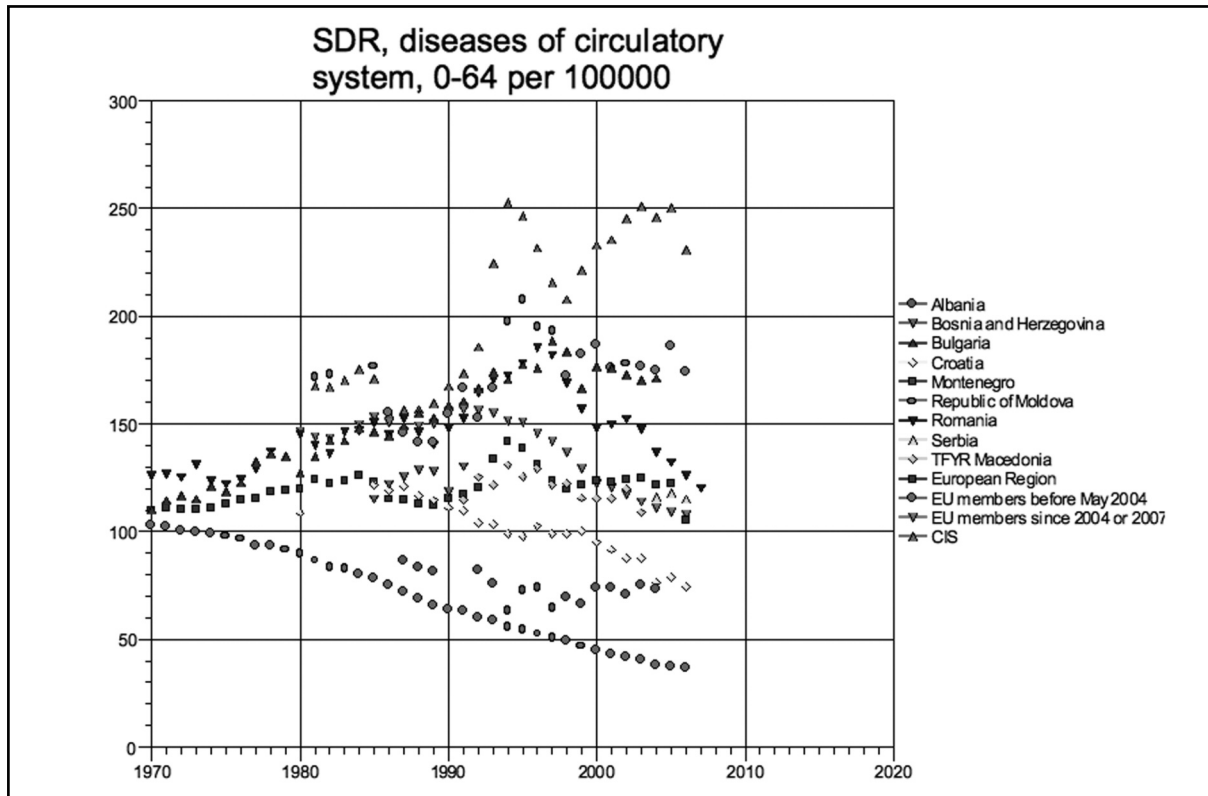
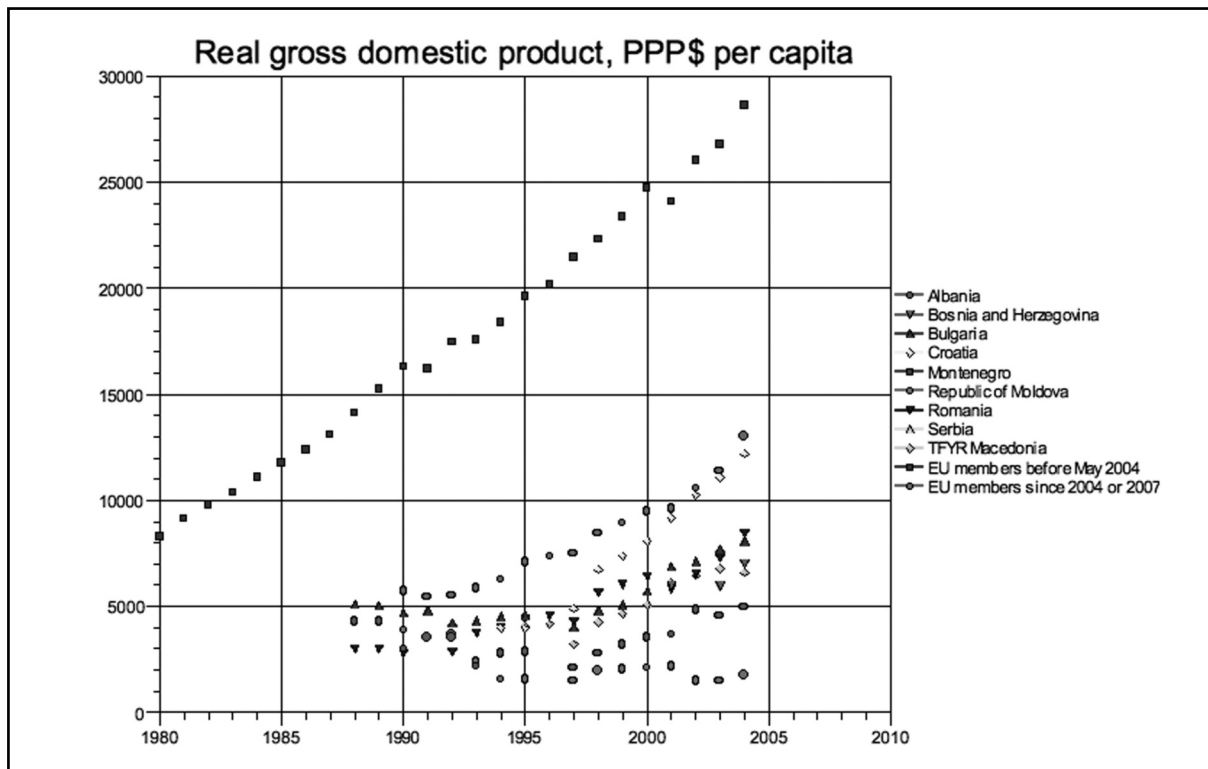


