

HEALTH SYSTEMS CONFRONT POVERTY

Edited by:

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Public Health

Case Studies,

No. 1

HEALTH SYSTEMS CONFRONT POVERTY



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HEALTH SYSTEMS
CONFRONT POVERTY

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The WHO European Office for Investment for Health and Development, which coordinated the activities leading to this publication, was set up by the WHO Regional Office for Europe, with cooperation and support from the Ministry of Health and the Veneto Region of Italy. One of its key responsibilities is to provide evidence on and act upon the social and economic determinants of health. The Office systematically reviews what is involved in drawing together the concepts, scientific evidence, technology and policy action necessary to achieve effective investment for the promotion of health and synergy between social, economic and health development. The Office fulfils two interrelated main functions:

- to monitor, review and systematize the policy implications of the social and economic determinants of population health; and
- to provide services to help Member States in the WHO European Region increase their capacity to invest in health by addressing these policy implications and integrating them into the agenda for development.

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Contents

<i>Foreword</i>	<i>vii</i>
Acknowledgements	ix
Photograph credits	xi
Introduction	1
Poverty and health: an overview of selected case studies in WHO European Member States	5
Poverty and health case studies: an analytical framework.....	13
Case study 1	19
Case study 2	31
Case study 3	45
Case study 4	57
Case study 5	69
Case study 6	79
Case study 7	93
Case study 8	107
Case study 9	121
Case study 10	131

Case study 11	141
Case study 12	149
Conclusions	161
Annex 1. Template for writers	165
Annex 2. List of invited experts	169
Annex 3. Template for group discussions	175

Foreword

At its fifty-first session, held in Madrid, Spain, in September 2001, the WHO Regional Committee for Europe recognized that, in view of the overwhelming evidence of the link between poverty and health, health systems have a responsibility to contribute to efforts to reduce poverty. The Regional Committee decided to take up this challenge by adopting a resolution in which, as Regional Director, I was asked to initiate a systematic process for gathering, analysing and disseminating information on direct action taken by health care systems in the European Member States, with the explicit aim of reducing the effects of poverty on health.

The magnitude of the problem of poverty in the European Region today is beyond dispute: gross inequities in health and wellbeing persist in all our countries and, in many, the gap between rich and poor is widening still further. The problem is complex and daunting, but nevertheless much has been, and is being, done by health care systems across the Region to tackle the issues involved. To date, however, these efforts have been sporadic, and even where results have been encouraging they have received little visibility.

In order to implement the Regional Committee's resolution on poverty and health, the WHO Regional Office for Europe decided to adopt an innovative approach by giving priority, in this first phase of collecting information, to initiatives already undertaken by health systems in a sample of Member States. Responsibility for this task was assigned to the new WHO European Office for Investment for Health and Development, in Venice.

This report is the fruit of our efforts in this new area over the past year, and it documents WHO's preliminary findings on how health systems can have a positive impact on alleviating poverty. The analysis of the case studies documented leads to three main conclusions: (a) that health systems can indeed take effective action to improve the health of the poor; (b) that in some cases health systems can actually represent an additional barrier for the poor; and (c) that there is an urgent need for more knowledge, training and capacity building in this area.

Health systems confront poverty

In the spirit of solidarity expressed in the Regional Committee's resolution, it is now my sincere hope that the Regional Office, in collaboration with Member States, can build on this initial experience and proceed to the next phase of its work: to tackle poverty through the direct intervention of health care systems. We need to expand our collection of data and case studies to include all our Member States. We need to set up a database through which these experiences and analyses can be made available to all for suggestions, discussion, inspiration and action. We need to transform our new knowledge into training materials to increase the know-how and confidence of health professionals in all our Member States, so that we can address the issue of poverty.

The path to equitable development is a long one, but I am convinced that we have taken an important step in the right direction. Alongside ongoing work at WHO headquarters, we are also playing our part in fulfilling the goals of the Millennium Declaration endorsed by the world community. I see our work in the area of poverty and health as a key to making the right to health a reality for every one of the people living in the European Region today.

Marc Danzon
WHO Regional Director for Europe

Acknowledgements

This publication was undertaken by the WHO European Office for Investment for Health and Development, Venice, Italy, and it is the result of the contribution of many experts and professionals from a wide range of disciplines. We editors and the WHO Regional Office for Europe are indebted to all of them for their interest and dedication, so essential for completing this work within just over six months.

