EUROPE

Regional Committee for Europe
Fifty-second session

Copenhagen, 16–19 September 2002

Provisional agenda item 5(c)

EUR/RC52/BD/2
7 August 2002
23261
ENGLISH ONLY
UNEDITED

FULL REPORT ON THE EXTERNAL EVALUATION OF THE WHO REGIONAL OFFICE'S HEALTH CARE REFORM PROGRAMMES

The attached document contains the full report by the external evaluators on their evaluation of the Regional Office's health care reform programme. It also contains the Regional Director's comments on the report.

It should be read in conjunction with the summary report by the external evaluators contained in document EUR/RC52/Inf.Doc./1.

Comments of the Regional Director on the summary report and recommendations and on the full report (EUR/RC52/Inf.Doc./1 and EUR/RC52/BD/2)

First of all, I should like to thank the team of external evaluators for the work carried out.

The terms of reference and the methodology of this evaluation were thoroughly prepared and discussed by the Standing Committee of the Regional Committee (SCRC) at several of its sessions. The terms of reference decided upon were "to assess the extent to which the WHO Regional Office has influenced governments to incorporate in their health care reform programmes the principles enshrined in the Ljubljana Charter".

I am satisfied to read in the evaluation report that the principles of the Ljubljana Charter are "widely accepted and form the basis for most reform programmes". I agree with the recommendation that these principles should be strongly emphasized in our advice to Member States. This will be reinforced in the next phase of the Health for All policy framework, which will include the translation of principles and values into concrete public health choices and actions.

However, a significant part of the report is outside the terms of reference agreed upon by the SCRC and deals with many different subjects, from the ongoing general management of the Regional Office to detailed line management issues. The fact that the terms of reference and methodology of this additional part of the report were not prepared in collaboration with the SCRC and Executive Management raises for me a number of methodological and ethical issues. In my opinion, it is questionable whether full use has been made of previous work done by the SCRC and Executive Management; of the numerous internal and external audits already carried out during the last biennium; and of policies, guidelines and regulations from WHO headquarters.

Many of the issues mentioned in the evaluation report are included in my presentation to the Regional Committee, and I will, of course, be happy to answer any questions.

In conclusion, I strongly believe that evaluation is an essential part of public health and of the management of public services. We have always welcomed the many audits and evaluations that have taken place at the Regional Office. We have made good use of their recommendations; one example of this is the recent evaluation of the EUROHEALTH programme. But evaluation has to be based on clear principles and on agreed methodology. I hope that the new global framework for evaluations in WHO, recently presented to the Executive Board, will make a breakthrough in this complex and sensitive area.

Marc Danzon, M.D.
Regional Director

7 August 2002

WORLD HEALTH ORGANIZATION
EUROPEAN REGION

REPORT OF AN INDEPENDENT EXTERNAL EVALUATION OF HEALTH CARE REFORM PROGRAMMES

EVALUATORS:

Dr. Ozen Asut
Dr. June Crown
Dr. Dana Farcasanu
Dr. Jose-Manuel Freire

Professional Assistants:
Ms. Angela Bartley
Dr. Somen Banerjee

July 2002

Contents

Page

Foreword ... 3

1. Introduction, Background and Context ... 4

2. Methods and Working Arrangements ... 6
   - 2.1 Team Meetings ... 6
   - 2.2 Information Gathering ... 7

3. Findings ... 8
   - 3.1 Documents ... 8
   - 3.2 Questionnaires ... 12
   - 3.3 Country visits ... 16

4. Issues Related to Health Care Reforms ... 19

5. Observations, Conclusions and Recommendations ... 23
   - 5.1 General Comment ... 23
   - 5.2 The WHO and the Position of the European Region ... 23
   - 5.3 The WHO Regional Office in Europe ... 23
   - 5.4 WHO Country Presence ... 28

Postscript ... 32

Appendix 1 Acknowledgements ... 33
- WHO Regional Office for Europe ... 33
- Albania ... 33
- Bulgaria ... 34
- Estonia ... 34
- Kazakhstan ... 34
- Kyrgyz Republic ... 34
- Poland ... 35
- Russian Federation ... 35
- Ukraine ... 35

Appendix 2 Questionnaire ... 37

Appendix 3 Reports to the Standing Committee of the Regional Committee ... 41

Foreword

The citizens of Europe have experienced massive changes since 1989 which have brought us welcome opportunities for communication and collaboration across the continent that were not easily available previously. Although almost all countries in Europe have been reforming their health services during this period, the changes have been most profound and most challenging in those countries that were experiencing extensive political and economic change at the same time. The World Health Organization in the European Region has responded to this situation by providing support to those countries that have been initiating radical health care reforms.

The Regional Committee asked for an external evaluation of the WHO health care reform programmes and we were honoured to be invited to undertake this task. It has been a privilege and a pleasure to meet many decision makers and professional colleagues who have given generously of their time and have shared their experiences and opinions so openly. We are very grateful to them all.

We wish to thank the Chairman of the Standing Committee of the Regional Committee, Dr. J. Kiely and the Regional Director, Dr. Marc Danzon, for their consistent support for our work. Mrs. Ainna Fawcett Henesey has given invaluable assistance in the organization of our project and in providing detailed information for our analyses. Ms. Dora Abplanalp has been unfailingly helpful and patient in responding to our practical problems and we are most grateful to her.

Our two professional assistants, Dr. Somen Banerjee and Miss Angela Bartley, have worked extremely hard in their own time to support the country visits and undertake much of the data analysis. We are indebted to them for their contributions to this evaluation and for the enthusiasm they have always displayed.

We are pleased to submit a unanimous report to the Regional Committee, for which we accept total responsibility. We offer this report as a positive and constructive contribution to the work of WHO European Region. We hope that it will help the Regional Director and his colleagues to extend still further their valuable work and that it will make a small contribution to the ultimate goal that we all share, of improving the health and health care of all European citizens.

Dr. Ozen Asut (Turkey)
Dr. June Crown (United Kingdom)
Dr. Dana Farcasanu (Romania)
Dr. Jose-Manuel Freire (Spain)

1. Introduction, Background and Context

The Regional Committee of the World Health Organization, European Region (WHO Euro) at its meeting in September 2001 agreed to commission an independent external evaluation of the Region's health care reform programmes and appointed four evaluators:

Dr. Ozen Asut (Turkey)
Dr. June Crown (United Kingdom)
Dr. Dana Farcasanu (Romania)
Dr. Jose-Manuel Freire (Spain)

At its first meeting, the Evaluation Team proposed the following terms of reference:

"the main purpose of the evaluation will be to assess the extent to which WHO Office has influenced governments to incorporate in their health care reform programmes the principles enshrined in the Ljubljana Charter.

To achieve this evaluation objective it will be necessary:

- *to devise a system for the selection of the most relevant programmes, activities and countries for detailed study*
- *to agree on a methodology*
- *to have the support required by the Regional Office*
- *to have clear guidance from the Standing Committee of the Regional Committee about the time period of work to be included in the evaluation"*

The Standing Committee of the Regional Committee approved this proposal and the suggested outline methodology at its meeting in December 2001.

It became clear after the initial country visits that there are matters that affect WHO's ability to influence that do not fall within a narrow interpretation of the terms of reference. The Chairman of the Standing Committee agreed that we should include these matters in this report.

It is important to note that the purpose of the external evaluation is to assess the impact and influence of WHO on reform programmes. It is not intended to be an evaluation of the health care reforms in individual Member States.

The evaluation was commissioned at a time of considerable change.

Within central and Eastern Europe, the health impact of major political and economic changes following the break up of the Soviet Union is still being felt. In some countries life expectancy has declined and birth rates have fallen well below replacement levels. Communicable diseases such as tuberculosis and HIV/AIDS have become matters of major concern, while the main non-communicable diseases such as coronary heart disease and cancers continue to take their toll across the whole continent. Tobacco related health problems create a present and future threat to most countries of central and Eastern Europe where smoking rates are still high, and there is worryingly high mortality among younger man in some countries, much of which is related to excess alcohol consumption.

At the same time, many countries across Europe are contemplating or have embarked on health care reforms that involve changes in patterns of delivery of care and also, in many cases, changes in the funding of health services.

Changes in the European Union are also important, as accession countries work hard to achieve the economic and social standards required for entry to the Union.

Sadly, Europe continues to experience armed conflict in several areas. This has resulted in the urgent need for humanitarian aid and support for relief and reconstruction. WHO in common with other UN agencies, donor organizations and voluntary bodies has responded and given priority to these demands.

In WHO Euro itself changes to the organizational structure have been implemented following the appointment of the Regional Director, Dr. Marc Danzon. Programmes and priorities have been amended to ensure that WHO Euro can make a full and effective contribution to the achievement of the global targets set by the WHO Director, Dr. Gro Harlem Brundtland.

It might therefore be argued that it is not appropriate to undertake an evaluation of health care reform programmes at a time of such turbulence.

The evaluators take the view that in a complex area such as health care across Europe, change is continuous. There will never be a period of stability when systems could be assessed in a static state. Moreover, important lessons may be learned during a period of change when countries are at different stages in the process.

It is, however, important to set a realistic timescale to our investigation. We decided, with the agreement of the Standing Committee, to use as a starting point the publication in 1996 of the *Ljubljana Charter on Reforming Health Care in Europe*[1]. This document was endorsed by all the Member States and sets out six fundamental principles.

It states that health care systems need to be:

1. Driven by values
Health care reforms must be governed by principles of human dignity, equity, solidarity and professional ethics.

2. Targeted on health
Any major health care reform should relate to clear targets for health gain. The protection and promotion of health must be a prime concern of all society.

3. Centred on people
Health care reforms must address citizens' needs taking into account, through the democratic process, their expectations about health and health care. They should ensure that the citizen's voice and choice decisively influence the way in which health services are designed and operate. Citizens must also share responsibility for their own health.

4. Focused on quality
Any health care reform must have as its aim – and include a clear strategy for – continuous improvement in the quality of the health care delivered, including its cost effectiveness.

5. Based on sound financing
The financing of health care systems should enable such care to be delivered to all citizens in a sustainable way. This entails universal coverage and equitable access by all people to the necessary care. That, in turn, requires the efficient use of health resources. To guarantee solidarity, governments must play a crucial role in regulating the financing of health care systems.

6. Orientated towards primary health care
Reforms, with primary health care as a philosophy, should ensure that health services at all levels protect and promote health, improve the quality of life, prevent and treat diseases, rehabilitate patients and care for the suffering and terminally ill. They should reinforce joint decision-making by the patient and care provider and promote the comprehensiveness and continuity of care within their specified cultural environments.

These principles provide the basis for our assessment of the contribution of WHO to health care reforms across Europe.

At the outset, the evaluation team experienced problems because the Regional Office has not had clearly designated healthcare reform programmes throughout this period. Parts of programmes have been defined, often retrospectively, as contributions to 'health care reforms'. We have therefore taken a broad view and included in our assessments a variety of the WHO European Region's activities such as the Observatory, educational and training programmes and many of the country support activities.

The evaluators' aim is to make a constructive contribution to the assessment of the WHO European Region's work in the field of health care reforms that will help in refining priorities and refocusing systems. We hope to help WHO to become even more effective and responsive in its work with Member States and in improving the health of all European citizens.

Definitions

At an early stage of our work, we recognised that the terminology in this field is unclear. The same words mean different things to different people. In order to clarify our report and to reduce misunderstanding we set out below the definitions we have adopted.