Figure 2. Standard Mortality rate of circulatory diseases in SEE region.

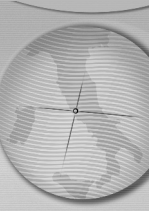


Source: WHO Health for All database 2007

Figure 3. GDP trend in SEE Region.



Source: WHO Health for All database 2007



as the displaced, the old and the unemployed. However, the configuration of poverty in the region is complex. The particular form of economic crisis and political collapse in much of the region has meant poverty has affected large numbers of people, and been a 'whole-economy' phenomenon. Poverty remains a problem and several countries have poverty reduction strategies to address it. Migration (internally displaced people and especially outward migration) is also an issue that considerably affects the public health status of the region. And there are remained marginalized groups whose position is significantly worse than the mainstream.

Challenge for the health system

The rise in poverty has occurred hand in hand with changes to the structure of health services, with the potential to reinforce the patterns of poverty and inequality already present because of economic transition. Low income groups use significantly fewer specialist health services than higher income groups with the same health status. Throughout the region, out-of-pocket payments, both formal and informal, have become a major source of health financing since 1989. This has disproportionately affected lower income groups, and undermined equal access to health services. Aside from those who are uninsured, there are significant variations in access to health care and facilities due to the ability to pay. In addition, privatization of some services has introduced a two tier system, as the efficiency and quality of state-owned health services have in many cases been allowed to deteriorate, with those on low incomes, the marginalised and the remote again being most at risk.

As far as Public Health is concerned, although most of the formal hierarchical systems have remained in place, the infrastructure in many countries has degenerated and facilities have suffered from years of under-investments. In this, the public health services and systems in these countries and in particular the sanitary epidemiological services are especially affected (SANEPID). Furthermore, the public health services and systems in these countries, and in particular the sanitary epidemiological service (SANEPID). Sanepid Public health services have traditionally played an important role in Eastern Europe countries, including SEE countries, and the countries of the former Soviet Union. Services foster the health of the population and address health threats caused by various sources with a predominant emphasis on hygiene and

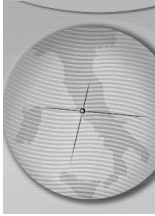
surveillance of essential communicable diseases. There is an ongoing process of organizational changes to those services in most of the countries. SANEPID traditionally concentrated on environmental surveillance and the control of communicable diseases, has in some cases been dismantled or allowed to decay and has not been replaced with adequate alternatives. In essence, in those countries where it occurred, there is strong evidence to indicate that the public health system is in disarray and there is a clear need to strengthen public health infrastructures. Transition from a centralised Semashko model of health services in planned, socialist economies to a market orientated, decentralised and contract based model continues to present difficult adjustments. The so-called Health Care Model Semashko was present mostly in Eastern Europe countries and the countries of the former Soviet Union. It was named after a Russian doctor and politician N.A. Semashko (1874-1949). In the Semashko model, universal, free and comprehensive health care services are provided by the state to the citizens. The process is fully controlled by the government and integrated within the planned socialist economy with an emphasis on supply & specialized care.