We should also like to acknowledge that the work presented here benefited a great deal from the interest in the issue of poverty and health expressed by the Member States of the WHO European Region. We are thankful to the WHO Regional Committee for Europe for its support and for providing the impetus for this work.

We thank the writers of the cases studies for their hard work, and are grateful to a large number of people in Croatia, France, Germany, Hungary, Italy, Kyrgyzstan, Poland, the Republic of Moldova, the Russian Federation and the United Kingdom who were interviewed or provided support to the writers in the field. In addition, we consulted or received advice from a number of colleagues from other countries. An exhaustive list of names cannot be included here but we appreciate the support received from: Hrair Aslanian, Juliette Bloch, Michael Debrus, Teresa Edmans, Jane Falkingham, Alexander Gavrilov, Igor Glasunov, Jette Grønholt, Iwona Iwanicka, Stephen Jacobs, Bernard Kaic, Antoinette Kaic-Rak, Mauno Konttinen, Piret Laur, Alina Lubinska, Pat Mason, Andrei Mochniaga, Oleg Moldakov, Oscon Moldokulov, Eliane Pihl Kristensen, M. Popovich, Nezahat Ruzdic, Tobias Schüth, Gillian Seabright, Carole Sharrock, Zofia Slonska, David Stout, Diliara Sunyakova, Marianne Szatmari, Vappu Taipale, Gerhard Trabert, Jane Woolley and Andrzej Zbonikowski. The WHO liaison officers and the team of the WHO Special Representative of the Director-General in the Russian Federation, including staff from the Tuberculosis Demonstration Project in that country, deserve special mention.

Health systems confront poverty

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Finally, special thanks go to the Italian Ministry of Health and the Veneto Region. The establishment of the WHO European Office for Investment for Health and Development is the result of cooperation between the Italian Ministry of Health, the Veneto Region and the WHO Regional Office for Europe. This publication is one of its first tangible results.

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Photograph credits

Photograph editor

Steve Turner

Case study 1

“Roma village when the initiative first started, in 1997” and “1997 – UNICEF food parcel and the immunization information brochure”:
County of Međimurje Social and Health Department

Other photographs: Jelena Sedlak

Case study 2

Caisse primaire d'assurance maladie de la Seine-Saint-Denis

Case study 3

Sigrún Davídsdóttir

Case study 4

Katalin Zoldhegyi

Case study 5

Department of Preventive Medicine for Migration, Tourism and Tropical Dermatology, San Gallicano Institute for Hospitalization and Cure with a Scientific Approach, Rome

Case study 6

Anes Alic

Case study 7

“Dr Michał Kowalski, Director of Palma”, “Dr Pashinska and Jerzy Czapla” and “Sławomir recalls his experience of homelessness”: Palma Marketing Department

Other photographs: Steve Turner

Case study 8

Anes Alic

Case study 9

Susan Poizner

Case study 10

“Alla Sokol, founder of St Petersburg Urban Gardening Club”, “Nataliya has leafy green house plants on every window sill”, “Nutrient-rich compost is produced in the basement” (close-up of worms) and “Alla shows Nataliya how to grow bean sprouts”: Susan Poizner

“Nutrient-rich compost is produced in the basement” (long shot of three people and bins), “The roof garden is designed to be self-financing” and “Alexander Gavrilov (right) shows the Kresty inmates how to garden”: Urban Gardening Club, St Petersburg

Case study 11

Sigrún Davídsdóttir

Case study 12

Sigrún Davídsdóttir

Introduction

This publication describes a sample of wide-ranging experiences, collected over a period of two months, of how health care systems¹ are addressing issues of poverty and health in Europe. It acknowledges that poverty in Europe is multidimensional and is linked not only to material deprivation but also to low educational achievement, poor health, vulnerability and exposure to environmental and occupational risks, as well as voicelessness and powerlessness. Furthermore, it recognizes that poverty deprives individuals of the freedom to satisfy basic needs and rights. This might include freedom to achieve sufficient nutrition (food security), to obtain remedies for treatable illnesses, or to enjoy clean water or sanitary facilities. This lack of freedom prevents individuals from fulfilling their potential, thus leading to a great loss for society and hampering development.² Poverty might also be the source of stigmatization within subgroups of our societies, within national borders and among countries – both rich and poor. Finally, this publication confirms that the impact of poverty might be unequally distributed among the poor and that it can have different impacts according, for example, to gender and age group.³

Many of these several dimensions of poverty are evident from the case studies presented here. This is due in part to an explicit effort to collect varied experiences.