Health care reform:

> the process that involves sustained and profound institutional and structural change led by government and seeking to attain a series of explicit policies. It should be a political top-down process led by national, regional and local governments[7].

Health system:

> all the activities whose primary purpose is to promote, restore and maintain health[5].

Health care system:

> the structural and functional bases on which the health services and all health care activities are managed and provided

Primary health care:

> direct access first contact health care based on a system of general practice or family medicine.

Health care policy:

> policy related to health care services, incorporating the principles, legislation, rules and regulations that determine the nature of health services and the way in which they are managed and operated at national, regional and local levels.

Health services:

> any service which can contribute to improved health or the diagnosis, treatment and rehabilitation of sick people and not necessarily limited to medical or health-care services[6].

2. Methods and Working Arrangements

2.1 Team Meetings

The team met on 4 occasions, twice in Copenhagen at the beginning of the project, once in Dublin and once in Copenhagen at the end of the project. During the first two meetings, terms of reference were prepared which were subsequently approved by the Standing Committee of the Regional Committee. The team also had the opportunity to meet key WHO Euro staff involved with healthcare reform programmes (see Appendix 1). The team met Dr. J. Kiely, Chairman of the Standing Committee and Dr. M. Danzon, Regional Director, during their meeting in Dublin. This provided a valuable opportunity to clarify the work of the team and to agree on the organization and timetable for the work. We had a final meeting in

Copenhagen to finalise the report. We again met Dr. Danzon and other senior officers who provided up to date information about the organization and activities of the Regional Office.

2.2 Information Gathering

2.2.1 Documents

a. WHO Euro provided useful background information about healthcare reform programmes and previous evaluations. The Euro Health evaluation report was especially helpful as a background source for this evaluation.

   We were also given detailed information about budgets, Biennial Collaborative Agreements (BCAs) and human resources.

b. The team was provided with background material for each of the country visits. This varied from country to country, but each one included:

   - Brief curriculum vitae of the Minister of Health
   - Biennial Collaborative Agreement between the Ministry of Health and WHO Regional Office, 2002-2003
   - Medium Term Programme of collaboration between the Ministry of Health and WHO Regional Office, 2000-2001
   - European Observatory on Health Care Systems Reports Health Care Systems in Transition' (HiT's)
   - Short Country Profile
   - Overview of WHO/EURO Technical Unit work
   - European Union report on progress towards accession (where applicable)

During each country visit, we were provided with additional supporting material and up-to-date reports.

2.2.2 Country Visits

The team wanted to examine in depth the WHO impact on healthcare reforms in a sample of Member States. We agreed the following criteria for the selection of countries for visits:

- Level of organizational change, as identified in Eurohealth programme
- Extent of WHO involvement and resource allocation the country (assessed by level of Biennial Collaborative Agreement and funded posts)
- Geographic spread
- Country size

On this basis, the following countries were selected for visits:

Albania
Bulgaria
Estonia
Kazakhstan
Kyrgyzstan
Poland
Russian Federation
Ukraine

WHO Regional Office asked Ministers of Health in these countries to agree to the visits and we are grateful that all accepted. The detailed arrangements for the visits were made by the country Liaison Officers. Each was asked to arrange meetings with:

- The Minister of Health
- Senior Officials in the Ministry of Health

- Senior Public Health professional(s)
- A representative of the health insurance or equivalent organization
- A representative of a major donor agency, non-governmental organization (NGO) or other long term international experts in the country.

Two members of the evaluation team undertook each visit and they were accompanied by one of the professional assistants.

2.2.3 Questionnaires

The external evaluation team wished to obtain views from all Member States about WHO's role in their healthcare reform programmes. As it was only possible to visit eight countries, we decided to complement the visits with a questionnaire which was sent to the Minister of Health in each country, with a covering letter from Dr. Kiely, asking for the Minister's co-operation and assistance in arranging completion. The questionnaire was translated into all four WHO languages. A copy of the questionnaire is attached in Appendix 2.

Respondents were invited to outline the most important health care reforms in their country since 1990 and to identify the specific help, support and resources they had received from WHO. They were asked to assess the influence of the Ljubljana Charter on the development of national strategies for health care reform. Respondents were also invited to suggest possible future WHO roles and activities that would help them in their continuing reform programmes.

2.2.4 Information from Experts

A group of people known to have special interest and expertise in health care reforms in Europe were asked to comment on WHO's role and effectiveness. Our discussions enabled us to test our views and observations. We are grateful for the contributions submitted by those people.

3. Findings

3.1 Documents

We perused a large number of documents and reports, which were of great assistance in our work. It would not be appropriate to record all the information in detail here.

3.1.1 Resource allocation between WHO Regions

We were interested in the allocation of resources by WHO to the European Region and by the Region to member states. We were informed that these allocations are determined by United Nations formulae. The World Health Organization consists of six Regions. Table I shows the number of countries in each Region and the budget allocated in 2000-2001 and 2002-2003.

TABLE 1: WHO ALLOCATIONS TO REGIONS

Region	Number of member states	Regular Budget ($ million) (2000-2001)	Regular budget ($ million) (2002-2003)
Africa	46	177	186
Americas (PAHO)	35	78	75
Eastern Mediterranean	22	86	83
Europe	51	51	53
South East Asia	10	95	93
Western Pacific	27	76	73

This allocation is determined by WHO Headquarters according to UN formulae and reflects the health needs in each Region. It is not directly related to the number of countries.

3.1.2 Resource allocation to countries within WHO European Region

a. Financial resources : Biennial Collaborative Agreements

The WHO European Region responded to the major pressures on health services across Eastern Europe in the early 1990s by providing direct support to the affected countries in a variety of ways, including the Biennial Collaborative Agreements (BCAs) and staff placements in countries in liaison offices and targeted programmes. Table 2 provides information about the WHO country budget allocated to the BCAs for 2002-2003. In some instances this is supplemented by funds from other sources to support BCA projects.

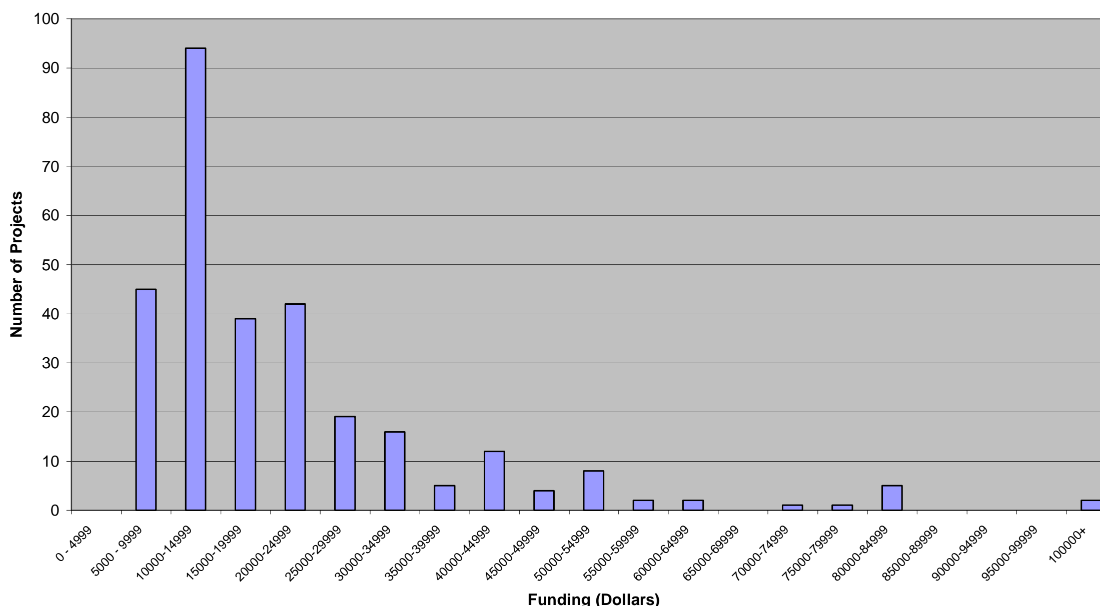
TABLE 2: 2002-2003 BIENNIAL COLLABORATIVE AGREEMENTS
IN WHO EUROPEAN REGION

COUNTRY	POPULATION (millions) Source European HFA 2001	BCA 2002-3 ($ '000s)	$/1,000pop.	No. PROJECTS in BCA
Albania	3.2	164	52.1	11
Armenia	3.8	463	122.3	18
Azerbaijan	8.1	463	57.2	15
Belarus	10.1	168	16.6	12
Bosnia and Herzegovina	4.1	463	113.8	16
Bulgaria	7.9	86	10.9	10
Croatia	4.7	156	33.5	6
Czech Republic	10.3	77	7.5	4
Estonia	1.4	68	49.4	7
Georgia	5.2	163	31.0	12
Hungary	9.9	81	8.2	9
Kazakhstan	16.1	184	12.4	13
Kyrgyzstan	5.0	463	96.5	19
Latvia	2.4	74	30.8	7
Lithuania	3.7	75	20.3	8
Poland	38.7	116	3.0	10
Moldova	4.3	463	108.1	7
Romania	22.3	108	4.8	10
Russian Federation	145.3	447	3.1	23
Slovakia	5.4	74	13.7	6
Slovenia	2.0	25	12.6	3
Tajikistan	6.1	463	75.5	12
Former Yugoslav Republic of Macedonia	2.0	154	75.5	13
Turkey	67.6	339	5.0	7
Turkmenistan	4.8	168	34.7	10
Ukraine	49.1	240	4.9	10
Uzbekistan	25.3	214	8.5	8
Yugoslavia	10.5	92	8.7	11

We were informed that these allocations are also determined according to a UN formula. Analysis of the BCA allocations and indicators such as life expectancy, disability-free life expectancy and infant mortality did not reveal any direct relationships.

There is considerable variation in the number and size of projects funded in each BCA.
Figure 1 shows the distribution of the BCA financial allocation between projects in each country. 137 of the 297 projects (46%) have allocations of less than $15,000.

Figure 1 Size of allocation to individual projects (BCAs 2002-3)



b. Human resources

The WHO European Region has established Liaison Offices in 27 countries. In the Russian Federation there is an office that is led by the representative of the Director General of WHO. Several countries also have separate offices for specific projects such as humanitarian aid or tuberculosis control. Table 3 shows the WHO funded staff based in countries.

TABLE 3. WHO FUNDED STAFF IN COUNTRIES WITH LIAISON OFFICES

COUNTRY		LIAISON OFFICE			OTHER OFFICES	
	Professional staff	Support/admin. staff	Driver	Professional staff	Support/admin. Staff	Driver
Albania L.O. Humanitarian Office	1	1	1	 5	 6	 4
Armenia	1	0	1			
Azerbaijan	1	2	1			
Belarus	1	1	1			
Bosnia and Herzegovina	1	3	0			
Bulgaria	1	1	0			
Croatia	1	1	0			
Czech Republic	0	1	0			
Estonia	1	1	0			
Georgia	1	1	1			
Hungary	1	1	0			
Kazakhstan LO Commun. Dis.	2	1	1	 1 1 1	 1 1 1	 0 0 0

TB Control Child health						
Kyrgyzstan LO Inform Centre Advisor	2	2	1	3 1	1	0
Latvia	1	1	0			
Lithuania	1	1	0			
Poland	1	1	0			
Moldova	1	2	1			
Romania	1	2	0			
Slovakia	1	1	0			
Slovenia	?	?	?			
Former Yugoslav LO Republic of Macedonia Human ass.	1	1	0	8	2	2
Tajikistan LO Human. Ass. Reprod. Health Malaria	1	2	1	0 0 1	1 2 1	1 1 0
Turkey	1	1	1			
Turkmenistan LO Human.Ass.	1	1	1	2	1	1
Ukraine LO TB	1	1	0	1	4	1
Uzbekistan LO Human.Ass	0	1	1	2 2	0 1	1 1
Yugoslavia LO Human Ass.	0	0	0	5 2 14	3 0 25	2 0 4
Russia LO Human. Ass. TB	2	3	1	3 3 6	1 2 13	0 4 0

Some of the activities of the WHO European Office are outposted from the Copenhagen office to other centres. Table 4 shows the staffing of these centres. It includes the Copenhagen based staff of the Observatory who are about to move to Brussels.

