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REPORT

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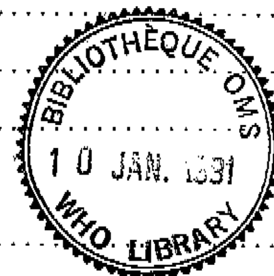

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1. INTRODUCTION

1. This report summarizes the discussions held at the Informal Consultation convened 1-3 August 1990 by Dr Hiroshi Nakajima, Director-General of WHO, concerning the state and the needs of the health sector in central and eastern European countries. Participants in the consultation included several ministers of health, welfare and the environment as well as high level government officials in charge of planning, finance and economics in the health sector of their respective countries. There were six ministerial delegations from Bulgaria, the Czech and Slovak Federal Republic, Hungary, Poland, Romania and Yugoslavia, representatives from a dozen industrialized countries, the United Nations Development Programme (UNDP) and the World Bank, and a group of WHO experts contributing to the discussions. The list of participants is attached as Annex 1.

2. The purpose of the consultation, as outlined by the Director-General, was to demonstrate WHO's global solidarity with the central and eastern European countries undergoing profound societal changes, consider ways and means of intensified cooperation for health development in the face of deteriorating health conditions for specific groups and in certain areas of the countries concerned, and to assist in coordinating additional resources forthcoming from the international community.

3. The meeting evolved as shown in the agenda attached as Annex 2. In his opening address (Annex 3), Dr Nakajima drew attention to the changing social, economic and political environment in central and eastern Europe. Health systems are also part of the broader reforms in those countries. Especially noteworthy is the considerable gap between the social expectations as guaranteed by existing health systems and their objective capabilities. The population in those countries has high hopes for the provision of more adequate amounts of quality care as a result of planned reforms.

3.1 With respect to health sector reform, a number of fundamental questions arise: (1) The responsibility of governments for appropriate health policies including health promotion, disease prevention and environmental health; (2) the appropriate combination of health care services provided by the public and private sectors; (3) the optimum mix of inputs for achieving the health-for-all goal, accompanied by measures and incentives in favour of public health and preventive action; (4) policy options for health care financing, including health insurance schemes, that respect people's aspirations as well as the principles of equal access and the most economical use of resources.

4. Support for the countries of central and eastern Europe will come from many countries across the globe. To assure an appropriate response to the new requirements, WHO is acting as an honest broker, bringing together a number of those most closely involved to discuss how the international community can best respond. However, the Director-General cautioned participants that despite the attention given to the special situation of central and eastern Europe, one should not forget the problems of the developing world. Dr Nakajima insisted that WHO's regular budget resources should thus not be shifted from the developing countries to these European countries. He also recalled the actual and potential contributions of the countries of central and eastern Europe to the developing world, notably in the form of human resources and the furnishing of pharmaceutical products and equipment either directly or through international organizations.

5. An overview of general health conditions in countries of central and eastern Europe within an overall European context was presented by Dr J.E. Asvall, Director of the WHO Regional Office for Europe in Copenhagen. He drew attention to the working papers, background documents and country monographs that had been prepared by the Regional Office for Europe for this consultation (Annex 4) and highlighted current programme activities in each of the countries concerned. The consultation would help to reinforce action aimed at bringing the countries of central and eastern Europe closer to the health standards of the rest of Europe. He outlined an array of immediate and relatively inexpensive measures that governments and health administrations could take so as to increase the credibility and visibility of health care reforms (e.g. treating patients as customers, service quality improvements, health promotion campaigns, pollution abatement interventions, etc.).

6. Following these introductory statements, the heads of delegations of the six countries together with their experts presented their health reform processes and priorities, outlined the most pressing problems, identified areas for international collaboration, and specified their urgent needs (see Annex 5).

7. This provided rich ground for the ensuing exchange of views on a number of common issues and priorities, with focus on (i) health system financing including insurance options, (ii) specific aspects of health care delivery systems and especially human resources, (iii) health promotion and lifestyles, and (iv) environment and health. Both the representatives from other industrialized countries and international agencies and the WHO experts invited to the consultation shared their views and experiences on these issues and offered important suggestions for follow-up.

8. A draft summary report and a set of conclusions, prepared by a small steering group of headquarters and regional office staff, served as an informal base for the benefit of all participants with a view to identifying directions for further action, and these have been integrated into the present report.

II. COUNTRY PRESENTATIONS

9. In each of the countries reporting, major political, economic and social transformations are underway, involving a move towards multiparty systems, from planned to market economies and to increased personal freedom and choice. Reforms are divergent in scope and timing, as indeed are the countries themselves in terms of their cultural traditions, resources and socioeconomic development. These countries share, however, a commitment to a major restructuring of their health systems and are looking to WHO and the international community for support. The dimensions of the problems the countries are facing in the short term are of such magnitude that the measures and resources traditionally utilized are insufficient. At the same time, the collectively agreed policies for health development in Europe, within the framework of the Health-for-All Policy goal, have been reconfirmed.

10. Available indicators covering health status, health habits, health facilities and resources, show that health conditions in central and eastern European countries are unfavourable compared to the rest of Europe and, in many cases, are deteriorating. For instance, from the reports presented it seems that average life expectancy at birth in central and eastern European countries is considerably lower than in the rest of Europe. The situation is similar for life expectancy at age 65. The east-west gap is also widening in the case of mortality rates for circulatory, cerebrovascular and ischaemic heart disease. In the case of cancer, morbidity and mortality rates are among the highest in some of these countries and the rates of increase are the steepest in heavily industrialized regions.

Comparative data on women's health causes concern. For instance, cancer death rates from 1970 to 1985 have continuously declined in women aged 25 to 54 in western Europe; the corresponding rates in eastern Europe remained stationary. Infant mortality rates show a two-fold to three-fold difference between central and eastern European countries and the rest of Europe, with no real signs that the disparity is diminishing. Massive pollution of the environment, unhealthy lifestyles and insufficient resources for developing the infrastructure of health services, manifest themselves in the substandard health status of the people.

11. The potential for improvement is considerable, building in most countries on established health and sanitation facilities and geographical distribution of health personnel, except in a few cases. The challenge of improving the living conditions of people through reforms and economic restructuring is wide-ranging. The transition period in most countries is likely to entail additional social strain - reductions in public expenditure, growing unemployment, shortages and price increases for basic goods, including in the health sector. Effective health protection measures therefore need to be in place and included in the economic adjustment process. Countries are aware of the risks and new inequalities that a restructured health system could create, unless the model is carefully designed to prevent them. A framework of equity and long-term health development must therefore be maintained in the process of institutional and societal transformation. Lasting health improvements are also central to achieving higher productivity and social stability.

1. Common features

12. Each central and eastern European country has a unique and deep-rooted culture. While their differences have to be respected, their reform agenda and specific problems have many strong commonalities that make regional actions a cost effective aspect of a comprehensive strategy.