The evaluation of PHS: aims and methods

The Evaluation of Public Health Services (PHS) in South-eastern European countries and the production of national and regional reports of this evaluation is a key undertaking of the South-eastern European Health Network. [3,4,5] The SEE Health Network project on the Public Health Services is being developed and implemented within the framework of the Stability Pact Initiative for Social Cohesion, with the technical and financial support of the Council of Europe Development Bank and the WHO Regional Office for Europe.

The purpose of the evaluation of public health services in the SEE countries is to understand where these countries now stand in the provision of public health services, the developments that are taking place and to identify strengths and weaknesses in their public health systems and services in order to inform decision about investment and future reform.

The evaluation of public health services performance was undertaken using a methodology developed in conjunction with the nine SEE countries, along with others. It was orientated around ten "essential public health operations", which constitute the activities and services seen as forming the core of public health



services and being essential to adequate public health services delivery in any country. The activities and services cover the public health domains of health protection, disease prevention and health promotion. The “essential public health operations” are:

- Surveillance and assessment of the population’s health and well being.
- Identifying health problems and health hazards in the community.
- Health protection.
- Preparedness and planning of public health emergencies.
- Disease Prevention.
- Health Promotion.
- Evaluation of quality and effectiveness of personal and community health services.
- Assuring a competent Public Health and personal health care workforce.
- Leadership, governance and the initiation, development and planning of public health policy.
- Health related research.

During the evaluation public health activities and services, the ‘essential operations’ are analysed within the framework of the four “health system framework functions” (stewardship, resource generation, financing and provision of services, as developed in the World Health Report of 2000 [6]).

During the 2007 a comprehensive self-assessment and evaluation of public health services was conducted, which included analysis of the development of policy, and concluded with recommendations for future investment and reform. The ongoing experiences have been shared and extremely fruitful discussion had been held during the special round tables which followed after the completion of the work.

The evaluation was undertaken using a comprehensive questionnaire. National Focal Points from the nine countries in the region were nominated in order to coordinate the work on the national process. A Regional Project Manager was also appointed to coordinate the process between countries and produce the regional report. At the national level, working teams were convened as deemed necessary by the national focal points. The process of evaluation is by definition subjective and qualitative (although conclusions are supported with objective information) and the collegial nature of the working teams, including national experts from all parts of the public health system, is a vital part of the added value of the self-assessment process.

The process in the SEE countries also served the

purpose of developing a web-based self-assessment tool for the evaluation of public health services, which will be finalised early in 2009 and will be available to all the countries as a means of on-going self-assessment.

Results and findings of the evaluation

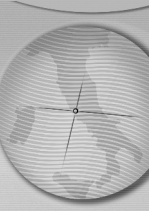
The results of the evaluation focused on the key areas and activities of public health; contextual information was also gathered on economic and social factors that affect both the health status of the population and the resources of government and individuals to fund health related activities and services.

Health status of the population

The overview of the health status of the population shows that the SEE countries face the same basic health challenges as western European countries, with the emergence of both communicable and non-communicable diseases. However, not only is the capacity to meet those challenges seriously compromised but the trends in health status have been particularly affected by transition and war. During that time and in the period since - and despite the substantial work done through the existing institutions and services and the support of WHO and various donor countries and organisations - the health status of the population in a majority of the countries has been subject to marked deterioration. In parallel with the rising concern from the infectious diseases, non-communicable diseases, especially of the circulatory system, are also a major problem in the region. There are obvious limits to the ability of these countries to tackle non-communicable diseases, lifestyle risk factors and socio-economic determinants of health. Furthermore, even though infant and maternal deaths have been decreasing, improvements appear to have halted and the ratio remains much worse than the average for EU countries.