TABLE 4. WHO STAFF IN OUTPOSTED CENTRES

CENTRE	PROFESSIONAL STAFF	SUPPORT STAFF
Health Impact of Environmental and Development Policies(Rome)	2	10

Food Safety (Rome)	1	1
Water and Sanitation (Rome)	2	0
Children's Health and Environment (Rome)	2	0
Health Impact Assessment Methods and Strategies (Rome)	2	2
Global Change and Health (Rome)	3	0
Transport and Health (Rome)	1	0
Waste Management (Rome)	0	1
Mediterranean Action Plan (Athens)	2	0
Health and Urban Environment Quality (Bonn)	1	1
Air Quality (Bonn)	4	1
Noise and Housing (Bonn)	3	1
Nuclear Emergency Response and Public Health (Bonn)	1	1
Investment for Health and Development (Venice)	1	0
Socioeconomic Determinants of Health (Venice)	1	0
Integrated Health Care Services (Barcelona)	2	7
Observatory(ex-Copenhagen) United Kingdom Spain	4 9 (4 are 50% WHO funded) 2	5 1 1

3.2 Questionnaires

3.2.1 Response

25 of the 51 Member States responded to the questionnaire. They are shown in bold in the list below.

Albania *
Andorra
Armenia*
Austria
Azerbaijan*
Belarus*
Belgium
Bosnia
Herzegovina*
Bulgaria*
Croatia*
Czech Republic*
Denmark
Estonia*

Iceland
Italy
Ireland
Israel
Kazakhstan*
Kyrgyzstan*
Latvia*
Lithuania*
Luxembourg
Malta (*)
Monaco
Norway
Netherlands

Slovakia*
Slovenia(*)
Spain
Sweden
Switzerland
The Former Yugoslav
Re. Of Macedonia*
Tajikistan*
Turkey*
Turkmenistan*
United Kingdom
Ukraine*

Finland	Poland*	Uzbekistan*
France	Portugal	Yugoslavia*
	Rep. Moldova*	
Georgia*	**Romania**	
Germany	Russian Federation*	
Greece	San Marino	
Hungary*		

* Denotes that country has a Biennial Collaborative Agreement (BCA)
(*) Denotes BCA is discontinued

3.2.2 Support from WHO

In this section of the report we have made a distinction between countries with a BCA and those without. Table 5 outlines the main areas of support identified by countries with and without BCAs.

TABLE 5. SUPPORT TO COUNTRIES, 1999-2001

Countries with BCAs	Countries without BCAs
• In country workshops on pharmaceutical policy, health information • In country and international conferences • Fellowships • Network participation (e.g. CARNET, CINDI, Healthy Cities, Healthy Schools) • Training and curriculum development for family doctors and practice nurse training and development • Technical support – WHO experts including, support with clinical guidelines, national strategy documents & information systems • WHO information – publications: e.g. Health Care Systems in Transition • Health For All (HFA) • Euphin Database	• In country workshops on pharmaceutical policy, effective health promotion structures, Futures Forum • Network participation, Healthy Cities, HP Schools, HP Hospitals, Tobacco Control, European Health Communication Network • Technical support – WHO Information: HiTs, European Health Care Reform, WHO standards, Health for All, WHO web pages

Countries with BCAs have received more expert advice, in-country workshops, conferences and fellowships. Those without BCAs report more support in areas such as health promotion, with little mention of WHO involvement in health care reforms.

Most countries acknowledge support from networks and in pharmaceutical policy development.

3.2.3 Influence of WHO in the development of Health Care Policy and Reforms and the influence of the Ljubljana Charter

Two broad areas were identified:

a. *WHO influence on principles and values*

All respondents reported that the principles of the Ljubljana Charter are reflected in or critically inform their health care reforms. The Alma-Ata declaration, Health 21[4], Health for All[3] and Heidelberg guidelines were also mentioned.

b. *WHO influence on implementation*

Countries with BCAs

Table 6 shows some examples from countries with BCAs of areas of reform that are intended to contribute to the achievement of the Ljubljana principles and where WHO has contributed to implementation.

TABLE 6: WHO INFLUENCE ON IMPLEMENTATION OF HEALTH CARE REFORMS IN COUNTRIES WITH BCAs

Principles of Ljubljana Charter	WHO Input to Implementation
• Driven by Values	• Provision of frameworks to develop national health plans and policies
• Targeted on health	• Assessment of health care needs, including mental health, as basis for reforms
• Centred on people	• The inclusion of public involvement, equity and patient choice within the reform programmes
• Focused on quality	• Support for continuous professional education and development for health professionals. • Support for the development of professional bodies and professional organizations. • Development of pharmaceutical policy including essential drug lists.
• Based on sound financing	• Not a major item, although two countries noted WHO support in reorganising health care financing
• Orientated towards primary health care	• Collaboration in development of integrated primary health care.

Countries without BCAs

Countries that have not received direct financial support from WHO through BCAs also reported that the principles are a strong influence on health policy and that technical support through publications has assisted with implementation of reforms.

Observatory reports are valued as a source of comparative information across all countries.

No examples of programmes aimed specifically at achieving equity of access or patients’ rights were reported.

3.2.4 The use of materials produced by the WHO

The responses to this question from BCA and non-BCA countries were similar.

Table 7 lists the publications mentioned in responses.

TABLE 7. WHO PUBLICATIONS MENTIONED BY COUNTRIES

WHO Publications	Number of countries
Health Care Systems in Transition (HiTs)	19
European Health Care Reform	12
Health for All	11
Newsletter of ECOHCS	3
Critical Challenges for Health Care Reform in Europe	3
Health and Environment	3
Health 21	2
Funding for Health Care: Options for Europe	1
Regulating Entrepreneurial Behaviours in European Health Care Systems	1
World Health Report 2000	1
World Health Report 2001	1

Many countries also stated that they use general information and documents in the areas of pharmaceutical policy, investment options for health care, primary care, health promotion and evaluation. Several countries from Eastern Europe remarked that the absence of translated versions of materials limited their usefulness.

"These materials are published in English which creates a barrier for their widespread use"

Finally, one country noted that materials produced by the WHO Observatory were sometimes out of date by the time they were published because of the rapid changes in health care.

3.2.5 The most valuable contributions of WHO/EURO to health care policy.

a. All respondents

- Technical advice and information on communicable and non-communicable diseases.
- Information on the comparative analysis on health care systems across Europe.
- Support for networks and information exchange across Europe.

b. Countries with a BCA

- Direct technical and expert support to countries in the development of health strategies.
- Assistance with specific programmes such as development of primary care, elimination of measles, tuberculosis.
- Technical help in developing methods for prioritising and systems for the monitoring and evaluation of reforms.
- Facilitating co ordination between the Ministry of Health and other donor organizations.
- Help in responding to emergencies.
- Assistance in the development of pharmaceutical policies.
- Support in developing information systems.
- Information on determinants of health and environmental issues, such as the Verona Initiative.
- Support in developing public health capacity within the country.

c. Non BCA Countries

- Support with health promotion frameworks, associated with Health For All and including the provision of information on tobacco and alcohol use.

- The development of measures of quality of care, including evidence-based practice and guidelines.

3.2.6 What should be the future role of WHO/EURO in relation to health care policy?

The responses to this question have been grouped according to the Ljubljana principles.

a. Driven By Values

- Producing statements of principles and standards for health care and overall health improvement
- Leadership in defining health and building broad support in countries.
- Surveillance of health reforms and working with health ministries to identify gaps in provision
- Providing guidelines on quality of care.

b. Targeted on health

- Support in the development of national health strategies
- Coordination of international agencies at a strategic level to maximise the health gain of existing health programmes.
- Development of more sustainable long-term support and encouragement of continuing links with consultants who work in the country.

c. Centred on people

- Support for countries in policy development related to demographic change, an ageing population and mental health problems.

d. Focused on quality

- Focus on evidence based practice
- Information and technical support on health service delivery and risk reduction
- Training and support on change and other relevant management skills in health care settings

e. Based on sound financing

- Support for international exchange of experience related to health care finance.
- Reactivate the Taskforce on Health Economics

f. Oriented towards primary health care

- Provision of primary care data, information, analysis and comparative documents
- Support in the development and dissemination of guidelines for primary care.

g. Other WHO activities

- Technical support for the publication and dissemination of examples of evaluation.
- The further development of networks linking countries with similar health and economic problems and / or geographical proximity.
- Collaboration on data collection with other agencies such as the European Union and OECD.

3.3 Country visits

3.3.1

The evaluators visited eight countries (Albania, Bulgaria, Estonia, Kazakhstan, Kyrgyzstan, Poland, Russian Federation, Ukraine) where they met key individuals from the Ministry of Health and a range of

other organizations (listed in Appendix 1) who were selected by the Liaison Officers in accordance with the requests of the evaluators (para. 2.2.2).

Interviews were conducted according to a semi-structured format based on the questionnaire sent out to the countries. The main findings of the visits are summarised below and are largely consistent with the findings from the questionnaires.

The interviews confirmed WHO's high reputation for authoritative advice on all health matters, neutrality and independence. WHO principles and conceptual frameworks were often seen as the starting point for developing national strategy and it is usually the first point of contact for support relating to health and health care.

However, in most countries WHO is associated more with public health than with health care reforms, which are often more influenced by the major donor organizations such as the World Bank or the European Union.

3.3.2 The influence of the Ljubljana Charter

Although there was widespread awareness of the principles of the Ljubljana Charter its direct influence was not easy to assess. In many places it was seen to reflect already established values ('these are our own values') and penetration into policy and implementation was not always evident. A frequent comment was that whilst principles such as equity, solidarity, patient involvement and primary care development are important, the priority is to manage the cost pressures of the health system ('our priority is simply to make the system work'). Several people thought that the WHO could play a stronger role in promoting these values.

3.3.3 WHO Technical Support

The findings were largely consistent with those obtained from the questionnaire. They confirmed the usefulness of Health of Countries in Transition (HiTs), European Health Care Reform, Health 2000 and Highlights on Health and reinforced the need to provide better information about the range of publications and more translations, especially into Russian.

Organizations outside Ministries, such as academic institutions, professional bodies and regional governmental organizations, are not usually on the Observatory distribution list. Few countries were aware of the services available from the Integrated Health Care Services Centre in Barcelona, and none that we visited had received support from that centre.

3.3.4 WHO Country Support

The contributions of the Liaison Officers were highly regarded in all countries.

Support in the development of national strategy, legislation, health information infrastructure, pharmaceutical policy, primary health care, medical education, quality indicators and clinical guidelines was welcomed. WHO was consistently seen as an appropriate, reliable and authoritative organization to provide such support.