13. The WHO Health-for-All Policy, based on equity, with its targets, indicators and measurement methodology, was strongly endorsed as the framework within which new health policies and systems should be developed.

14. The countries in transition are committed to increasingly decentralized decision making: multiple and varied sources of health care financing; and the privatization of some elements of the health care. WHO was invited to assist in analyzing the pros and cons of such reforms.

15. Health promotion and disease prevention were regarded as essential building blocks for all new health systems. Environmental degradation in relation to human health and well being has reached crisis proportions that exceed the resources which the countries, WHO and the interested parties present could bring to bear. Meaningful reform will require generating multinational, bilateral, and internal resources applied within a long-term strategy. The recommended medium- and long-term health care and environmental health reforms should be developed while an immediate action strategy is implemented to address the most pressing needs in health and environmental health services.

16. Reform strategies and collaboration from WHO and other agencies need to be protective of those positive aspects of the existing health policies and systems in each of these countries.

2. Specific highlights

17. As can be seen from the chart in Annex 5, there is some degree of variety among countries in terms of specific policy principles and priorities, with respect to concrete proposals for international collaboration, especially support from WHO, and also as regards the identification of immediate needs.

18. In Bulgaria, work on the structure, organization and management of a national health insurance scheme has started. Particular attention is paid to the establishment of an information system as an aid to price-setting and analyzing performance. There is also the intention to reduce unequal access to the health care system among different groups of workers and across the different regions.

18.1 With regard to environmental problems, a five-year plan of action involving the ministries of health and environment has been approved.

18.2 The Bulgarian delegation expressed an urgent need for hard currency support in order to finance pharmaceuticals and medical equipment. It also stressed the need for policy advisory services.

19. Particular policy concern in the Czech and Slovak Federal Republic focuses on the shortage of drugs and qualified health personnel such as nurses, the existence of obsolete medical equipment, and lack of management and motivation among health personnel. There is also the problem of unequal access among the population to health care services, the existence of waiting lists for surgical interventions, and the high abortion rate.

19.1 Major reforms are announced in the area of provision and financing of health care; they include the establishment of health insurance schemes for basic health care, the promotion of private practice and the free choice of physicians. The delegation stressed the need to link short-term reform activities to a long-term strategy in the area of public health promotion.

19.2 The major request is for help to solve both the drug shortage and the shortage of professional nursing staff. In addition there is a basic need for policy advice, for training and promoting research programmes and study groups.

20. Hungary's reform programme emphasizes primary health care and rebuilding a family doctor system. In addition, graduate training should be improved to raise the professional standards of health care managers. Concerning finance issues, it is intended to establish a National Health Fund and apply output financing for hospital services.

20.1 Hungary's list of expected services from international collaboration highlights the need for expertise to build, improve and interconnect the health, medical and environmental information system, to draw up training programmes in various fields, and to obtain advice in organization, management development, and finance.

21. Poland's new health policy consists of (i) diversifying the sources of health financing; (ii) enhancing the efficiency of the system by means of good management and better supplies of drugs and medical equipment; (iii) delivering higher quality care; (iv) improving the access to health care; and (v) introducing health prevention programmes, particularly concerning AIDS.

21.1 Poland expressed a high priority for converting parts of its external debt in ways that could provide fresh resources to the health sector. There is also the demand for new Schools of Public Health, and for health information systems for management. Assistance is needed in the short run for imports of vaccines, drugs and medical equipment. As a temporary device, older-generation equipment is welcome provided maintenance services are available in the country. Investment is also needed for finishing a number of hospitals under construction.

22. In Romania, major problems have resulted from import restrictions, difficulties in vaccine supplies, drug production and distribution. The country drew up an emergency plan with WHO assistance in January this year.

22.1 The delegation gave an overview of current reform efforts, specifically with regard to decentralizing health services, privatization of some health facilities and a new salary system for health care providers. Romania is also studying the financing of health services via a health insurance scheme.

23. The Yugoslavian delegation referred to the relative success of the country's economic reform with respect to price stability, and currency convertibility. However, unemployment had become one of the country's major problems.

23.1 Concerning the health sector, there was a demand for technical expertise for quality assurance, the establishment of norms, standards and safety measures, especially in the environmental field.

24. In conclusion, it should be stressed that the consultation was not designed to discuss detailed problems and requests in a definite way, but rather to highlight areas for follow-up attention within broader action programmes country-by-country, including bilateral arrangements with interested parties present at the consultation.

24.1 A clear desire was expressed for WHO's overall coordinating role with UN and non-UN system organizations, including development agencies.

III. MAJOR ISSUES AND PRIORITIES FOR INTERNATIONAL COLLABORATION

25. The recurrent theme during the exchange of views and experiences in the sessions following the six country presentations was the intimate link of the health and social sectors to the broader political and economic evolution. The forces of pluralism, democracy and market orientation are bound to affect the health care delivery system in various ways. In an attempt to focus the discussions on a number of crucial issues, it was generally agreed to single out for particular attention the following clusters of common concern:

- Health financing, including health insurance, public/private mix in the provision of health services, and institutional reform, particularly decentralization.

- Health care services, with focus on management and administration, quality control, human resources, and required material inputs.

- Health promotion and protection, lifestyle related disease prevention and control, community and citizen engagement and local development strategies (e.g. the Healthy Cities Project).

- Environment and health, particularly current initiatives towards assessment, programming and short-term action planning.

25.1 It should be borne in mind, however, that these categories of concern are to be connected to one another in the process of establishing a new health system.

1. Health financing and insurance

26. The vast economic restructuring process affects the health sector in a number of profound ways. The past system of overcentralized services paid for through central budgets in anonymous ways and without appropriate income and expenditure control mechanisms is being replaced by various formulas specific to each country's broader political and economic framework and aspirations. Government budgets are being restructured and made less inflation-prone. Tax authority is being broadened, yet giving district and local governments a certain degree of autonomy. Drastic cuts in expenditure and reduced foreign exchange allocations have led to critical shortages in the health delivery system and further reduced morale and motivation of health workers, whose level of remuneration is already poor. Rising unemployment levels in the face of a virtually non-existent social protection net as in other industrialized countries constitute an additional burden.

The health sector within a macroeconomic framework

27. The health sector is thus intimately related to the economic and social activities in each country. Investments in the health sector that lead to better health are, in fact, investments in quantity and quality of human capital. In this sense, the health sector contributes to the country's economic growth and social stability, particularly important in the current phase of transition.

28. The health sector is also linked to the macroeconomy for its financing. The government may directly contribute to the health sector via taxation. And in the case of a national health insurance scheme, a fraction of the national outlays for labour will usually be allocated to its financing. But the financing of part of health insurance via employer and employee contributions may increase the cost of labour. One has to see to it that this way of financing does not affect the international competitiveness of a country. The latter is especially needed in view of the macroeconomic adjustment policies in many countries.