Stewardship: the planning and evaluation of public health

The results of the evaluation in relation to the stewardship of public health in the region showed a mixed picture. Most countries have an ongoing process of strategic planning in some form or other, many in the form of strategic plans that have been drawn up for several years ahead. The configuration of planning between national, regional and local levels varies. The relationship between the centre and regions and localities also differs in the extent of supervision by the centre



of the provision of public health services at community level. In the majority of countries, there is some form of central supervision, although in some this is devolved to district or local level. However, while there are robust legal underpinnings to the provision of services in the health sector across the region, most countries do not have a separate policy document dealing exclusively with public health. Rather, public health functions and services are defined within broader health sector legislation and policy.

A wide variety of measurable health objectives and indicators is used to evaluate services and activities in the field of public health. Demographic indicators and mortality and morbidity indicators are used widely. Immunisation and communicable disease surveillance indicators are also used in the countries. Rarely are lifestyle risk factors and social determinants of health used as a basis for evaluating services as this information is not systematically collected (see below). Nevertheless, there is some activity in this area. In Serbia, for example, a comprehensive Public Health Strategy paper has been developed by the Ministry of Health in conjunction with the EU-EAR funded project "Support to Public Health Development in Serbia (August 2003 - July 2005)". The strategy focuses on a wide range of measurable health objectives. All countries pay some attention to the social determinants of health in some areas of services, including, variously, nutrition, tobacco use, children's rights, policies to reduce differences in health status, and others. However, in general the region's approach in this field is underdeveloped and there are few broadly-based strategies that seek to take account of housing, employment, and social exclusion in the formation or focus of public health policy.

Despite the fact that intersectoral collaboration is an important mechanism for the achievement of comprehensive approaches to public health, formalised and permanent structures for intersectoral collaboration are not widely established in the region. In particular areas there are examples of operational collaboration, including coordination and inter-ministerial bodies and informal committees in such areas as food policy in Bosnia & Herzegovina, occupational health in Macedonia and Bulgaria, tobacco control in Romania, and the Environmental Health Action plan in Albania. Bosnia & Herzegovina also represents a good example of a poverty reduction strategy with the participation of many sectors of the government.

The implementation of policy is a key concern

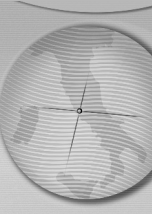
across the nine countries. Moreover, the monitoring of policy implementation is generally weak. There is inadequate systematic assessment and monitoring to provide intelligence on the effectiveness of policy and programmes, and to feed back into the policy and operational processes of public health services.

The stewardship of public health in the SEE region is not only a concern of national governments but also of the many international organisations that operate there. The role of such organisations in the health sector is substantial, and most countries have a considerable number of ongoing internationally funded projects. The Global Fund to fight AIDS, Tuberculosis and Malaria is among the most active in the region. UNDP, WHO and the World Bank are also active supporters of public health projects. The EU is active in some countries, principally through the PHARE programme in both Bulgaria and Romania, as new EU Member States, and also through EAR, the European Agency for Reconstruction, [7] in Serbia, Montenegro, Kosovo and Macedonia. In the past several years, expanding operations in the SEE countries was one of the highest priorities of The Council of Europe Development Bank [8].

Information and surveillance

Information systems and the capacity for surveillance and assessment of population health are quite well developed in the region but with notable gaps, such as the collection of data on risk factors for non-communicable diseases. Public health sector capacity for the collection, analysis and dissemination of health information, including in the area of health systems performance, is good across the region and nearly all countries collect information at various levels, although in a couple of countries improving capacity in this area is currently ongoing. In recent years, Romania has undertaken a programme to develop health information systems, with the support of the World Bank. In Serbia a network of public health institutes collects data for monitoring quality of personal health services according to the National Continuous Quality Improvement Programme. They are also responsible as resource centres for the annual National Patient Satisfaction surveys. Reports are available on line from their websites.

Most countries collect some forms of socioeconomic data, including the World Bank's Living Standards Measurement Study (LSMS) and the Multiple Indicator Cluster Survey (MICS). The LSMS have become an important tool for measuring poverty and the studies are conducted



in several countries of the SEE region. MICS surveys are a major source of data for the monitoring of the Millennium Development Goals (MDGs), as well as the assessment of progress towards other international goals, such as those included in "A World Fit for Children", [9] and the UNGASS on HIV/AIDS, [10] etc. However, independent, nationally-based research into areas such as housing, access to health services, identification of vulnerable groups, is less prevalent.

All countries of the SEE region have the capacity for population based - descriptive epidemiological research (morbidity, mortality, consumption and lifestyle surveys,) although there is a region-wide lack of capacity in information technology and systems. Real research work (based on a referent scientific procedure, including experiments and lab work) in public health is still missing. Information systems constitute the weak link in the ability of the region to conduct health-related research.