¹ This publication defines a health system as one that includes all the activities whose primary purpose is to promote, restore or maintain health. This includes, for example, the delivery of personal medical attention; traditional public health activities, such as promoting health and preventing disease; and interventions in other sectors that are intended chiefly to improve health, such as health-related education (*The world health report 2000 – Health systems: improving performance*. Geneva, World Health Organization, 2000). Despite the wider definition, most of the experiences reported here focus on the provision of, and investment in, health care services – that is, the health care system.

² SEN, A. *Development as freedom*. New York, Oxford University Press, 2000.

³ *Poverty and health: evidence and action in WHO's European Region*. Copenhagen, WHO Regional Office for Europe, 2001 (document EUR/RC51/8).

Health systems confront poverty

The process of data collection that led to the case studies started with a request to all Member States of the WHO European Region, through their health ministries or equivalent bodies, to propose evidence-based examples of health care systems that had been influential in tackling poverty. In addition, public health experts and senior staff in the Region were invited to suggest cases that could complement the breadth of the suggestions proposed by the Member States.

Notwithstanding the positive feedback received, a short deadline for replies meant that it was not possible to report on examples from all Member States: late replies had to be set aside for future consideration. Similarly, criteria were needed for selecting a manageable number of initiatives on which to report. Here, the main effort was to identify the specific aspects of poverty and ill health that can be addressed by the action of the health care system. Great importance was also attached to reported evidence on the successes achieved, the relevance of the initiative to other work to alleviate or reduce poverty, the potential for the initiative to be replicated elsewhere, the geographical distribution of cases across the Region, the relative “weight” of the lessons learned, and the innovative aspect of the initiative relative to the pool of suggestions received. Furthermore, efforts were made to include initiatives taken at different levels: national, regional and local community.

The process resulted in the selection of a series of 12 case studies from 10 countries. A core team of professional writers with experience in journalism and health issues was commissioned to write the case studies. Each writer was assigned a small number of case studies and spent (depending on local circumstances) 3–4 days in the field, examining existing practices, interviewing key stakeholders, taking pictures and reviewing the existing literature. The mission was simple but challenging: to report on concrete experiences without forgetting that behind the figures and statistics lie fellow human beings who are suffering and, in many cases, are unnecessarily out of work, unhealthy and, as a result, at the margins of society. Being able to speak the national language of the countries visited, the writers were invited to talk not only to those in charge of the initiatives but also to the poor people – the people who are the real witnesses and beneficiaries of the initiatives. Their candid testimony was included in this report, presented in a common framework (Annex 1) but through the different styles chosen by the writers.

Introduction

The work, however, did not finish with the writers. WHO's mandate is to verify the evidence and to support its Member States in using that evidence to improve the state of health of their populations. Hence, in order to critically review the case studies and the process chosen for gathering evidence, a team of over 30 outside experts on public health, health care systems, economics and development studies, as well as experienced senior government officials and experts from international, governmental and nongovernmental organizations, was invited to take part in group discussions organized with the support of the Academy of Public Health in Düsseldorf, Germany (Annex 2). Fully briefed about all case studies and in possession of preliminary drafts, the participants in the technical discussions were also invited to provide input to the development of conclusions and recommendations on the potential for extending, improving and replicating the selected experiences on poverty and health in other contexts. The main conclusions from the interactive discussions are reported elsewhere in this book, and follow a framework of analysis (Annex 3) that started to take shape in Düsseldorf in April 2002.

The reader should not be surprised to find certain biases in the sample of experiences selected for this publication: overall, there is an emphasis on community-based initiatives, the urban poor, the homeless and the unemployed. Such a concentration, although unintentional, is symptomatic of commonly held perceptions about poverty, its definition, who experiences it and how it can be tackled. It indicates that there is still a great deal of work to be done on exposing poverty's many dimensions and on the interventions that can be successful in dealing with them.

Most important, however, are the stories in the following pages showing that it is possible to help reverse the impact of poverty on health, often without the need to deeply reform current practices or develop complex scientific models. Indeed, several of the initiatives presented here are not necessarily innovative and by no means represent "best practice" in each country or on the subject they address. They have, nevertheless, been shown to work in their particular contexts.

Recognizing that practices, social values and aspirations, as well as legislation, vary from country to country – and sometimes also within countries – makes it very difficult to recommend Europe-wide policies and measures to tackle the links between poverty and ill health. There is,

Health systems confront poverty

however, increased interest and capacity in the Regional Office to share frameworks for effective policy formulation, proposals of principles to be followed and information about what works. This publication makes a contribution in this direction.