29. Other links with the macroeconomy are established via the balance of payments. A basic question is whether sufficient foreign exchange is available or released by the Central Bank for imports of drugs or equipment needed? Furthermore, what part of international loan capital, direct investment, remittances and aid transfers will flow into the health sector?

Health insurance issues

30. Thus, among the new multiple sources of finance that are being tapped and which include in some cases new taxes on tobacco and alcohol, pollution charges and contributions from non-profit organizations, most countries have expressed a strong interest in the concept of health insurance. A number of countries have stressed specific aspects of their health insurance system, such as 'free access' to health services or a mixed system of government insurance of standard care and private insurance of extra care. Also, special national funds for health insurance and welfare are being considered. Furthermore, health insurance has to be seen and dealt with in the broader context of protection schemes in the public and private sectors, i.e. life, accident, old age, unemployment insurance. There are important issues to be investigated relating to economic impact (savings, capital market), financial efficiency, and performance and cost control. A number of questions arise, and some of

these have also been addressed in background document No. 6 (see Annex 4).

31. There is no doubt that health insurance has many benefits: Its major purpose is to spread risk and in general all sectors of the economy (employers-employees-central state) contribute in a visible way to its financing. The wider the insurance net, the more equity and social justice is usually accomplished. Systems extended to all citizens are the most equitable.

32. However, there are a number of warnings: Health insurance requires a considerable administrative set-up with administrators having sufficient actuarial knowledge. One must not forget the permanent necessity of cost-containment. Specific incentives placed on patients (such as deductibles and/or co-payment) and on providers (such as peer review of prescriptions of drugs or tests) may have to be considered. In addition, the government has to study whether it is appropriate to fix or control prices (of drugs for example) and fees (of physicians' consultations for example). The question of financing the health insurance of the unemployed was raised again by the Director-General in his closing remarks (Annex 6). Will the government, say through the Ministry of Labour, pay the unemployed's contributions to health insurance? How will the health insurance contributions be financed? The effects on the economy's demand for labour and via labour costs on international competitiveness are crucial policy issues. Will workers have the capacity to pay the necessary health insurance premiums? In other words, is the level of labour income net of health insurance contributions still judged reasonable by the population? And, finally, will the health insurance cover health promotion activities?

33. Another important potential source of financing, to which the Regional Director for Europe referred in his overview of health conditions, concerns the reallocation of resources that are wastefully engaged and can be channelled to better, more productive and more satisfactory use. Also, as was mentioned in several country reviews, considerable funds from private individual sources have gone into the purchase of health services or preferential treatment all along. Illegal practices and corruption have been the byproduct of malfunctioning bureaucratic systems characterized by rationing products or services, queues, and waiting-lists, and under-the-table additions to artificially low fixed prices and salaries.

34. This leads to the broader discussion of issues related to health sector reform and the public/private combination of services. The WHO Regional Office for Europe has been prominently involved in this process in all of the countries, and, together with headquarter's support, in the case of Poland.

2. Health care services reform

35. The reorganization and improved management of the health care delivery systems includes a wide spectrum of activities and interventions that have been summarized in the comparative presentation of countries' priorities in Annex 5 under the broad terms of system management (including health economics, information systems, facilities management, cost containment, quality assurance/reviews, and research) and of education and training for the above functions.

36. There are both general support and country specific mechanisms brought to bear in the unfolding international collaboration effort. These can be summarized as follows:

37. General support mechanisms

(a) Mobilizing expertise through several expert panels: on health care financing, on organization of health care, and on information/ management systems development. These panels will undertake state of the art reviews and will support country specific initiatives as outlined below.

(b) Improving the information base on European health services and expanding communication networks between countries and WHO, and among countries in order to ensure easy access to the health service information base.

38. Country specific mechanisms

(a) Facilitate policy development by: (i) broadening health system assessment that includes the macroeconomic context, emerging social policies and development strategies; and (ii) supporting a policy development process that includes both a formulation of the strategic intent and mechanisms for change in health services. The policy issues to be addressed are decentralization, appropriate private/public mix, health care financing, manpower development policies and incentive systems, specific policies in pharmaceutical drugs and technologies;

(b) Share concrete country experiences by establishing a health service innovation network that will allow for experimenting innovative approaches and to monitor at the local level the implementation of health policies. For example, the issues to be addressed could be more user friendly health services, resource management and output costing and financing, models of good practice for general practitioners and nursing, health management information systems.

(c) Stimulate the use of appropriate technical tools such as: quality assurance models, health service budgeting systems, smoking cessation packages, teaching/learning modules for health professionals.

(d) Enhance competence building; this includes both short-term initiatives, such as in-service training and fellowships (e.g. improvement of management skills) and institution building (e.g. schools of public health). Health service research is an essential element in supporting competence building.

(e) Deal with acute shortages in emergency situations.

Public-private mix

39. Regarding this issue, it is necessary to make a distinction between the public involvement in health care reform and the public/private mix in the provision of services. Government guidance is necessary in order to guarantee the respect of the principle of equity.

39.1 Regarding the optimum mix between the public and private dimension in the provision of services, several questions are of importance:

(a) who will own health care institutions and what is the payment system?;

(b) who will pay health personnel and how will they be paid?;

(c) how will prices of health services, drugs and equipment be set, and who will establish them?

39.2 Each country has to decide what mix delivers the most cost-effective health services. It is evident that the historical and cultural background of countries matters in this particular choice.

Health system reform plans

40. Regarding the reform, the following questions need to be further addressed:

(a) what do patients want in terms of quantity and quality of health services?;

(b) if, in general, higher productivity is wanted, what are the incentives for providers?;

(c) what drugs does one need?;

(d) what is the state of equipment and infrastructure and the need for rehabilitation? What is the need for new infrastructure?

Important criteria while studying these answers are:

(a) has the need for more and/or new drugs, or the need for more and new equipment been evaluated?; do these new technologies add to quality of care and patient satisfaction?

(b) what is the willingness of the people to pay for improvements in their health care system? For instance, will any recurrent costs (linked to capital investments) be financed domestically?;

c) what is the willingness of the international community to pay?

41. As can be seen from Annex 5, and mentioned previously, the immediate needs formulated during the consultation by the representatives of the six countries fell into this broad area of health services delivery and reform. They concern in particular imports of drugs, vaccines, and medical equipment, and detailed requests for sharing knowledge and experience and conducting state of the art reviews among experts from various countries, together with proposals for joint efforts to foster education, training and curricula development.