Nevertheless, there was a strong sense from the interviews that WHO could do more to support the implementation of health care reforms in areas such as the development of management capacity, quality control systems and drugs policies.

Foreign experts can be extremely helpful, but all too often they are not well enough acquainted with the local problems and culture. They are often in the country for brief periods of time so that the relevance and effectiveness of their recommendations is limited. It is widely considered that better use could be made of national experts or people from similar countries.

3.3.5 The role of WHO in health care reform.

There was widespread support for a greater WHO role in health care reform.
Suggestions are categorised according to the Ljubljana Charter principles:

a. Driven By Values
WHO should advise Governments about the most beneficial health reforms and assist in the establishment of broad support for agreed health care strategies.

b. Targeted on health
Many countries would welcome a comparative analysis of its health status and access to health care ten years after the initial reforms. A broader view, incorporating poverty, education and employment as major issues affecting health would also be welcome, as would support in the development of methodologies to monitor health inequalities.

c. Centred on people
Countries need help in finding effective and affordable ways to involve the public in health care policy making and to assess patient satisfaction with services. Many places would also like help in developing more productive relationships with the media as part of communications strategies.

d. Focused on quality
All countries agreed that WHO should increase its work in developing clinical and quality of care guidelines. They would also welcome support in the development of measures of health care provision.
Many countries commented that WHO networks had provided valuable opportunities to share good practice and experience with other countries.

e. Based on sound financing
Many countries visited believed WHO could play a stronger role in health service finance issues. In particular, there were requests for support in the evaluation of financial planning in relation to health policy, development of health service management training programmes, and identification of potential sources of funding to develop health care systems.
The production of comparative information and health impact analysis of financial options were seen as a useful way forward to aid the debate. This could be particularly valuable at a time when several countries are reviewing their financial systems.

f. Oriented towards primary health care
WHO is seen to have a major role in supporting the development of professional and regulatory bodies for primary care professionals. There was also support for a more active role in family doctor training such as training of trainers to for vocational training programmes and assistance with continuous professional development and medical education.

3.3.6 Other issues

Although the focus of the interviews was on the role of the WHO in health care reform in the country, a number of issues relating to the country presence of the WHO emerged. These are explored further in Chapter 5.

4. Issues Related to Health Care Reforms

We have stated earlier that this report is not concerned with the evaluation of actual health care reforms that have been implemented across Europe, but with the contributions that WHO has made to the processes of such reforms and to health care policy across the Region.

We tried to identify ways in which WHO has worked with Governments and with significant donor agencies to influence the design of health care systems in ways that will move towards the attainment of the Ljubljana principles. We also looked for evidence of support in the assessment of reform proposals and their implementation.

The priorities for health care reforms differ across Europe according to population health needs, the current state of health services, the economic situation and cultural differences. Within the complex mix across the Region it is possible to discern a set of common characteristics in those countries that shared similar health care models and political systems. The difficult challenges of reforms in established Bismarkian and Beveridge systems are well documented. Countries that decided to introduce social insurance-based financing as part of wider health care reforms, often during times of severe economic difficulties, have experienced even greater problems. It was not usually possible to ascertain whether WHO had been involved in the development of such systems or in any assessment of their impact.

Several countries have now established comprehensive health strategies, usually with assistance from WHO, and are attempting ambitious implementation programmes. Their greatest need is for help in overcoming the well-known barriers to change. These include public reluctance to lose familiar facilities, even though they can no longer provide services to acceptable standards, and professional reluctance to change longstanding patterns of practice. We think that WHO could do more to assist with training in change management in these countries.

The Ljubljana Charter on Reforming Health Care in Europe reflects the principles, unanimously accepted by the countries across the Region, for health care reforms and better health for the people of Europe. For this reason, this milestone document is also our reference for assessing the impact of the WHO Euro Office in bringing health care reforms in the Region towards the values and principles enshrined in the Charter.

In this section of the report we set out our conclusions according to the Ljubljana principles. (see Chapter 1).

a. Driven by values

The Ljubljana Charter was published in 1996 and endorsed by all Member States of the WHO European Region. It promotes values of human dignity, equity, solidarity and professional ethics that were accepted throughout a very diverse Europe. It was important that these values were stated explicitly at a time of such rapid change and it is encouraging to find that they remain deeply rooted. They are essential if this Region's enviable record in access to care is to be maintained.

Although the Charter has not been strongly promoted by WHO, the responses to our questionnaires and discussions at country visits confirmed that these values are central to all reform proposals. They are 'taken as read' by policy makers.

The Country Profiles (HiTs) produced by the WHO Observatory draw special attention to aspects of equity and solidarity. We welcome the fact that this perspective is now established as a standard contribution to policy analysis in WHO documents and publications. We are not however aware of any similar systematic approach to matters of human dignity and professional ethics.

Our examination of the new health care arrangements led us to believe that in some cases proposed reforms were potentially damaging to health. For example cost-sharing arrangements and closure of

inpatient clinics in rural areas, as well as some decentralisation measures, have resulted in reduced equity and access to services. We were not able to determine whether WHO had offered formal comments about those reforms that are not consistent with these values.

We think that there is a place for a more active role in promoting Ljubljana values by drawing attention to the implications of these values in every aspect of health services. Examples might include the marketing of pharmaceuticals, end of life issues and rationing of health care.

b. Targeted on health

The promotion of the health of the population should be a priority for all Governments for both humanitarian and economic reasons. Virtually all people aspire to a long and healthy life. A healthy population provides a strong workforce to support economic development and reduces the burden on health services.

The key task of WHO is to assist Member States to put the 'health' into health care reforms and to promote those changes that will maximise health gain, while other agencies such as the World Bank may concentrate on ensuring the efficiency of the health care systems. Nevertheless WHO publications should complement this by drawing attention to the importance of clear targets for the quality and health outcomes of care.

Representatives of several donor agencies informed us that they welcome WHO advice on their proposals. They claimed that they would be reluctant to fund projects about which WHO had reservations.

We were concerned that some health care reform programmes that we studied appeared to concentrate only on the diagnosis and treatment of disease, and did not encompass the full range of health care services, from health promotion and disease prevention through to continuing and terminal care. A first level of health service (primary care), that offers clinically effective preventive programmes such as vaccination and immunisation and maternal and child health, provides an extremely cost-effective investment in terms of health gain. It is therefore important that theses services are recognised and sustained when difficult decisions about resource allocation are taken.

Although the WHO vertical programmes, such as the tuberculosis control and HIV/AIDS programmes are much appreciated, readily funded by donors and essential for dealing with emergency situations, they can only be effective and sustainable when they are integrated into fully established comprehensive health services.

It was clear from our studies that countries look to WHO to provide guidance and tools that can assess the effectiveness of health care and the achievement of health gain. These might include the impact of service reconfiguration on outcomes such as maternal and infant mortality, rates of hospital infections, years of life without disability and numbers of avoidable deaths. Many country representatives told us that they would welcome information about health and health care in other countries facing similar problems.

The WHO has already made important contributions to the development of information systems and to the training of health professionals that are highly valued by countries.

It is uniquely placed to support the development of health information systems that facilitate valid comparisons between countries. This would help in the monitoring of services and the early identification of those that are successful in achieving good health outcomes.

We consider these information development and training activities to be essential in helping countries to increase local capacity and to focus service developments on health outcomes.

iii. Centred on People

The Ljubljana Charter stresses the importance of patients' rights and citizens' involvement in health services. This should include public involvement in the design of services and user involvement in measuring the quality of and satisfaction with service delivery. There is widespread acceptance of this principle, although limited evidence of successful inclusion in the planning and implementation of reform programmes.

We were pleased to note the inclusion in the World Health Report of measures of 'responsiveness' which recognise this aspect of health care. We are aware, however, of the difficulties of developing suitable methodologies, especially in countries where there has been no tradition of 'consumerism'. Many countries are understandably reluctant to use scarce resources on complex arrangements for public involvement when basic clinical services are not adequately funded.

We think that WHO could assist Member States in the development of realistic measures of patient satisfaction and public involvement which will help to ensure that new services will encompass the views of users and thus enhance their quality and effectiveness.

iv. Focused on Quality

All countries aim to develop high quality health services. They recognise the importance of excellence in both clinical and service components of health care as well as in their management, organizational and financial aspects and acknowledge that much can be achieved without extra expenditure. Indeed, high quality care can contribute significantly to efficiency and effectiveness by ensuring that ' the right treatment is delivered in the right way', minimising the complications and iatrogenic disease that can add so much to health service costs.

WHO is already helping with quality initiatives in many countries through educational and training programmes for nurses and for family doctors (general practitioners). These programmes could be extended to include the development of basic curricula and other minimum standards for primary health care doctors and other health professionals. Programmes of continuing education for all health professionals are also needed.

A great deal of work has been done across the world on improving the quality of clinical care through the use of evidence-based guidelines. The analysis of research and other evidence does not necessarily have to be repeated in every country, though specific guidelines have to be developed that take account of local problems, resources, facilities and culture. WHO could provide valuable help by acting as a guidelines 'clearing house', disseminating information to organizations and practitioners.

The use of guidelines should be accompanied by monitoring systems such as professionally led clinical audit that encourage adherence to the agreed standards of practice. Here again, WHO could offer valuable assistance to professional and regulatory bodies in the introduction of such systems and in the establishment of codes of ethical practice to underpin them.

v. Sound financing

All countries in Europe face difficulties in the financing of their health services to provide the standards that the public expects. We congratulate WHO on the support it has given in this area for example through the publications by the Observatory[2]. These documents are likely to be of value to all countries but particularly to those that are introducing radically new funding systems. Unfortunately, much of the information is available only in English and every effort should be made to translate these works into Russian, to maximise their usefulness.

The OECD produces '*Health Data*' that offers the most comprehensive source of comparable statistics on health and health systems across OECD countries. It has become an essential tool for researchers and

governments, the private sector and the academic community. WHO could help to introduce similar data collection methodology for all countries in the Region to facilitate international comparisons.

We gained the impression that insurance based systems of funding health care are being introduced in some countries under the powerful influence if significant donor agencies, without serious assessment of their suitability. We believe that the introduction of insurance-based systems when health care remains essentially state funded can lead to escalating transaction costs without providing significant increases in funding for clinical services and that a full options appraisal of alternative funding arrangements should be carried out. It was not clear whether WHO had commented on proposals and offered assistance with such assessments.

There is widespread concern about the continuing inclusion of 'out of pocket' payments in the health sector which can hamper efforts to reform finance systems and provide equitable and accessible health delivery services. WHO, perhaps in collaboration with other agencies, could assist in the analysis of this problem and the identification of possible solutions. However, the levels of remuneration of physicians and other health professionals point to the most obvious reason of this problem. At the present moment, every effort should be made by countries to increase the salaries of health workers to a minimum acceptable level advocated by WHO.

vi. Orientated towards primary health care

The Ljubljana Charter sees primary health care as the philosophy and the leading organizational structure by which the other five principles are implemented and it advocates the shift of health services from hospitals to primary health care.

We found that there is general support for the concept of reorientation of health services towards primary care. However, there is very uneven progress towards this goal and a suspicion that in some places the commitment of officials and professionals is not strong.