Resources and the delivery of public health services

Institutional arrangements are largely sound and established, with strong vertical structures that contribute significantly to the efficient delivery of vital public health services. In particular the region has good structures underpinning communicable disease surveillance, with well defined surveillance systems, identification of threats and organised institutional networks for the control of infectious disease. Moreover, crisis management arrangements are generally robust. All countries have good, effective and comprehensive vaccination programmes, through well organised immunisation systems. The only clear problem with coverage is among some marginalized groups. Some particular areas demonstrate significant strength, such as food safety. In many countries, the food safety control system is one of the better parts of public health service delivery.

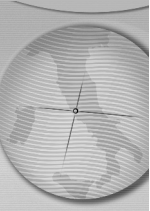
There are some positive developments in health promotion in the region, although this dimension of public health is not well developed. Croatia has adopted the modern concept of health promotion that aims to increase the level of health of the population, and not only prevent diseases. Health promotion is targeted at the entire population and its environment, unlike preventative procedures that are mainly targeted at the highest-risk population groups. Promotion programmes for nutrition, physical activity and tackling obesity in Bulgaria, or the violence and injuries prevention

programme in Macedonia, have also demonstrated success at tackling their respective problems.

Many problems with the delivery of public health services in the region arise from resource constraints, in particular in the area of information technology and information systems. Preventative services are in need of capacity building. There is little development in preventative services in many of the countries; screening programmes in the area of non-communicable disease are not comprehensive and are generally poor. Further strategic development and additional investment is required to achieve efficient and adequate levels of service delivery in the area of non-communicable diseases. Health promotion activities are mostly in their formative stages across the region. In addition, the social determinants of health have been recognised in the region as important in underpinning long term disease prevention, securing adequate health promotion and addressing health inequalities but real services on the ground are yet to be developed that adequately take account of these factors.

All SEE countries are characterised by the quality of their basic public health human resources. There are well educated, highly trained and expert personnel within the health system. Good university structures and institutes of public health underpin the public health system as a whole. There are also good strategies already developed in some countries, specifically Macedonia and Bosnia & Herzegovina (Republika Srpska). However, they are overall more weaknesses than strengths in the area of public health resources in general, and human resources are no exception.

There is in some countries a lack of a planning unit within ministries of health for human resources and a lack of an adequate, regularised planning process. There is a significant difficulty with the distribution of human resources across most of the region and a particular problem with coverage in rural areas. Linked to the lack of planning in some countries, there is little identification of community needs as a basis for defining education and training. Despite the generally positive picture regarding laboratory resources, some countries have a lack of capacity in this area. The provision of laboratory resources is one area where regional collaboration can underpin efficiency and effectiveness. The evaluations suggest that the greatest weakness in the provision of resources for public health is the absence of adequate information technology.



Conclusions and main challenges

While there are many positive developments in public health in the SEE countries, there are wide ranging problems across the region and significant challenges for developing comprehensive, effective and efficient modern public health services. At the core of all the challenges is a lack of updated strategy and strategic planning and the insufficient political focus on public health that underpins this. All other problems are subordinate to this. There is a need to maintain general interest in public health and in the reform of health systems, among governments as well as other stakeholders and the general public, to ensure a strategic, and not haphazard, approach to reform. This includes the approaches taken to structural reforms and to privatisation.

There is also insufficient funding of essential activities and services and the need for the economic case for improved public health to be made. Public health advocacy is weak.

There are also particular problems and challenges in resources and the development of modern services. There are, for example, noticeable gaps in human resources for health in terms of number, distribution, training, and, crucially, for motivation and incentives. Collaboration, cooperation and partnership in public health are still weak. There remains an inadequate focus and provision of services in the areas of disease prevention and health promotion. Public health laboratory services need to be strengthened to enable them to address new public health threats and to maintain safe living and occupational environments (air, water, food, commodities, safety). There is a lack of integrated

information and communication systems, with variations in the quality of data and insufficient indicators for monitoring and evaluation.

Quality assessment of public health services and activities are almost absent. A continuous quality improvement culture is absent in public health as are accreditation processes for public health institutions. Mechanisms for accreditation and for assessment and evaluation are essential to successful reform.

The picture in the SEE countries is by no means bleak, and there is a long heritage of robust public health institutions, professions and activities. But the challenge of transition has not yet been met and there is a great deal that can be achieved both nationally but also through continued regional cooperation in health, where the challenges the region faces do not respect borders.

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