3. Health promotion and lifestyles

42. In their presentations the central and eastern European countries placed strong emphasis on the need to develop programmes and infrastructures for health promotion and disease prevention and make it an essential component of health reform. In many of the health reforms presented, action to support lifestyles conducive to health ranked first. The epidemiological situation totally supports this policy choice: life expectancy for males is going down, the life expectancy "gap" between eastern and central Europe and the rest of Europe is on average five to seven years, main causes of early death are cardiovascular diseases, injuries and cancers. These relate on the one hand to bad living and working conditions (housing, double work, hazardous work, environmental pollution) and on the other to high rates of smoking, alcohol, unhealthy nutrition. Of particular concern is the health of women due to high rates of abortion and lack of contraception.

43. All countries indicated their political will to strengthen the capacity for health promotion within their health systems and to substantially increase the resources allocated to health promotion and disease prevention activities. At the same time they indicated the need to be able to influence policies in other sectors in relation to their health consequences. The strong interaction of social, economic and health policies in a period of rapid change was underlined, as was the possible competition for resources between the sectors and the dilemmas that arise for policy makers in periods of scarcity of resources.

44. The importance of strategies that are built on convergence of interest and broad partnerships with and between the public and private sector, non-governmental and non-profit organizations, trade and industry, was underlined. The involvement of the community was regarded as essential.

45. It was noted that countries were not starting from zero, but had infrastructures and experiences in public health which could be redesigned and developed. Particularly in the area of disease prevention (CINDI, INTERHEALTH) existing structures could be strengthened and refocussed to allow for the integration of broader health promotion initiatives. A strong need was felt to increase the knowledge base of health and social professionals in health promotion.

Immediate action priorities

46. A key contribution WHO can make at this stage towards the development of health promotion in central and eastern Europe is competence building for health promotion. Two areas need special urgent attention: (i) skills development and experience exchange, and (ii) information on infrastructure development and models of good practice.

47. A wide range of new skills is necessary to formulate and implement programmes and policies, to negotiate and advocate health actions with other partners, to develop programmes that integrate community action, to devise media campaigns, to research health behaviour and to evaluate programme impact. Rapid access must be ensured to successful models of good practice that have reached significant impact on the health status of populations. A series of immediate impact responses was offered to participants in this area, including a series of workshops, training seminars and information packages.

48. Since there are still political difficulties in many countries to ensure a priority setting for health promotion, supportive actions by WHO that explicitly advocate investment in health promotion were felt to be necessary. They include integrated country visits to assist with policy and planning, to advise on how to integrate a health promotion agenda into overall health development and health reform and how to ensure funding for health promotion activities.

49. The development of an integrated collaborative programme on health promotion was suggested in view of the very similar challenges the countries were facing in health promotion and prevention. It proposes action strategies in six key areas with a particular focus to invest in the health of the young population. This will be further explored with countries as part of the follow-up of the Regional Office for Europe and the assessment missions that are already planned for.

4. Environment and health

50. The representatives of central and eastern European countries placed considerable stress on environmental problems which were of concern to human health and referred to a number of geographical areas where particularly severe conditions have developed, requiring immediate remedial action.

51. There was strong emphasis on the need for an improved environmental health data base. Although considerable environmental monitoring activities were in progress, these were of limited relevance to health concerns and there was a need for a much more systematic approach covering all possible routes of exposure. The help of WHO was requested in this area.

52. Several of the countries referred to health hazards arising from contaminated water, air pollution, the disposal of wastes and inadequate food safety; they requested assistance in their solution by transfer of appropriate technologies, by introduction of training programmes and exchange of experience. Assistance was also requested in relation to hazardous exposures received within the working environment.

53. There was general awareness of new and increased environmental health problems which might well result from the fundamental changes now in progress. Specific help was requested in relation to the economic aspects of environmental health management.

54. WHO initiated a high level Commission on Health and Environment, the results of which are expected to guide the global policy and programme of environmental health.

55. The European Charter on Environment and Health, which was approved by Ministers of Health and of the Environment of 29 countries including those of central and eastern Europe in December 1989, was also mentioned. The consultation was informed of the establishment of a WHO European Centre with units in Italy and the Netherlands, which would have as first priority the development of an improved environmental health data base with a first publication expected in 1992.

56. There was general acceptance of the importance of transfrontier problems and specific reference was made to the Danube and Adriatic.

57. The WHO representatives indicated that planning missions to the central and eastern European countries with a view to developing an eighteen-month immediate action programme would take place within the next three months. This programme would be implemented in close collaboration with other international bodies, forming the basis for longer term activities; it would have as prime objectives the alleviation of particular urgent problems and the establishment of mechanisms to ensure that future socio-economic development would incorporate appropriate safeguards for the protection of human health.

IV. DIRECTIONS FOR FURTHER ACTION

58. The situation in central and eastern Europe has the potential for being a model of close international cooperation, including intergovernmental organizations, particularly the World Bank, UNDP and WHO. The interested parties participating in the informal consultation suggested that external support for health development in countries is more likely to be secured if WHO could assist the countries in:

(a) demonstrating that improvement in health status is a high national priority, in view of its importance for sustaining the process of economic development as well as for the general welfare of the people;

(b) designing health policy whereby actions addressing the immediate needs and long-term strategies are properly integrated;

(c) developing strategies for health promotion, disease prevention and environmental health and incorporating them in a country's overall health policy;

(d) drafting proposals for external support, containing an adequate formulation of goals, programmes and implementation procedures, as well as in-depth economic and financial analysis.

58.1 A clear desire was expressed for WHO's overall coordinating role with UN and non-UN system organizations, including development agencies.

59. In view of the need to place health high on the political agenda, as well as to ensure that health gets high priority on the international assistance programmes, WHO continues to take advocacy action with political leaders in the Member States including central and eastern Europe. Such advocacy action needs to be addressed to all major ministries: labour, transportation, education, housing, energy, trade, etc. Furthermore, it was stressed that finance ministers and the government as a body should give health sufficient status in order to warrant support from such lenders as the World Bank.

60. The representatives of countries of central and eastern Europe identified the financing of health care systems, including the design of health insurance systems, as the most important issue to be tackled within national health systems in the overall national economic reform process. However, it was noted that this process would require firm national political commitment, as well as intensive technical support. It was recommended that WHO should provide the necessary technical advice, and organize priority concerted action with other interested parties, according to the specific priority needs of the countries concerned.

61. It was felt that the management, as well as the quality, of the health care delivery systems in the countries of central and eastern Europe need to improve. Member States should formulate priority national health plans including human resources development. Technical support by WHO was strongly recommended, especially in terms of training.

62. Supplies of essential drugs, vaccines, various material supplies and essential medical equipment are needed and short-term support as an emergency measure should be studied by WHO, other multilateral development agencies, and bilateral agencies.

63. Considerable interest has been expressed in disease prevention and proper lifestyles. Health promotion and prevention will have to become an integral component of all elements of the country health reform plan, not just one well-articulated section.

63.1 Lifestyle-related disease prevention and control activities, and health promotion are in principle low cost investments resulting in high returns. It is recommended that countries of central and eastern Europe should establish their priorities as regards: control of alcohol and tobacco, prevention of cardiovascular diseases by appropriate nutrition; AIDS, and safe motherhood/family planning. It is also recommended that appropriate support from WHO should continue and that the Organization should expand its technical support according to the countries' preferences.