Unfortunately, the arrangements for well-functioning primary health care systems are far from effective in some of the countries where health care reforms were supported by WHO. In most of these countries, the gate-keeping function of the primary health care units has been abandoned or is not functioning well. In many underdeveloped and rural areas, the closure of inpatient clinics without any replacement by primary health care facilities has resulted in diminished access to services. The limitations of primary health care have created the need for vertical disease programmes to deal with urgent health needs that have emerged in association with adverse economical and political situations.

We were disappointed to find no evidence that the WHO Integrated Health Care Services Centre in Barcelona has been active in promoting primary care.

On the other hand, all countries seem to appreciate the importance of the primary health care philosophy and aim to develop suitable services. It was very pleasing to note that almost all of the governments are intending to improve the capacity of general practitioners or family physicians by vocational training programs. The training programmes for GP trainers were generally supported by WHO and financed by donor agencies.

There is widespread appreciation of the support that has been provided for training, though it is clear that much more could be done. This should maintain the emphasis on training for local trainers and should wherever possible be multi-disciplinary, to encourage the establishment of effective primary care teams.

Other initiatives could include support in countries for medical schools to develop adequate primary care undergraduate training and experience, and help in the establishment of professional bodies that can develop ethical values and standards of professional practice for primary care.

5. Observations, Conclusions and Recommendations

5.1 General Comment

It is pleasing to report as an initial observation that WHO is universally respected and trusted. It is perceived across Europe as an invaluable source of independent and authoritative advice in all matters concerning health. Its opinions are seen as important in influencing decision-makers, professionals and funding agencies. It is a valued partner in health projects.

We would like our conclusions and recommendations to be seen within this generally positive background as constructive efforts to assist WHO to build on its strong reputation and to become even more effective in the future.

5.2 The WHO and the Position of the European Region

The European Region is unique in WHO in the change it has experienced in recent years. In 1989, our Region had 32 member states and it now has 51. The countries that comprise the European Region are extremely diverse. They vary in size, terrain, climate and natural resources. There is wide variation in economic situations and population health status and differing levels of organizational and health policy development.

Across the Region, many countries have had to deal with the collapse of former health care systems. Some are still experiencing conflict or having to cope with its aftermath and require considerable humanitarian aid. There is widespread concern about the emergence of new diseases such as HIV infections and AIDS, and the re-emergence of others such as tuberculosis.

These imperatives have stretched the Region's limited resources and have probably contributed to the fact that the response to health care reforms has in some places been slower than would have been wished.

5.3 The WHO Regional Office in Europe

We fully support the formulation of the aim of the WHO Regional Office for Europe[8] presented to the Standing Committee of the Regional Committee in April 2002:

> *"To support Member States in developing their own health policies, health systems and public health programmes; preventing and overcoming threats to health; anticipating future challenges; and advocating public health."*

5.3.1 Functions of the Regional Office

In order to achieve this aim, the Regional Office must fulfil several functions:

a. Leadership and Guidance

Although the Region was slow in responding to the dramatic changes of the 1980s and 1990s, it has nevertheless made significant and valuable contributions. The Ljubljana Charter brought together for the first time the key principles for health care reforms which were accepted by all Member States and have, explicitly or implicitly, underpinned virtually all reform proposals.

The Region established the Eurohealth programme, set up Liaison Offices, was a prime mover in the establishment of the European Observatory on Health Care Systems and has offered training programmes, all of which have made an impact.

Ten years on, it is timely to review these arrangements and where necessary to modify them so as to position the organization to meet effectively the new challenges of the 21st. century.

The Member States look to WHO for leadership and guidance in matters relating to population health and health care. It is seen as an independent, authoritative organization that is well placed to co-ordinate health care projects in collaboration with the European Union and major donor agencies such as the World Bank.

However, during the period under review there have been massive organizational changes in the Regional Office that are not yet complete. These have led to uncertainty about leadership and direction. Disruption of management arrangements has had consequences throughout the organization.

Recommendation 1:
WHO should invite Member States to confirm their commitment to the Ljubljana principles and assist them to develop methods to measure their progress towards them.

Recommendation 2:
WHO should confirm its prime role of leadership and guidance in relation to all aspects of health and health care in the Region. In the field of health care, this should include the periodic updating of the Ljubljana Charter, further development of the European Observatory and regular review of relevant programmes, activities and arrangements in the Office and Member States.

b. Developing Political Commitment
It was not surprising to discover that the greatest progress in healthcare reforms has been made in those countries where there is strong political commitment and where there has been relative political stability, rather than where Ministers of Health and Senior Officials have changed frequently. This point is well illustrated in the Kyrgyz Republic, where the Manas project has provided a long-term and widely supported framework for health care reforms.

WHO, as part of the UN, must of course respect the political arrangements in Member States. However, it is uniquely equipped, through its knowledge, reputation and independence, to assist Member States to understand that health care systems can only develop satisfactorily if there is broad agreement on the key principles. It could make a valuable contribution to the development of cross party support for the general thrust of health care reforms. This can not only help maintain the momentum of the reform process following changes of Government, but also give confidence to donors. Constant changes of direction can bring much-needed reforms to a standstill, prevent adequate implementation, waste resources, produce cynicism in health professionals and managers and most important, delay improvements in services for the population.

Recommendation 3:
WHO should seek opportunities to work with the Governments of Member States to develop broadly based support for health care reform programmes based on the Ljubljana Charter principles.

c. Strengthening Local Capacity
WHO European Region has a clear responsibility to help build local capacity and support colleagues whose professional development has been difficult to sustain in the past. We were impressed by the expertise of many officials and professionals whom we met during our visits. It is therefore disappointing that many countries feel overburdened by a host of visiting ‘experts’ and consultants who have not always become familiar with the specific needs, culture and organization of the country, who consume much needed resources and who may undermine the credibility of local expert practitioners. We do not doubt the usefulness of well focused and informed international advice and support, but we believe that more use could be made of local expertise either from within the country or from neighbouring countries with shared problems and similar cultures.

We welcome the recent initiative from the Division of Country Support to develop an expert panel of individuals who will become familiar with the issues in particular countries. This panel will provide a

sustainable resource for countries, comprising people who will be available for visits that are responsive to country needs and who will support the development of local capacity.

Recommendation 4:
WHO should develop a comprehensive policy for strengthening capacity in countries to help fulfil its commitment to help Member States to develop their own policies and services. This may include:

- **providing or working with others to promote further training in public health and health care policy and management, especially for young professionals**
- **support for the establishment of a European network of Schools of Public Health with strong programmes in health policy and management**
- **support for other measures to develop local capacities such as participation of local experts in international professional activities, fuller use of internet based information, and English language training**
- **inviting more experts from Eastern European countries to contribute to projects across the Region.**

d. Putting Health into Public Policy: Promoting Health Impact Analysis
Health care reforms in many countries are only a part of extensive reform programmes across many sectors. In some places the impact of changes in non-health sectors such as education, environment, housing or employment may be detrimental to population health. In many countries, there is no requirement for a 'health impact analysis' nor the capacity and experience to undertake such studies. Such analyses can make decision makers aware of the likely health effects of their policies and projects, so that amendments can be introduced at an early stage to maximise health gain and mitigate any adverse effects on health. WHO could offer countries technical support with health impact analysis as a further contribution to their health improvement activities.

Recommendation 5:
WHO should offer assistance and expertise to Member States in the health impact analysis of their policies within health and other fields.

e. Influence on External Agencies
WHO is largely an advisory organization rather than a donor organization. It does however have the potential to exert considerable influence on donors in relation to the strategies and priorities for health projects. In some countries there are impressive communications with external agencies, with WHO often playing a valued co-ordinating role. It is particularly important that close links are maintained with the European Union at a time of proposed expansion that will have major implications for health and health services for several Member States.

Recommendation 6:
WHO Regional Office should maintain its strategic links with all major donor agencies. In particular, it should ensure that there is close communication with the European Union to ensure consistency of health related policies and, wherever possible, synergy in implementation.

f. Balance of Programmes
In the 1980s many countries in Western Europe were introducing major changes in health care, with little or no involvement by WHO. In Eastern Europe, health services were not often seen as a pressing issue before 1989.

The Health for All strategy, which was launched in the 1980s, is still recognised as an important framework for the development of comprehensive health policies. However it is thought that this emphasis sometimes resulted in insufficient attention being paid by WHO to the problems of health services and health care, which are usually a major concern for Governments and Ministers of Health and for the public. The shift to a more active involvement in health care reforms is welcomed. The Regional

Committee and the Regional Director should review programmes regularly to see that a proper balance is maintained between health and health services work. Current work arising from 'Health 21' and the proposed review of 'Health for All' should aim to ensure that essential long term, but often less politically pressing, matters of population health and its determinants are not neglected.

Recommendation 7:
WHO should regularly review its policies and projects to ensure that a proper balance is maintained between population health promotion and health care activities.

g. Networks
Most countries welcome the opportunity to share experience, problems and solutions with others. The networks that were established by WHO (Carnet, Southnet etc.) were generally found useful. The settings networks (Healthy Cities, Healthy Schools etc.) are also valued by countries and merit support. WHO could explore ways of facilitating new networks that would meet the current needs of Member States. These could be in geographic clusters or health problem clusters. It might also be useful to explore the potential for some form of 'twinning' as a means of establishing longer term sustainable relationships between organizations in the more advanced and the less advanced countries.

Recommendation 8:
WHO should facilitate the development of health networks and other linkages between Member States and between professional bodies.

h. Specific Programmes
The condition specific programmes (tuberculosis control, measles, rubella immunisation, HIV /AIDS control) which have been promoted by WHO and which readily attract donor funding are greatly appreciated. They could with advantage be better integrated into health care systems in countries, and in some instances they need more technical support.

Recommendation 9:
WHO should seek to ensure that disease specific programmes are fully integrated into the country health care system to assure long term sustainability.

5.3.2 The Organization of the Regional Office

a. Capacity
The main strength of WHO is seen as its technical excellence, which underpins its reputation as a source of reliable and authoritative information, advice and innovation. We were therefore concerned to find that there are a large number of senior level posts (P5 and above) vacant, some of which have been frozen.

We agree with Dr. Danzon's statement that:

> *"Today the challenge for the WHO Regional Office for Europe is to* ***understand and anticipate*** *the fundamental changes taking place in the field of health, to adjust to them and to satisfy the expectations and requirements of its Member States and their populations. The WHO Regional Office for Europe can draw on two major assets to achieve this, namely recognised and valued* ***technical expertise*** *combined with a strategic framework adapted to regional health issues and recently brought up to date."*
> (Dr. Danzon's emphasis)

WHO Euro office should seek to retain staff of sufficient calibre and experience, in sufficient numbers, to maintain a 'critical mass' of professional excellence. This is needed both to sustain the intellectual dynamism of the organization and to provide adequate and timely responses to requests for assistance.

Recommendation 10:
Priority should be given to maintaining professional excellence and assuring a critical mass of expertise in all relevant areas within the WHO Regional Office senior team.

b. Organizational Structure of Regional Office
New organizational structures are still being developed so the total effect is not yet clear. Our main concern is for the managerial arrangements in the Division of Country Support. Effective management of staff who have little direct contact with the centre is always difficult. We think that it will not prove satisfactory to place responsibility for the line management of all the Liaison (Country) Officers with one Director. This is likely to place an inappropriate burden on the Director and divert attention from more strategic responsibilities. A delegated structure, perhaps with a senior member of staff responsible for an area (e.g. Baltic, Caucasus, Central Asia) group of Liaison (Country) officers should be considered.