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Poverty and health: an overview of selected case studies in WHO European Member States

The case studies included here are certainly not representative of all the different areas where health care systems can have a positive impact on poverty, but they do constitute relevant examples of actions targeted at real problems. Most importantly, they show concrete examples of specific strategies to overcome them.

In Medimurje County in **Croatia** the Roma (gypsy) community had to be persuaded, contrary to its traditional view, to participate in a vaccination programme. The staff of the local medical team visited village communities and, with the help of village leaders, learned a sufficient Romany vocabulary to communicate with the Roma people in their own language. This became known as the “Communication Initiative”, even though the effort involved more than just using language as a bridge. With increased communication, trust in the programme increased. As a result, levels of immunization in Medimurje County have been reported to be higher than the national average. The newer generation in the Roma community is becoming convinced of the necessity to comply with the full national vaccination programme, including emergency vaccination, regular vaccination and other preventive health care initiatives.

In **France**, universal health insurance (*couverture maladie universelle*, CMU) was introduced in early 2000. It provides benefits in three ways. First, all people properly resident in France who do not contribute through their employment and who are not beneficiaries will automatically be affiliated with the social security system. Second, people below a certain income ceiling can obtain supplementary insurance free of charge to cover some costs. Third, people in France whose status is unclear but whose income is lower than the ceiling for CMU can obtain free access to hospital treatment,

Health systems confront poverty

and those who have been in France for three years can obtain free access to general practitioner care. An essential part of CMU is that it does away with advance payments, by paying doctors or hospitals directly from the insurance funds and supplementary insurance bodies. The country's universal health insurance covers most of the health expenses of 4.7 million French people. While its introduction was a culture shock for the organizations responsible for implementing it, CMU is now regarded by many as being "successful" in offering the poorest groups in society easy access to health care.

In the affluent city of Mainz in **Germany**, the homeless are generally in worse health than the average citizen. An independent study suggested that, compared with the general population, the homeless generally made less use of preventive medical examinations, health promotion activities and medical care. The study found that the homeless have strong feelings of shame and fear associated with attending health centres, that they mistrust medical personnel, and that many of them do not perceive a need for pursuing health promotion and disease prevention. Recognizing the specific circumstances and needs of the homeless, an initiative called the "Mainz Model" attempts to address some of these difficulties by adopting a low-profile, interdisciplinary approach to providing health care for the homeless – wherever they are. As a result of the actions taken, the initiative has been publicly acclaimed for highlighting the problem of homelessness and the problems experienced by the homeless. The Mainz Model has increased public acceptance that such problems exist in Germany and that they need to be tackled. The initiative actively engaged a greater part of society in addressing poverty and health, and it has stimulated different types of social networks and re-socialization processes in Germany.

In **Hungary**, patients with tuberculosis have to attend tuberculosis dispensaries. In practice, however, medical personnel in many hospitals refuse to treat homeless patients, who are often drunk and poorly dressed. In the 1980s, a special tuberculosis department was established at Korányi Hospital in Budapest. Considering homelessness and multiple illness as a common background for many tuberculosis patients, the department developed a treatment programme that took into account the social and economic problems of the homeless patients as part of the overall tuberculosis treatment. Medical personnel had to learn new skills to deal with traditionally marginalized people, and a three-pronged programme was

An overview of selected case studies in WHO European Member States

developed: alcohol rehabilitation, tuberculosis treatment and an employment and housing plan, financed by a special fund established by the hospital and the local church. The relapse rate among former patients of this special unit is claimed to be around 17%, compared with nearly 100% for those who return to the streets without taking part in the programme.

In **Italy**, in view of the importance of the immigration phenomenon, a Department of Preventive Medicine for Migration, Tourism and Tropical Dermatology (DPMM) was opened at San Gallicano Institute, Rome, in 1985. The Department provides services for all Italians and foreigners present in Italy. The services focus particularly on immigrants (regular, illegal and clandestine), the homeless, travellers and those without the proper documents needed to gain access to the national health insurance system. Since 1996, a group of linguistic-cultural mediators has helped foreign patients, by explaining the services available to them in their own language. The mediators also explain the particular cultural and religious needs of the patient to other health professionals in secondary and tertiary care institutions. In addition, the Department has become an “observatory” for studying and monitoring the health conditions and health hazards of this particular segment of the Rome population. It collects relevant data, providing interested parties with statistical information on the state of health of these patients. The Department’s preventive and screening activities have led to the detection of diseases in the initial phase, thus limiting and controlling their progression to a more severe clinical stage and the resulting need for hospital admission. The work of the Department is also believed to have influenced the development of modern legislation for the care of immigrants. The legislation gives all foreign citizens, regularly or irregularly present in Italy, access to the National Health Service.