64. The issue of environment and health was discussed as one of the important areas that needed support. The development of national systems, particularly for the monitoring of air and water, should be a short-term activity. In the medium and long term, a plan of action on how to control pollutant emissions should be worked out by the countries, with WHO and other appropriate institutions.

65. It is expected that the countries concerned would determine their priorities for action in restructuring their health care systems over the short, medium and long term as soon as possible. It is understood that the reform, rehabilitation and restructuration effort should be undertaken on a country-by-country basis. In his closing remarks (<u>Annex 6</u>), the Director-General emphasized in particular the importance of short-term policy action.

66. WHO will continue the dialogue with all interested parties with a view to developing a comprehensive action programme for central and eastern Europe health development, based on individual countries' needs and common elements. As part of this process, close coordination between potential donors and the countries concerned will be established or improved, and technical arrangements made, in the form of seminars, conferences, information networks, etc., to ensure that essential expertise can be made available, exchanged and acquired as rapidly as possible. WHO will continue its efforts to raise additional resources for these tasks.

67. The Director-General announced the formation of a special task force involving staff of WHO headquarters and its Regional Office for Europe to make recommendations regarding measures to be taken in favour of countries in central and eastern Europe. He also announced that, in order to assist the process of reform of national health care systems and their financing, he would convene a meeting of advisers drawn from the highest levels of global expertise. Appropriate panels of experts and/or advisory groups for the various priority areas will be established as deemed necessary.

68. In order to reinforce the dialogue, WHO missions, possibly together with staff from other relevant organizations, will be directed at helping countries with priority setting. Missions will be planned to be completed before the end of 1990. One outcome of these missions is to develop with the country its own strategy for coordinating external assistance within the country.

69. Taken together, these directions represent the opportunity to turn the situation in central and eastern Europe into a model with fine global value. So doing would not only be of use in all developed/industrialized countries but would also produce a return-on-investment applicable to the Third World including the least developed countries.

ANNEX 1

WHO INFORMAL CONSULTATION ON CENTRAL AND EASTERN EUROPEAN COUNTRIES
Geneva, 1-3 August 1990

CONSULTATION INFORMELLE DE L'OMS SUR LES PAYS D'EUROPE CENTRALE ET ORIENTALE
Genève, 1er-3 août 1990

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Annex 1

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Annex 1

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Annex 1

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ANNEX 2

WHO Informal Consultation on Central and Eastern European Countries, Geneva, 1-3 August 1990

Agenda

1. Opening of the informal consultation by the Director-General

2. Overview of health conditions in countries of central and eastern Europe by the Regional Director for Europe

3. Specific country situations by heads of delegations

4. Discussions on health development in countries

5. Update on WHO's response

6. Strategies for further action

7. Conclusions and recommendations

8. Closure of the informal consultation by the Director-General

ANNEX 3

Opening address by Dr Hiroshi Nakajima,
Director-General of the World Health Organization
at the
INFORMAL CONSULTATION ON CENTRAL AND EASTERN EUROPEAN COUNTRIES
WHO, Geneva, 1-3 August 1990
Executive Board Room, starting 11h00

Honourable Ministers,
Distinguished Colleagues,
Ladies and Gentlemen,

This meeting comes at a time of unprecedented change. A time when physical and political walls are falling - and a time when societies are visualizing new horizons. It is a time of rebirth both in Europe and elsewhere on this planet - a time of enormous potential but of equally great challenge.

The socio-political revolution is not limited to Europe; changes are taking place in countries throughout the world. While the problems of the countries of central and eastern Europe are certainly serious, we must not forget the plight of the peoples of the developing world, especially those in greatest need. Issues in Europe cannot be examined in isolation - and indeed support for the countries of central and eastern Europe will come from many countries across the globe. We should recognize also the contribution countries of eastern Europe have made to the developing world, especially for human resources development, and in supplying pharmaceuticals and equipment, either directly or through international organizations. In a number of international forums, concern has been expressed by representatives of developing countries that resources previously directed to them might move to the countries of central and eastern Europe. They have been assured, however, that these are two separate issues of different dimensions.

For this reason I decided to hold the consultation in Geneva. It gives us the opportunity to demonstrate the type of international solidarity that WHO is striving to achieve on a global scale. Our WHO Regional Office for Europe in Copenhagen, under Dr Asvall, the Regional Director, is already undertaking reviews of the situation in each country of central and western Europe, with a view to renewed commitment on the part of WHO. From Geneva we are joining forces with the Regional Office in assessing the emerging needs of one country and stand ready to do the same for others. While operational activities will largely be the responsibility of the Regional Office, WHO as a whole is prepared to provide its full intensified technical support.

The countries of central and eastern Europe are undergoing rapid social, political and economic change. In this environment, with the initiation of profound structural adjustment policies, they have turned to WHO for support in seeking new approaches and methods towards assuring the health of their peoples, and in the restructuring of their health systems. What is needed is a dynamic response to the fast changing socio-political situation. WHO is acting as an honest broker in bringing together a number of those most closely involved in this rapidly evolving situation, to discuss how the international community can best respond.

Great potential for social development is offered by possible reductions in spending on defence, following the accelerating process of detente. If only a fraction of the sums previously spent in the arms race could be devoted to financing social development, especially the health systems of countries in need, there will be dramatic improvements in levels of health. Considering the wave of change which is sweeping the world, this is surely not an unrealistic hope.

In inviting representatives of the countries of central and eastern Europe to this consultation, I suggested that each should come prepared to present a picture of the existing situation in regard to the financing of their health system, and to discuss health care reform. Each of these countries has both strengths and weaknesses. Each has its own history of central planning and is responding to the emerging aspirations of its people. Each is seeking its own path to the future. Each can learn from the others. I urge the representatives of these countries who are present here today to use this opportunity to put forward their most pressing needs and priorities. Similarly, I ask the representatives of the other countries and organizations present to be prepared to review the ways in which they can provide the most appropriate support.

First of all, we must rid ourselves of the concept that the health sector is only a consumer. It is in fact, a productive sector - its product being a healthy population, with the energy and will to advance the economy of the country, without which no significant socioeconomic development can take place.

Health issues are intimately interwoven with issues of development and of social equity. The countries of central and eastern Europe, in their move towards more open and democratic forms of government, are increasingly also moving towards a market-type economy. In this there are both challenges and promises. Countries have to decide for themselves on an appropriate balance of social and economic activities to be conducted by the State, and activities for which the private sector, including individual and community entities, will be responsible. To find the appropriate mix and to ensure both equity and efficiency will be far from easy, requiring open and frank discussion and the full involvement of the community.