Recommendation 11:
Consideration should be given to alternative structures for the management of the Regional Office presence in countries.

c. Office Dispersion
Table 4 in Section 3 of this report shows that several important areas of work are undertaken in outposted centres across Europe. Some of these have been established for historical reasons and do not necessarily make sense in relation to current priorities.

Though it might be too soon to judge the impact of the move of the Integrated Health Care Services section to Barcelona, we have to report that the responses to our enquiries about its contribution lead us to believe that it has not yet established awareness of its activities within Member States. The impending move of the Copenhagen-based staff of the European Observatory on Health Care Systems to Brussels adds to our concern that reductions in the staff in Copenhagen will reduce the effectiveness of the Regional Office and diminish its attractiveness to potential senior recruits.

We are also concerned about the management of the outposted sections of the European Office. They represent a considerable proportion of the Office resource and it is important that they make an effective contribution to overall strategic and operational activities of the Region.

We were pleased to hear from the Regional Director that their management and functions are being reviewed. This process should be accompanied by a comprehensive assessment of policies on Office cohesion, integration and devolution.

Recommendation 12:
The Regional Director's review of all the outposted Regional centres should include assessment of the impact on the Copenhagen office and on general strategic development as well as on management arrangements.

d. Communications
Communications within WHO Euro and between the Office and countries require improvement. Within the Office, the wide responsibilities and frequent duty travel required of senior staff limit the opportunities for integrated teamwork. This sometimes means that people are not always aware of the range of projects that are being planned or implemented, so that opportunities to complement activities and to reduce overlap are lost.

In countries, we heard complaints about delayed or non-response to requests for advice and assistance which were often compounded by excess bureaucracy, resulting in reluctance to turn to WHO for help in future.

It was also clear that some Ministers and officials are not aware of the range of materials and services that WHO can provide. This is a particular problem in places where there have been frequent changes of post

holders. A brief summary of WHO services that could be given to all new Ministers and senior officials when they are first appointed would be useful.

Recommendation 13:
Consideration should be given to a review of communications strategy and performance within the Office and with countries. Suitable information about WHO's services and materials should be made available to incoming Ministers and senior officials.

e. Publications
WHO publications are generally greatly appreciated and there is a widespread view that there should be more of them, and that they should be more readily accessible. In particular, the Technical Series are valued by staff at all levels of health care organizations. However, many of them are not translated into the four official languages. The lack of Russian versions is a particular problem in Eastern Europe. The Health Care Systems in Transition (HiT) documents are also helpful to staff at many levels. Translation into the language of the country concerned would enhance their usefulness.

We did not discern a comprehensive publication and dissemination policy. There are plentiful opportunities to promote WHO activities and services and to draw attention to useful publications from the WHO Headquarters and from other Regions that are not at present being fully realised.

Recommendation 14:
Consideration should be given to the preparation of a comprehensive, up to date publication and dissemination strategy

Recommendation 15:
Whenever possible publications that are relevant to a wide range of decision makers and professionals should be translated into the WHO official languages, with priority given to translation into Russian.

5.4 WHO Country Presence

5.4.1 General Observations

WHO contributes to health policy development and health care reforms in different ways according to the needs of individual countries. Part of the response to the dramatic changes in the 1990s was the introduction of Liaison Offices in the relevant countries. Europe is the only WHO Region to have introduced such an arrangement for country technical and policy support. Different systems of WHO local country presence exist in other Regions, for example in the Americas, where Region country offices are led by non-nationals and also have international professional staff. We think that the country presence should have the capacity for advocacy and policy analysis as well as for technical support and the management of funded projects. It should be regularly reviewed in the light of significant changes such as the enlargement of the European Union, which might reduce the accession countries' needs for WHO resources and allow reallocation elsewhere.

We were pleased to learn that plans are in hand to strengthen WHO's country presence and in particular that the offices in Tajikistan, Uzbekistan, Armenia, Turkey and the Republic of Moldova are to be strengthened. These changes should be carefully monitored with a view to rationalisation of resource allocations and further strengthening of the offices in those countries with greatest need.

5.4.2 Advocacy and Leadership

WHO's advice is welcomed and heeded at Government and Ministerial levels, and could perhaps be more forthcoming at sub-national level and with professional organizations. An important part of this role is to advise on the issues that determine population health as well as on health services.

There is a widespread view that the job of WHO is to put the 'health' into healthcare policy and reforms. WHO should show leadership in advocating for the principles and values of the Ljubljana Charter. It should critically appraise reform plans and advise Governments about possible adverse effects on matters such as equity, universal access to care, quality, effectiveness and efficiency, so that such effects can be mitigated in implementation.

Although WHO is recognised as the leader in health policy, it is not a donor agency and cannot provide sufficient resources to implement all country proposals. Many representatives of donor agencies assured us that they would only fund projects that receive WHO support, but we doubt that this is the universal situation. In the event of disagreement, it is understandable that Governments tend to adhere to the wishes of donors.

5.4.3 Direct WHO Support to Countries: Biennial Collaborative Agreements

Table 2 in Chapter 3 of this report indicates the extent of WHO support in countries through Biennial Collaborative Agreements (BCAs).

We were informed that the existence of BCAs and the size of the allocations are determined by a United Nations formula but it was not obvious from the information available to us that they reflect the present health status or health care needs of countries. At times of rapid change the application of formulae should be regularly reviewed to ensure sensitivity and fairness. It is also important to ensure that the recipient countries are able to play their part in implementing BCA projects and making good use of the resources provided to them.

The content of BCAs is decided jointly by countries and WHO, though it was not always clear to us which partner initiated the process and finally decided on the distribution of the allocation.

Figure 1 in Chapter 3 of this report (page 13) shows that a significant proportion of some BCA allocations is used in projects of less than $15,000. While we realise that there may be times when this is justified, for example when it is a WHO contribution to a larger project, we think this is unlikely to be effective or give good value for money for countries.

In addition, we think that detailed two-year programmes of this kind are unnecessarily rigid and provide no capacity for ready and flexible responses to unanticipated problems or opportunities during the 2 year period. It may be advantageous to replace the small items in the BCA with an undesignated sum that can be deployed on the recommendation of the Liaison Officer at the request of the country, within guidelines and management controls agreed by WHO.

Recommendation 16:
The arrangements for the allocation of BCAs should be kept under review to ensure that resources remain fairly apportioned and appropriate to countries' current needs.

Recommendation 17:
Guidelines should be developed for the inclusion of small projects in BCAs.

Recommendation 18:
BCAs should include an undesignated allocation that can be available for in-biennium developments.

5.4.4 Direct WHO Support to Countries: WHO presence in Countries

Table 3 in Section 3 of this report indicates the numbers of WHO funded staff based in countries. It shows the levels of staffing of Liaison Offices and of other supporting activities that are provided in certain countries.

a. WHO Country Presence
We pointed out in para 4.4.1 that WHO responded to the dramatic changes in Europe in the 1980s and 1990s by establishing a network of Liaison Offices. Other WHO Regions have established different arrangements to provide support, ranging from extensive humanitarian aid and technical support to a simple representative role.

We agree with the statement in the Eurohealth report that the primary duties of the Liaison Offices in this Region are:

- acting as an interface between WHO and the country
- ensuring coordinated support in the countries
- maintaining regular contact with the representatives of other international organizations and development agencies
- assisting Ministries of Health in coordination of activities of external partners and national programmes

Now, with the experience that has been gained over the past few years and with developments in countries, the task of 'representing the Regional Director in the country' could be added to this list. Such a change should only take place when the current arrangements for Country Offices have been reviewed and amended to reflect this new role.

We confirmed the findings of the Eurohealth evaluation that there is considerable variation between countries in the functions and effectiveness of Liaison Offices.

Many of the Liaison Offices have only two WHO funded posts (the Liaison Officer and an administrative assistant) and extremely limited budgets for running costs.
We think that Liaison Offices should be adequately staffed and funded to provide a credible presence for WHO in the country, both in terms of "critical mass" and calibre. An under-resourced liaison office undermines the dignity and standing of WHO and diminishes its influence.

A single-handed Liaison Officer cannot be expected to carry out all the tasks that would benefit WHO and the host country, so we have concerns that in some places resources may be wasted by maintaining offices that cannot perform effectively. In general, offices with single, isolated professionals should not be encouraged.

We believe that in the medium term the Liaison Offices should be gradually replaced by local WHO Country Offices with international professional staff. The aim should be to provide solid technical support in all areas of local need and in addition to act as the representative of the Regional Director. In order to ensure the independence, stability and expertise of this new type of Country Office, the Director should normally be international, and should be supported by experienced professional staff.

Recommendation 19:
The changes in the current arrangements for the Liaison Office system should aim to provide local technical support, to ensure stronger WHO representation in countries and to allocate adequate resources to fulfil the roles of WHO Country Offices.

b. Liaison Officers
We consider that the Liaison Officer, as WHO Country Offices representative, ought to be able to provide personally, or secure within the office the skills necessary for:

- technical support relevant to the health needs of the country
- health impact analysis of country policies
- support to the country in communications relevant to health
- leadership in coordination of donor programmes

We note that all the Liaison Officer posts are shortly to be advertised and filled by open competition. Although this may risk reducing the morale of existing post holders and may appear to deny their value and loyalty to WHO, it provides an opportunity to clarify the role and responsibilities of the job.

The restructuring of the Liaison Officer posts also gives an opportunity to consider how they can be made more attractive and professionally fulfilling and we agree with many of the conclusions of the Eurohealth evaluation.

We have commented elsewhere on our concerns about the management of the WHO Country Offices (para 5.3.2.b). We think it is essential that there is proper appraisal, linked to opportunities for professional development and training. We also think that the new Liaison Officers/WHO Country representatives should be given greater authority, within guidelines approved by the Regional Office and subject to normal audit processes.

We have encountered different opinions on the advantages of the Liaison Officer being a national of the country, as is the case for all except the Russian Federation at present. At the outset there were advantages in having someone familiar with the country and the arrangements in the Ministry. We think that circumstances have now changed and that the balance favours the introduction of international WHO representatives and professional staff in WHO country Offices. This matter should be kept under review as circumstances, opportunities and capacity in countries change.

At the same time, we think the interface role can only be carried out effectively by someone with a good knowledge of the host country's culture and history, so the post holder should come from a country with a similar background and situation. Knowledge of the language is also important, both in terms of respect for the host country and in reducing interpreter costs.

In places where there is a non-national Country Officer, a national officer of appropriate seniority and experience should also be appointed.

Recommendation 20:
The new arrangements for Liaison Officers or WHO Representatives should seek to enhance their status and give them more authority, independence and stability.

Recommendation 21:
There are advantages at present in having an international Liaison Officer or WHO Representative. The selection criteria for such a post need to be carefully developed and the policy should be kept under review.

c. Location of Country Office
We encountered differing views on the best location for the Liaison Office. On the one hand, location in the Ministry facilitates easy access and communications between WHO and Ministry staff. On the other hand, it can undermine the independence of the WHO office, especially when limited resources result in dependence on the Ministry for some services and where the country presence is limited to one national professional, the Liaison Officer.

There is probably not one right answer for all countries, but where the opportunity arises, and especially in the present circumstances, we think that the possibility of location of the WHO Office in a UN House should be carefully considered. Wherever it is located, the office should be adequately resourced to carry out its tasks efficiently and effectively.