In **Kyrgyzstan**, since 1991, state health institutions have charged fees for health services and the maintenance services related to health care. Evidence showed that additional, illegal and informal payments made by patients far outweighed the legal user fees.⁴ This has placed health care beyond the reach of many people, and for those able to afford some health treatment the full costs are unknown until after the treatment is complete. Recent reforms in Kyrgyzstan attempt to address these prohibitive illegal payments and to

⁴ KUTZIN, J. ET AL. Addressing informal payments in Kyrgyz hospitals: a preliminary assessment. *Eurohealth*, 7(3): 90–96 (2001).

Health systems confront poverty

provide a system of entitlement for those who cannot pay at all. One national initiative is the co-payment policy. It is aimed at establishing the cost of medical treatment before delivery, maintaining an affordable level of cost for most of the population, and providing free health care to the seriously impoverished community through a “reserve” fund. From revenues collected under this system, predictable by both the health ministry and the patient, a proportion is allocated to pay for treatment needed by those unable to pay anything. The policy was introduced in two *oblasts* (regions) in March 2001 and covers approximately 25% of the population. Results of surveys carried out after the first phase of implementation showed a reduction in informal payments to medical staff and suppliers, thus generating an additional source of income for hospitals. Recent evidence also suggests that poorer people have benefited from the policy through access to health care previously beyond their means. Progress is being carefully monitored, as the experience is being scaled up nationally.

By law in **Poland**, every person has the right to emergency medical care, regardless of his or her legal status. Primary health care, however, is not available for those in the marginal or minority sections of society who are not registered under the various categories of eligibility. As a result, when these people fall ill they remain without treatment until their condition becomes chronic, or an “emergency”. At this point, treatment may come too late or be very costly, or these people may have spread infections to others. To address this issue, a special programme was started in Poland’s second largest city, Łódź, in June 2000. It provides primary health care to all residents in selected homeless shelters, regardless of their status. Currently, two shelters are involved in this scheme, and each has consulting rooms for doctors and isolation rooms for the sick. Many people have been treated under this scheme, which has been reported to have reduced the need for inpatient treatment and has also enabled former homeless people to take up full-time employment.

Less than 10 years ago, patients with sexually transmitted diseases in the **Republic of Moldova** were forced to be registered and to carry a certificate to that effect. The registration meant that patients were not allowed to apply for jobs or travel freely in the country. Investigators searched for the partners of infected people and, if necessary, registered them too. Household incomes could be severely affected by forced hospital treatment of a breadwinner. In recent years, by removing past intimidation tactics and

An overview of selected case studies in WHO European Member States

replacing them with a system that offers confidentiality and anonymity, the government is seeking to motivate people to seek treatment themselves, without the use of force. The change from hospital treatment to outpatient care has been initiated to reduce the financial burden on the health care system and the patient. New drugs and a shift from laboratory diagnosis to syndromic case management promise to lessen the period of non-treatment, and patients are offered services free of charge. Ambitious steps – though latent and just beginning – are being taken in the area of prevention, focusing on educating the public about the causes and consequences of sexually transmitted diseases and about the urgency of screening. New methodologies are being developed: attitudinal research is contributing to education programmes, partnerships with nongovernmental organizations are helping the implementation of information programmes and expensive inpatient care is being replaced by more affordable and less disruptive outpatient treatment. In 2001, under a new system, 470 000 people across the country were screened free of charge for sexually transmitted diseases, of which 50% of syphilis patients and 40% of gonorrhoea patients received anonymous treatment. Today, all hospitals and clinics aim at beginning treatment of infected persons within 24 hours of screening – an important accomplishment that has helped to reduce the period of non-treatment and lessen the further spread of disease.