Turning more specifically to the health sector, each country, through its agenda for reform, is faced with at least five fundamental questions:

— What is the degree of responsibility the state should assume in formulating overall policies for health systems development?

— What should be the optimum share of the private and the public sector in the provision of health care?

— How should public health and the curative medical system be integrated?

— How can the health care system be financed?

— Finally, how can each country maintain its current support to developing countries?

Let me briefly review these questions. First, there is the responsibility of governments to develop appropriate health policies for their societies. Even when countries move towards more market-oriented systems, governments retain a substantial degree of responsibility for public health policies. People still need to be fully informed about health hazards, and the benefits of healthy lifestyles.

Health issues of increasing importance, such as those related to an aging population, need to be addressed by governments. Appropriate measures have to be taken to ensure that the special requirements of this population group are met. Relevant health technologies will have to be utilized, to ensure the effective provision of community based preventive, promotive, and rehabilitative care, which responds to the needs of an aging population, and which includes emotional and spiritual aspects.

Likewise, diseases such as AIDS will have to be given high priority in health policy formulation and strategy development. And the health hazards associated with urbanization and industrialization, and population movement, must be among the urgent concerns of governments. Many of these issues are important components of the WHO strategy for achieving health for all in Europe, and initiatives such as the Healthy Cities Project and the third International Conference on Health Promotion/Supportive Environment for Health, to be held in Sundsvall, Sweden, in June 1991, are illustrations of these efforts.

Secondly, the question of the provision of health care services, through the most appropriate mix of private and public health care services, requires careful study and assessment. Whatever the course of action chosen, the goal of ensuring equity and efficiency remains paramount.

The third question relates to the optimum mix of inputs for achieving the health-for-all goal. We should not forget that, if we want to stress preventive services and public health in general, the appropriate incentives for health care providers should be put in place.

Fourthly, the issue of health care financing is a complex one, in view of the many policy options available. Let me simplify this difficult question by identifying two broad options at different ends of the scale. Should health care be provided through national taxation or through a social security system? Within these two options, a further decision is needed on whether patients should contribute financially, or whether the services will be provided relatively free of charge.

Both of these options have dangers to be avoided. On the one hand, if the financing of the health care system is based on taxation, it is important to ensure that a type of rationing of health care does not evolve. If this happens, communities will develop ways of "jumping the queue", such as offering unofficial "gifts" or fees, and this will subvert the principle of equity.

On the other hand, the danger in using a social security system as the basis is that too many sub-programmes may develop, each with its own budget for specific population groups, such as groups of workers. Once again, this can lead to inequity, and different qualities of service, as it detracts from a true sharing of costs and benefits among the population as a whole.

There is thus no uniform answer to any of the questions above. WHO itself adopts a pluralistic approach in the development of health systems. Nor is there a model that can be followed easily, as the patterns that have evolved slowly, and often painfully, in the countries of Western Europe and elsewhere, are still changing in search of improvement. The answers will have to be given by the people themselves, and will be shaped by their own historical and social backgrounds, and by the environment in which they live.

Whatever option is chosen or answer provided, it is essential that all sectors of the population should have equal access to health care services, and should benefit from them equally. This lies at the heart of strategies to achieve health for all by the year 2000 using the primary health care approach.

An important concern must also be that, throughout the design of appropriate national plans for health care reform, the principle of efficient use of available resources must be adhered to. In other words, the tools and methods of health economics must be used. Techniques such as cost effectiveness and cost-benefit analysis can contribute to the careful selection of appropriate strategies and health technologies. The rational use of drugs,

an integrated approach to maternal and child health, including family planning and nutrition, child survival and development, immunization, the control of diarrhoeal diseases and acute respiratory infections, and psychosocial development, are all examples of areas in which the rationale of health economics can be utilized in increasing the effectiveness of health development activities. Other examples of how the rational and optimum use of available resources can be achieved are: using the school system for health education activities; community orientation for health programmes in urban areas; and the application of modern technology in care of the elderly and control of noncommunicable diseases.

In an increasingly open economic environment, in which health technology is most likely to be transferred among countries, medical technology assessment, which includes epidemiological and economic evaluation, is a valuable instrument in making the most appropriate choice. Other important parameters, such as infrastructure development and the availability of human resources, will also have to be taken into careful consideration when such choices are made. WHO is ready to support decision-makers in undertaking the analysis required to enable them to choose the most appropriate policy option for their country.

Appropriate policies for achieving health-for-all objectives must be chosen according to local - and changing - needs and opportunities, in full consultation with the community to be served, and with its full involvement. We must never forget the central role of people - it is they who create and constitute the wealth of society and formulate its values.

As I stated at the World Health Assembly in May this year, "We are witnessing a resurgence of people's common aspirations and expectations for peace and security, sustainable socioeconomic development and a better quality of life". Good health is an essential component of that better quality of life.

With all this discussion on the financing of health services, let us not forget that health is intimately interwoven with activities in many other sectors, such as education, agriculture and industry. Industry is of great potential benefit for national economy but if we are not vigilant in safeguarding the environment in which we live there will be a heavy price to pay in health. The increasing deterioration of the environment is of concern to everyone, and WHO, as the leading health authority, is playing its role. Its Commission on Health and Environment and the Commission's four panels - on energy, urbanization, food and agriculture, and industry - met for the first time in June. I know this is a problem of serious dimensions in many countries of central and eastern Europe.

WHO is by definition your Organization, but it is now our Organization in terms of solidarity. It stands ready to provide whatever form of support you consider most appropriate and useful - we seek your guidance in this.

Also, even if it is not a main item on today's agenda, we should consider together the continuing role of countries of central and eastern Europe in supporting the developing countries.

While not wishing to pre-judge the outcome of this consultation, I hope that, at the very least, we can gain a clearer picture of the most urgent problems facing our colleagues from central and eastern Europe, and some idea of the manner in which other countries and organizations can best respond to those needs.

Colleagues and friends, the success of this meeting lies in your hands. With full and frank discussion, together we can lay the foundations for a steady and lasting improvement in the health of all the peoples of a uniting Europe.

ANNEX 4

WHO Informal Consultation on Central and Eastern European Countries, Geneva, 1-3 August 1990

List of Papers[1]

Working papers

1.	Scope and Purpose of the Consultation	EURO/ICP/GPD 120.2
	Intensified Cooperation with Countries of central and eastern Europe:	
2.	Health Services	EURO/ICP/GPD 120.6.a
3.	Overall Programme in Environment and Health	EURO/ICP/GPD 120.6.b
4.	Investment in Health WHO Collaborative Programme for Health Promotion 1990-1995	EURO/ICP/GPD 120.6.c

Background documents

5.	Intensified Health Cooperation with central and eastern Europe (Framework for short-term, practical action)	EURO/ICP/GPD 118
6.	Health Insurance and Health for All, by B. Abel-Smith	EURO/ICP/MPN 531

Background material by country

7.	Albania[2]	EURO/ALB/GPD 099
8.	Bulgaria	EURO/BUL/GPD 099
9.	Czech and Slovak Federal Republic	EURO/CZE/GDP 099
10.	German Democratic Republic[2]	EURO/DDR/GDP 099
11.	Hungary	EURO/HUN/GPD 099
12.	Poland	EURO/POL/GPD 099
13.	Romania	EURO/ROM/GPD 099
14.	Union of Soviet Socialist Republics[2]	EURO/SSR/GPD 099
15.	Yugoslavia	EURO/YUG/GPD 099

Notes: [1] Copies of the extensive transparency material displayed during the Consultation are also available.