Recommendation 22:
Consideration should be given to the location of WHO Country Offices in UN houses when this is possible.

d. Multiple WHO Country Offices
In some countries there are two or more WHO offices, for example in Albania where there is a Liaison Office and a Humanitarian Office. The two offices have different functions and the Humanitarian Office receives some resources from WHO, but is also responsible for activities funded by donor agencies. We think the existence of multiple offices in one country can cause confusion and that wherever possible the coordination of all WHO activities in a country should be the responsibility of the Liaison Office.

Recommendation 23:
All WHO activities in a country should be coordinated from a single office.

Postscript

We all wish to place on record our admiration for the work of WHO European Region and our hope that it will take the opportunities of current changes to further strengthen its activities and to help it to engage more effectively and sensitively with Member States.

It has been a privilege to participate in country visits. We are enormously impressed by the achievements of colleagues in the face of daunting health, organizational and economic problems. We greatly welcome the opportunities that are now available to all of us to show our solidarity as Europeans.

We hope that this report will help both WHO European Regional Office and Member States in their efforts to achieve better health and health care across our continent.

Appendix 1

Acknowledgements

The Evaluation Team wishes to thank the following people, all of whom gave generously of their time and experience to help us in our work.

Standing Committee of the Regional Committee

Dr J Kiely, Chairman

WHO Regional Office for Europe

Dr M Danzon	Regional Director, WHO Regional Office for Europe, World Health Organization
Ms A Fawcett Henesy	Regional Advisor, Health Systems Organizations and Programme Management
Dr J Goicoechea	Director, Division of Country Support
Dr J Figueras	Regional Advisor, European Observatory of Health Care Systems
Dr H Zollner	Regional Advisor, Futures Fora
Dr Y Charpak	Senior Policy Advisor
Dr A M Worning	Senior Advisor, Programme Management and Implementation
Dr N Menabde	Acting Director, Division of Country Support
Dr A Tsouros	Regional Advisor, Healthy Cities and Urban Governance
Ms Z Jakab	Director, Division of Administration and Management Support

Albania

Dr Vasil Miho	Liaison Officer, World Health Organization
Dr. Petrit Vasili	Deputy Minister of Health
Dr Nurie Caushi,	Chief of Statistics Sector, Ministry of Health
Dr Gjergji Leka,	Director, Institute of Health Insurance
Dr Luzhiana Abazaj	Director, Regional Health Authority of Tirana
Dr Leonard Solis,	Adviser of Prime Minister and Former Minister of Health, Ministry of Health
Dr Lorena Kostallari	Project Officer, Health, World Bank
Ms Sabrina Mayoufi	Head of Mission, ECHO
Dr. Melita Petanovic	Health Coordinator, ECHO
Dr Zhanetra Shatri	Health Specialist, United States of America Agency for International Development (USAID)
Mr Arben Qesku,	Project Officer, Department for International Development (DFID)
Dr Santino Severoni	Head, WHO Emergency and Humanitarian Aid Office
Mr Lindita Backa	Coordination and Planning Director, Ministry of Health
Dr Agin Shehi	Director Primary Health Care, Ministry of Health
Dr Fatmir Brahimi	Director Health Care, Ministry of Health
Ms Natalina Lesi	Director Human Resources, Ministry of Health
Ramajan Juli	Pharmaceuticals Dept, Ministry of Health
Dr Thanas Poci	Director Economics, Ministry of Health
Mr Lenin Gusman	
Dr Mariana Bukli	Officers, UNICEF
Dr Din Abazaj	President, Albanian Medical Order
Dr Shaqir Krasta	General Secretary, Albanian Medical Order
Dr. Silva Bino	Director, Institute of Public Health

Bulgaria

Dr Dora Mircheva	WHO Liaison Officer
Slavcho Bogoev	Deputy Minister for Health, Ministry of Health
Dr Staiko Koulaksazov	Director, International Cooperation and European Integration Directorate, Ministry of Health
Professor Miroslav Popov	**Director, National Institute of Public Health**
Dr Petar Tenchev	Deputy Minister, Ministry of Health
Dr Tatjana Benisheva-Dimitrova	Head of Drug Policy Department, Ministry of Health
Dr Irina Velinova	Chief Expert, Ministry of Health
Dr Lubomir Kumanov	Deputy Minster, Ministry of Health
Dr Mihail Popov	Director, State Health Control Administration, Ministry of Health
Dr Gencho Nachev	Acting Director, National Health Insurance Foundation
Boryana Gotcheva	Senior Social Sector Operations Officer
Antonia Viyachka	Procurement Analyst, World Bank
Professor Stoyan Alexandrov	Director diagnostics/ therapeutics, Ministry of Health
Dr Rostislave Dimitrova	Senior Expert. Directorate 'International Cooperation and European Integration', Ministry of Health

Estonia

Piret Laur	WHO Liaison Officer
Siiri Oviir	Minister of Social Affairs
Dr Katrin Saluvere	Deputy State Secretary on Health, Ministry of Social Affairs.
Dr Ahti Kallikorn,	Director of North Estonian Regional Hospital
Dr Maris Jesse	Director of Health Insurance Fund for Estonia,
Dr Ivi Normat	Head of Health Care Department in the Ministry of Social Affairs.
Dr Ain Aaviksoo	Head of Public Health Department
Dr Helge Hallika	Political Advisor on health issues to Minister of Social Affairs (was a family doctor in Tallinn)
Dr Tomas Palu	Vice Director of Estonian Health Insurance Fund
Tiit Jurimae	Director of Health Care Project in The Ministry of Social Affairs

Kazakhstan

Dr. Mourat Ussataev	WHO Liaison Officer
Dr Zhaksylyk Doskaliev	Minister for Health, Ministry of Health, Kazakhstan
Dr Arman Aydarkhanov	Vice Minister for Health, Ministry of Health Kazakhstan
Professor A Akanov	Director General, National Centre for Healthy Lifestyle Promotion
Professor M Kulzhanov	Dean, Kazak School of Public Health
Mr S Strachen	Senior Project Officer, UNICEF
Ms T Popova	DATS Manager, The British Council Kazakhstan/ Kyrgyzstan
Ms N Beisenova	Operations Manager, The World Bank Office in Kazakhstan
Sheila O'Dougherty	Regional Director Zdrav Plus (CAR health reform programme delivered by Abt Associates: Major funder USAID)

Kyrgyz Republic

Dr Oscon Moldokulov	WHO Liaison Officer
Prof. Tilek Meimanaliev	Minister for Health
Dr Ainura Ibraimova	Deputy Minister of Health
Ms Dinara Djoldosheva	World Bank Operations Officer
Mr Joe Kutzin	WHO Senior Advisor on health policy analyses

Dr Marat Mambetov	Head of the Department of Implementation and Co ordination Ministry Of Health
Dr Chinara Seitalieva	Head of MANAS Team
Dr C. Aidyralieva	Programme Manager, UNICEF
Dr Ludmila Shteinke	Deputy Minister for Health, Chief State Sanitarian Doctor
Dr Sabirjan Abdikerimov	General Director of the State Dept of Sanitation & Epidemiological surveillance
Mrs Natalia Hilt	Liaison Officer, Kreditanstalt Fur Wiederaufbau, Germany
Mr Jan Bultman	World Bank Regional Director, Central Asian Republics
Dr. Elmir Asylbekov	Director, Sokuluk Rayon Centre of Family Medicine

Poland

Dr. Andrzej Zbonikowski	Liaison Officer World Health Organization
Dr. Aleksander Nauman	Deputy Minister of Health, Ministry of Health
Director Jadwiga Jaszczyk	Office of Foreign Aid Programmes in Health Care, Ministry of Health
Mr. Maciej Tokarczyk	State Office of Health Insurance Surveillance
Dir. Piotr Warczynski	Department of Accreditation and Quality Monitoring in Health Care, Ministry of Health
Director Joanna Didkowska	Department of Epidemiology
Director Zbigniew Kulaga	Health Policy Department
Prof. Jerzy Leowski	Member of Advisory Council to Minister of Health & Dean of Public Health University of Warsaw
Director Miroslaw Manicki	Head of Department of International Relations and European Integration Ministry of Health

Russian Federation

Dr Mikko Vienonen	WHO Special Representative of the Director General in the Russian Federation
Dr T I Stukolova	Deputy Minister, Minister of Health
Ms Tatiana Loginova	Operations Officer, Health and Social Development Moscow Office, World Bank
Ms Elena Tkachenko	Development Section Officer, British Embassy Department for International Development (DFID) Russia
Ms Kerry Pelzman	Chief of Health Division, United States of America Agency for International Development (USAID) Russia
Dr. Olga V. Andreyeva	Deputy Director, Federal Fund of Obligatory Medical Insurance
Roustem J. Devichev	Senior Health Care Expert, Health Care Economics, Central Research Institute
Professor V I Starodubov	Central Health Research Institute, Ministry of Health
Dr Anna V Korotkova	
Dr Alexei I Savinykh,	
Ms Sandra Mounier-Jack	Officer, Technical Assistance Section, Delegation of the European Commission in Russia, European Union
Eugeny T Tishuk	Shemasko Institute Russian Medical Science Academy
Dr S M Furgal	Department of International Cooperation, Ministry of Health
Dr A V Pavlov	
Dr VK Raizantsev,	

Ukraine

Dr Yuriy Sobbotin	Liaison Officer World Health Organization
Mr Alexander Korotko	Deputy State Secretary to Ministry of Health
Dr Anatoliy Khartysh	Deputy State Secretary to Ministry of Health
Dr Olga Bobyleva	First Deputy State Secretary to the Ministry of Health
Ms Tatiana Chernyshenko	Deputy Head, Dept of Medical Education and Science, Ministry of Health

Dr Alexander Evtushenko	Deputy Head, State Department Pharmaceuticals and Medical Appliances, Ministry of Health
Dr Nina Goyda	Deputy State Secretary to Ministry of Health
Dr Eliot Pearlman	International HIV/AIDS Institute (ex USAIDS)
Dr Vladimir Zagarodny	Deputy Head, City Health Administration
Ms Pamela Mandel	Director, Office of Social Transition, USAID

Appendix 2

Questionnaire

COVERING LETTER TO MINISTERS OF HEALTH, TO ACCOMPANY QUESTIONNAIRE

Dear ………..

Re: External Evaluation of World Health Organization European Region Health Care Reform Programme

You are probably aware that the European Regional Committee of WHO requested an independent evaluation of the Region's health care reform programme. A group of four external evaluators has been appointed for this task. The Standing Committee has approved their terms of reference and approach to the work. The evaluators have also discussed the project with me and with the Regional Director.

We all agree that it is important that the work is undertaken in an open, transparent and fair manner and that conclusions and recommendations are based on the widest possible evidence. The timescale for the project is short, with a final report expected at the Regional Committee meeting in September 2002, so it will not be possible to include visits to all countries. The evaluators have therefore decided to ask all countries to complete a questionnaire about experience of WHO support for health care reforms, a copy of which is enclosed with this letter.

I should be grateful if you would arrange for this questionnaire to be completed as soon as possible and returned to the evaluators as indicated on the form. All responses will be confidential to the evaluators and will not be seen by me or by anyone in the WHO office. Comments and opinions from individual countries will not be identifiable in any reports.

Please ensure that replies are sent by April 30th. at the latest. We hope for a high response rate to this request, to ensure that the evaluation is comprehensive and provides a sound basis for the Standing Committee's discussion of future policy on the Region's approach to health care reform.

Thank you very much for your assistance.

Yours sincerely,

Dr. J. Kiely
Chairman, Standing Committee of Regional Committee, WHO European Region.
World Health Organization
European Regional Office

EXTERNAL EVALUATION OF THE HEALTH CARE REFORM PROGRAMME

QUESTIONNAIRE TO ALL MEMBER STATES

TO THE MINISTER OF HEALTH

This questionnaire is being sent to the Ministers of Health in all Member States of the European Region of the World Health Organization. It forms a part of the external evaluation of the WHO European Region health care reform programme that is being undertaken at the request of the Standing Committee of the Regional Committee. The information obtained from this questionnaire will be supplemented by visits to eight countries in the Region. The evaluators would be very grateful if you would arrange for this questionnaire to be completed as fully as possible to enable us to form a comprehensive picture of WHO's contributions to health care reforms across Europe.

The replies to this questionnaire will be completely confidential to the evaluators. WHO staff will not have access to them and the evaluators' report will not identify comments or opinions of individual countries.

Where it is possible, we should be grateful if you would send your response electronically to one of the evaluators. If this is not possible, please send the response by post to

Ms. Angela Bartley
Department of Public Health
Camden and Islington Health Authority
Insull Wing
110 Hampstead Road
London NW1 2LJ
United Kingdom

It would also help us a great deal if the reply could be in the language of one of the evaluators. If this is not possible, please reply in one of the WHO official languages and we will arrange translation.

Will you please reply within two weeks if possible, and **no later than April 30th. 2002**

Thank you very much for your assistance with this evaluation. We hope that the findings will be useful for both the WHO office and all the Member States.

Dr. Ozen Asut asut@ato.org.tr (Turkish)
Dr. June Crown junecrown@aol.com (English)
Dr. Dana Farcasanu dfarcasanu@dnt.ro (Romanian)
Dr. Jose-Manuel Freire jm_freire@terra.es (Spanish)

COUNTRY	**INSTITUTION/ DEPARTMENT**		
CONTACT PERSON		**DATE**	

1. **Describe the most important health care reforms in the country since 1990. Please provide examples and references.**

   - Reforms enacted in national legislation,
   - Reforms involving financing of services, insurance including details of population covered by the changes.
   - Public Health Services (health protection and disease prevention)
   - Personal Health Services (Primary Health Care, Hospital, Dental, etc.)

- Medicines / Pharmaceuticals
- The education and training of health professionals
- Patients' rights and choice
- Management and organization of services
- Other

2. What support has your country received from the WHO European Office in the last two years (1999-2001)?

- Financial (please state amount)
- WHO staff based in country (please state number and duration of appointment(s))
- Direct support from the WHO European Office (please describe)
- In-country workshops or other events. (please state number and type of events)
- Participation in workshops or other events outside your country (please state number of events, number of participants from your country and type of events)
- Membership of WHO networks
- Technical support provided by WHO European office: tools, standards, guidelines, evidence, etc. (please list)
- Assistance with information systems (please describe)
- Other

3. What has been the influence of the WHO European Office in the development of the country Health Care Policy and reforms?
Please provide at least one <u>concrete example</u> of its influence or support in areas such as:

- Principles and values underlying reforms
- Reforms geared towards the health needs of the population
- Public involvement and choice
- Quality of care
- Financing principles
- Development of Primary Health Care
- Health care management
- Education and training of health professionals
- Pharmaceutical policy
- Other

4. To what extent have health care reforms increased insurance coverage and equity of access? Please provide concrete examples.

5. **To what extent have the WHO European Office programmes and activities met the needs of your country in relation to health care policy and reforms?**

6. **To what extent has the Ljubljana Charter influenced the reforms or health policy in your country?**

7. **Have you used materials produced by WHO Observatory on Health Care Systems?**

8. **What do you consider the most valuable contributions of the WHO European Office to health care policy? Please list the three most important/useful to you.**

9. **What do you consider the most valuable publications from the WHO European Office? Please list the three most important/useful to you.**

10. **There are a number of international agencies (European Union, World Bank, bilateral aid, etc.) active in the field of health care policy and reforms. What do you think is the specific contribution of the WHO European Office?**

11. **What do you think SHOULD be the role of the WHO European Office in relation with health care policy and reforms? Please provide a detailed list.**

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE

February 23rd. 2002

Appendix 3

Reports to the Standing Committee of the Regional Committee

1. Report dated November 27th. 2001

EXTERNAL EVALUATION OF THE HEALTH CARE REFORM PROGRAMME

Report by the External Evaluators to the SCRC

BACKGROUND

We were invited by the Regional Director to undertake this external evaluation following the meeting of the SCRC of 9 of September 2001, following the request of the previous Regional Committee. We have been given copies of the reports submitted to the SCRC meetings of April and May of 2001 and of the minutes of those meetings.

On November 26th. and 27th, we attended a briefing meeting at the Regional Office where we had the opportunity to discuss the evaluation with staff of the Regional Office, who provided us with comprehensive documentation, including reports of previous external evaluations, among them that of the EUROHEALTH programme.

PROBLEMS AND CHALLENGES OF THIS EVALUATION

The evaluation team has not been presented by the SCRC with clear terms of reference to define the scope and purpose of the evaluation. We found from our discussions that opinions in the Office were mixed about the timeliness of this evaluation. This relates to the fact that many components of the WHO health care reform activities no longer exist in their original form, and the new organization structure of the Office meets some of the suggestions arising from previous evaluations. Also many of the people concerned both in the Office and in relevant countries are no longer in their former posts.

The evaluation team is therefore concerned about the appropriateness and usefulness of this evaluation at this stage. Nevertheless it thinks that it is possible to analyse the experience of past programmes to assist in improving the design and implementation of future Office activities in health care. We consider this important because previous evaluations of the EUROHEALTH programme have identified healthcare reforms as an important area and health systems have become a priority in the WHO global agenda.

In order to take forward the evaluation, the team needs the SCRC approval of the terms of reference and its endorsement of the proposed outlined methodology.

SUGGESTIONS AS TO THE SCOPE AND PURPOSE OF THIS EVALUATION

In the absence of explicit terms of reference the external evaluation team has taken the minutes of the SCRC meetings of April and May 2001 and the two reports submitted to these meetings in relation with this external evaluation as the starting points for the following suggestions. The Ljubljana Charter which

was endorsed by the ministers of health of all member states as a framework for heath care reform was considered the reference for this evaluation.

Aware of the problems surrounding the definition of health care reform, the external evaluation team suggests the following operational definition:

> "planned changes to the arrangements for insurance, finance, organization and delivery of health care".

The criteria for assessing a health care reform will be based on the principles of Ljubljana Charter.

SUGGESTED TERMS OF REFERENCE

In the light of all this, the main purpose of the evaluation will be to assess the extent to which WHO Office has influenced governments to incorporate in their health care reform programmes the principles enshrined in the Ljubljana Charter.

To achieve this evaluation objective it will be necessary:
- to devise a system for the selection of the most relevant programmes, activities and countries for detailed study
- to agree on a methodology
- to have the support required from WHO Office
- to have clear guidance from the SCRC about the time period of work to be included in the evaluation.

As requested, the evaluation team intends, as products:
- to provide an interim report for the SCRC meeting of April 2002
- to present the final report at the meeting of the SCRC in September 2002

OUTLINE OF METHODOLOGY

1. Design of a questionnaire on the perception of the WHO Office role and effectiveness in relation to the purpose of this evaluation
2. Survey of member state health ministries and several key independent experts
3. Discussions with key current and former WHO staff
4. Visits to selected countries by members of the team (usually by two members), following semi - structured interview schedule

TIME TABLE OF THE EVALUATION TEAM WORK

Subject to SCRC approval, the evaluation team intends to:

- Meet in January to refine the methodology (questionnaire design, interview framework, selection of programmes, activities, countries, etc.)
- Jan-March 2002 country visits, interviews and preparation of the interim report
- April-September completion of visits and interviews and preparation of final report

SUPPORT REQUIRED FROM WHO OFFICE

- Administrative, financial and logistical support
- Access to relevant information and documentation
- Identify a contact person in the Office
- Prepare analysis of information as required by the evaluation team

INVITATION TO THE SCRC

The SCRS is invited to:

1. Approve the draft of terms of reference
2. Comment on the outlined methodology
3. Approve support from WHO Office

The external evaluation team:

Dr Ozen Asut
Dr June Crown
Dr Dana Farcasanu
Dr Jose-Manuel Freire

Copenhagen, November 27, 2001

2. Report dated March 2002

REPORT FROM EXTERNAL EVALUATORS OF WHO EUROPEAN REGION HEALTH CARE REFORM PROGRAMMES TO

STANDING COMMITTEE OF THE REGIONAL COMMITTEE

1. This is a report on progress since the submission of our first report to the Standing Committee. The external evaluators are grateful to the members of the Standing Committee for their approval of the proposed terms of reference and for their support of the intended approach to the work.

2. The group met in Copenhagen on January 14th. and 15th. We are grateful to the WHO Euro office staff who arranged our visit and provided a wide range of documents to assist our work, and to those staff who gave time to talk to us about the project.

3. We agreed that the main focus of our enquiries will be the added value of WHO in country health care reforms, the extent to which they improve equity and access, and the extent to which they have been incorporated into legislation.

A great deal of information will be obtained from the examination of existing documents and reports on WHO projects and on individual countries. This will be supplemented by a series of country visits.

4. During the course of our meeting we agreed the criteria for selection of countries to visit. These are:

- Level of resources related to health care reforms allocated to country
- Geographic criteria
- Size of country

Using these criteria, with the information available to us, we propose to visit the following countries:

Albania
Bulgaria
Estonia
Kyrgyzstan
Kazakhstan
Poland
Russian Federation
Ukraine

Two evaluators will visit each country.

In each country we hope to meet the Minister of Health, officials in the Department of Health, a senior public health professional, a representative of the health insurance or equivalent organization, a representative of a major donor agency and other key individuals.

Staff at WHO Euro are at present making arrangements for these visits. We hope it will be possible to begin the visits in March and complete them in June.

5. The group also met in February in Dublin and had the opportunity to discuss the evaluation with the Chairman of the Standing Committee and the Regional Director. This was extremely useful in clarifying various issues, identifying information and other requirements, and agreeing timetables. It also revealed the need for precise definitions and terminology to ensure common understanding of our report and findings.

6.	During this meeting we completed preparation of a questionnaire for distribution to all countries in the European Region. We propose that the questionnaire is sent out by the WHO Office with a covering letter from the Chairman of the Standing Committee. Responses will be returned direct to one of the evaluators, to maintain confidentiality. We also agreed an interview schedule to ensure consistency in the country visits.

7.	The group wishes to form its conclusions on as broad an evidence base as possible. It has therefore decided to consult a group of experts in the field of health care reform. They will be sent the terms of reference of the project and invited to submit comments and observations from their own experience and research.

8.	Ms. Angela Bartley has been appointed as a part time professional assistant to the group. She is a public health specialist working in the United Kingdom National Health Service. We are grateful to Ms. Bartley for volunteering to help us and to her employers for facilitating her involvement.

9.	The group intends to meet in Copenhagen when the country visits are complete to finish drafting the final report. This will provide an opportunity to meet the Regional Director again to discuss emerging findings, conclusions and recommendations.

Dr. Ozen Asut
Dr. June Crown
Dr. Dana Farcasanu
Dr. Jose-Manuel Freire

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