[2] These documents were not discussed at the meeting.

ANNEX 5

WHO Informal Consultation on Central and Eastern European Countries, Geneva, 1-3 August 1990

Countries' new policy framework, proposals for international collaboration, and immediate needs

1. The chart below summarizes the key issues raised in and following the six presentations of Bulgaria, the Czech and Slovak Federal Republic, Hungary, Poland, Romania and Yugoslavia. It shows (A) Essential features of the emerging health policy and system framework, and (B) Item-by-item requests for WHO collaboration within the three broad subject areas on which the informal consultation focused, i.e. health services, environment and lifestyles, and including specific requests for external support, particularly to meet urgent needs in the delivery of health services.

2. A number of caveats are in order. The fact that a topic was not mentioned does not mean that the country has no position, interest or need. Many topics require more detail for meaningful analysis. For example, the terms "privatization" or "insurance" cover substantially different configurations, not always spelled out in sufficient detail by those in favour of the concepts. Similarly, the objective of "free access" (to what? - to care, free care, with or without limits, etc.) needs to be clarified in the follow-up work. Also, many of the options will depend upon reforms selected at the system level, e.g. "free choice" means one thing in a social welfare system, another in an insurance system. Not surprisingly, there was more precision about diseases because these comments were derived from factual assessments of existing health problems.

Annex 5

	BUL	CZE	HUN	POL	ROM	YUG
A. POLICY FRAMEWORK						
Health-for-all policy	X	X	X	X	X	X
Equity, social justice	X	X	X	X	X	X
Decentralization		X	X	X	X	X
Privatization		X		X	X	
Free choice of provider/service			X		X	
Free access		X	X			
Community/citizen participation		X	X			
B. MAJOR SUBJECT AREAS						
1. HEALTH CARE SERVICES						
Finance						
Decentralization	X	X	X	X	X	X
Insurance	X	X	X	X	X	
Social security/safety net		X	X	X	X	X
Incentives (indiv. & providers')	X	X	X	X		
Tax on tobacco/alcohol		X				
Diagnostic Related Groups		X	X			
Non-profit organizations		X	X			
Physician payment reforms	X	X	X			
Debt conversion				X		
Legislation/policy		X		X		X
System management						
Health economics	X			X		X
Information systems	X	X	X	X	X	X
Facilities management		X	X	X	X	X
Cost management		X	X	X	X	X
Quality assurance/reviews	X	X			X	X
Research		X				X
Education and training						
Public health education		X				
Health finance	X	X	X	X	X	X
Health management	X	X	X	X	X	X
Medical & health professions						
physicians		X	X		X	X
nurses		X	X			
social workers		X	X			
Non-health (lawyers, economists)		X				
Immediate needs						
Drugs, materials & supplies	X	X		X	X	
Technology/equipment	X	X		X	X	X
Facilities (hospitals)				X		
Access to experts[1]	X	X	X	X	X	X

	BUL	CZE	HUN	POL	ROM	YUG
2. HEALTH PROMOTION AND LIFESTYLES						
Primary care		X	X	X	X	
Health promotion/disease prev.		X	X	X	X	
Family planning		X			X	
Maternal & child health		X			X	
Smoking		X		X		
Stress		X	X	X		
Alcohol		X	X			
Drug abuse			X	X		
Occupational health				X	X	
AIDS				X	X	
Cancer		X	X	X	X	
Cardio-vascular diseases		X	X	X	X	
Disability, unemployment		X	X	X	X	
Ageing		X	X	X	X	
Injury prevention		X			X	
3. ENVIRONMENT AND HEALTH						
Overall degradation	X	X	X	X	X	X
Workers health				X	X	
Toxic waste and exposure		X			X	
Data and assessment systems	X	X	X	X	X	X
4. INTERNATIONAL COLLABORATION						
Coordination of external support	X	X	X	X	X	X
Assistance with preparing proposals for external support		X	X		X	

Note: [1] This item can be developed by indicating the specific types of expertise requested on a country-by-country basis.

ANNEX 6

WHO INFORMAL CONSULTATION ON
CENTRAL AND EASTERN EUROPEAN COUNTRIES
Geneva, 1-3 August 1990

CLOSING REMARKS BY DR H. NAKAJIMA
DIRECTOR-GENERAL

Honourable ministers, distinguished colleagues, ladies and gentlemen,

With your permission, before commencing my formal closing remarks, may I add just a few words. I hope you are as satisfied as I am that, in these three working days, we have accomplished a great deal together. Some of you may have been feeling a sense of frustration, but for me this has really been an opportunity to demonstrate global solidarity in looking towards the goal of health for all, and through it world peace, not only by the year 2000 but beyond it, for ever. I have spoken of the 1980s as being a decade of loss; according to the United Nations definition, for example, the number of least developed countries is now more than 40. Inequality and inequity are spreading all over the world, both between countries and within countries. In large segments of the world's population, poverty is increasing.

The situation in eastern Europe and the political and economic reform taking place provide us with fresh opportunities. For WHO it is the opportunity to gain new experience in working together with Member States, for example, in solving problems of financing their health care services. As we have all agreed, no country has been able to achieve an entirely satisfactory health care delivery system. Even if primary health care is perceived to be the best approach, it does not necessarily satisfy all those who are involved. Therefore, there must always be compromise and a prevailing spirit of consensus, both among Members States and in their cooperation with WHO and other international agencies. I have defined the 1990s as the decade not only of "debt", but also of "consensus". Now we must gain new experience for reaching consensus. Several representatives have referred to restructuring - but, first, national mechanisms must be developed to allow for genuine dialogue in order to obtain a consensus for development. This is why the first priority for me is that each country of eastern Europe should endeavour to strengthen its capability for talking frankly with WHO and with other countries. You need to have a better understanding of channels of communication, methods of data collection and other administrative procedures, as well as of the complicated bureaucracies of the United Nations system and members of the donor community, so that your designated representatives can talk with counterparts on a basis of trust and complete comprehension. Without this, without genuine dialogue, equally, counterpart to counterpart, it will not be possible for you to get the support you need. One of the roles of WHO, at regional or at global level, is to work with you in this, so that rapid reactions can be obtained from the donor community.

The WHO Regional Office for Europe is particularly qualified to help you in this dialogue for timely and relevant support, since its programmes of cooperation are mainly intercountry, and some of the ideas you have been expressing lend themselves to support through intercountry programmes rather than through individual country-specific programmes. I am sure the Regional Office is also willing to enter into programmes of cooperation directly with individual countries, and the five other Regional Directors will certainly wish to join the Regional Director for Europe in sharing experience and knowledge of

how to operate within countries. I, too, have nine years of experience in direct cooperation with countries, including countries such as China and Viet Nam and other socialist countries, which a few years ago were faced with situations similar to yours.

I myself am more convinced than ever that the time for action is now. It is time for the world health community to respond in a concerted manner to the challenge facing the countries of eastern and central Europe. I convened this consultation because of the huge challenge they face in adapting their health care systems - a challenge which is shared by other countries throughout the world. WHO is called on to support this important endeavour. In fact, extrabudgetary resources will certainly have to be mobilized, while continuing our programmes of cooperation in developing countries.

Health systems should not be seen in isolation from the economy. As the economy's rules are changing, so are those of health systems. It is evident that, if more productivity and efficiency are expected from a market economy, more efficiency will be required from a modified health system. It should be stressed that, apart from this goal of greater technical efficiency, there is also the more political objective for a health system, of incorporating the notion of social justice and equity. Patients will be able to perceive the benefits of a more decentralized economic system and a reformed health sector, only if it generates better and more equal access to health care services than in the past.

A health care system should not and cannot be changed overnight. It takes careful analysis, weighing of the pros and cons of taking a particular direction and, of course, democratic approval. Thus, there is no necessity to adopt in haste a health systems framework from a western European country. Bear in mind that it often took western European countries several decades to develop and adjust their health systems. It would be unwise and unfeasible to transfer their forms of health system too quickly to countries of eastern and central Europe. Nevertheless, it is extremely important to have the benefit of their experience in various areas, while not echoing mistakes, though unfortunately mistakes are often unavoidable.

But, while taking the time necessary to develop a new system, governments should be constantly alert to emerging problems, and should be prepared to design <u>short-term policy action</u>. Allow me to express four of my concerns for short-term policy.

First, what are the immediate concerns and needs of the people? I understand that, in a number of countries, a greater availability of drugs and medical equipment is among the immediate needs. The world health community is eager to be told of your needs and priorities, with a view to immediate relief operations to stabilize the situation, before engaging in further change or rehabilitation.

Secondly, if drug shortage is that prevalent, should we not start to analyse the structure of domestic industry and its current capacity to produce? In fact, some countries have a capacity to manufacture, and even to export, drugs or equipment. A revival of this manufacturing sector could be supported in order to alleviate the domestic shortage of drugs, or could reduce the needs for precious foreign exchange. While recognizing that there might be some obstacles to be overcome, WHO and UNIDO, with other related agencies such as UNDP, could very quickly help to formulate acceptable project proposals for this kind of activity.

Thirdly, many countries follow a road towards health insurance. National health insurance is indeed very attractive, not least because it respects the criterion of equity. But countries can quickly discover that health insurance entails a number of traps. In particular, how will it be financed? If wages are the main basis of financing, there is the risk that this will lead to an escalation in the cost of labour. An increasing cost of labour may provoke a reduced demand for labour or, put another way, a rise in unemployment. And this is clearly not what countries want. So, the basis of financing must be carefully studied. This is just an example.

While I am referring to unemployment, there is the question of financing the health care services of the unemployed. Will the state or local commune take care of them? Or will extra charges have to be financed by the active population?

These questions merely illustrate the important economic effects the establishment of a health insurance scheme may have, and that countries should be aware of them.

Fourthly, privatization as such will not produce miracles. Again, it needs to be carefully prepared. It is of overriding importance that the role of the private sector in the reformed health care system is confirmed by legislation.

One can also link the issue of privatization with establishing the necessary incentives for health care providers and health care institutions. For instance, hospitals need to be made accountable. In other words, appropriate rules are required for the payment or reimbursement of services that enhance both the efficiency and the quality of services. Physicians also need to be assured of such a payment system, which will lead them to provide good quality care to their patients.

I am convinced that such elements of short-term policy action could be considered favourably by citizens, patients and providers alike. Gradual work towards a more established system will then be more readily accepted by the community. Let me stress again the need for continuous health service research, which implies financial and technological analysis. At the same time, the design of cost-effective policy packages to enhance environmental health and healthy lifestyles, should be included in applied research activities.

There is no doubt that the international community will be ready to support the efforts of all the countries of central and eastern Europe. The speed with which this support is forthcoming depends on the information given by countries on their priorities and on their needs for international aid and loan financing. Of course, this international effort should not be merely a substitute for domestic effort. It is a complement to what people in countries can pay domestically for improvements in their own health systems.

In regard to resource mobilization, particularly financial resource mobilization, it might be useful for you to know how WHO functions, in order to avoid any misunderstandings and confusion. WHO's efforts to mobilize so-called extrabudgetary resources - that is resources in addition to WHO's regular budget resources - are handled by the office here in Geneva. Coordination of support to activities at all levels - global, interregional, intercountry and country - is not only Headquarters' traditional role, it was also discussed and

reaffirmed recently with all the regional directors. You will understand that this is necessary in order to avoid misuse of technical resources. While responsibility for donor coordination and for extrabudgetary resources mobilization is carried by WHO in Geneva, the operational aspects of programmes of cooperation with countries are primarily the responsibility of the regional office.

I intend to establish a task force consisting of the staff of both the Regional Office for Europe and Headquarters, which will be responsible for recommending to me the WHO action necessary to meet the priority needs of countries of central and eastern Europe. In the same way as for other countries, I am asking you what are the priority needs of your country. Let me recall the words of the Honourable Minister of Health and Welfare of Japan on the "feasibility" of health care. Taking into consideration political feasibility, what kind of priority cooperation can other countries provide? WHO can act as a clearing house in matching to the priority needs of recipient countries the perceived priorities for their cooperation of donor countries, taking into account issues of both donor and recipient political and financial feasibility. In this way, a very comprehensive programme of cooperation can rapidly be developed to meet the needs of your countries and their people.

In order to assist effectively in the process of reform for national health care financing and the adaptation of health care systems, I propose to convene a meeting of advisers drawn from the highest levels of expertise throughout the world. These of course are global issues not confined to the countries of central and eastern Europe. In countries of Latin America, for example, reform must accompany necessary economic adjustment.

Colleagues, ladies and gentlemen,

The health care reforms you are undertaking demand an adjustment of the skills and thinking of the population and also its involvement to a much greater extent. We must "think globally, act locally" always involving the people, which is the spirit of health-for-all endeavours. I am sure that, with patience, and with the necessary political commitment and strategic leadership, short-term constraints can be overcome. WHO is there to support you for concrete action, country by country.

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