In **Orel oblast, Russian Federation**, reported cases of tuberculosis increased from 41.4 per 100 000 in 1990 to 71.2 per 100 000 in 1999. In addition, the default rate during drug therapy was as high as 30% in some regions, adding to the problem by facilitating the development of drug-resistant strains. In 1999, the Orel *oblast* health authorities, recognizing that the poor were the most likely to contract tuberculosis, looked at the economic and social issues surrounding tuberculosis, at the issues contributing to the increase in cases, and at ways of improving the efficacy of treatment. A programme was established to relieve some of the problems that have a direct effect on the incidence of tuberculosis – problems that reduce immunity, that increase the incidence of the disease and that decrease the ability to respond to treatment. The programme uses the directly observed treatment, short-course (DOTS) strategy as a basis for treatment. Thus, daily or weekly food packages are distributed to patients every time they come to the clinic to take their medication. Not only does this encourage people to continue their treatment until it is completed, but also helps ensure that even the poorest sufferers will not go hungry. The success rate of

Health systems confront poverty

the overall scheme is encouraging: the default rate in Orel *oblast* was reported to be approximately 3%. A high-level working group that includes senior officials from the Ministry of Health, the Ministry of Justice and the Academy of Medical Sciences is considering adopting the project at federal level.

The case study from **St Petersburg, Russian Federation**, deals with vulnerable urban groups who may lack basic healthy food, which in turn can lead to low birth weight, stunted growth and long-term risks of chronic and infectious diseases. The St Petersburg Urban Gardening Club (UGC), which was officially registered in 1992 as a nongovernmental organization, works towards increasing the local production of vegetables. The UGC uses improved methods of cultivation and selected varieties of vegetables that can be grown on rooftops and in other confined urban areas, including residential buildings, schools, hospitals and institutions. It also provides advice and information to those interested in growing vegetables. Although the work is done on a small scale, fresh vegetables are being distributed to the poorer parts of the community, on a barter basis where necessary, and local people are being informed about uncommon but nutritious vegetables. The UGC has also started discussions with the local research institute about the possibility of growing bean sprouts on a larger scale, since they have a wide selection of nutrients. Beyond the local community, with the help of the UGC, projects have been established at the Rubin shipbuilding enterprise, at Secondary School Number 42 and at Kresty Prison, home to 10 000 inmates.

The northern coastal town of **Blackpool**, in the **United Kingdom**, is one of the most deprived areas in England. Poverty, homelessness, indebtedness and rapid social change cause stress and anxiety among many of the residents. They look to their general practitioners (GPs) for a cure for their anxiety, tension, sleeplessness, high blood pressure, depression and other ailments, which are frequently caused not by physical ailments but by a rapid decline in living standards. Following discussions with GPs, the local Citizens Advice Bureau (CAB) was invited to provide its services within the acceptable environment of GPs' surgeries. CAB provided much needed expert advice in a setting that overcame the resistance that previously had prevented patients from seeking help. Direct referral within the practice setting improved access for many deprived and socially excluded individuals: many users of CAB services in GP surgeries were reported to

An overview of selected case studies in WHO European Member States

have been previously unable or unwilling to use similar advice services. The experience has been reported to be of value to primary health care workers, who no longer have to deal with non-medical issues and can now concentrate on what they do best. Furthermore, besides making more time available for the GPs and nurses, authorities suggest that the cooperation with CAB has had a preventive effect in the local community.

Also in the **United Kingdom**, in the London borough of **Newham**, the “Fit for Work” project benefits from the National Health Service being one of the largest local employers, contributing directly to the local economy and economic health of the community it serves. The project is anchored in the regeneration of the area, thus linking health institutions and other organizations that deal with health. The linking of unrelated institutions has demanded that health aspects be “translated” into a language that is understood by many different disciplines and professions. Local health providers work closely with the government employment services and local businesses to provide training for local long-term unemployed people. People from vulnerable groups have found employment in the health service and other businesses.

Poverty and health case studies: an analytical framework

In the selection of this first series of case studies, the main effort was to identify which specific aspects of poverty and ill health can be directly addressed by the action of the health care system. Although no effort was made to select cases to “fit” particular frameworks, it might be helpful to cluster the experiences in order to identify similarities and “gaps” in the range of issues covered.

Initiatives that tackle the problem of affordability of essential health services

Some case studies describe actions taken to reduce or eliminate financial barriers to access to health care services. The analysis of this cluster of case studies at the group discussions held in Düsseldorf produced preliminary evidence that there are at least two main dimensions to this issue. First, poor people may not be able to afford the health care services they need when they fall ill; thus, they delay seeking care until their illness becomes more severe or chronic and, consequently, affects their livelihood. Second, they may be forced to find financial resources to either pay service fees or meet indirect costs related to service utilization (or both). In these circumstances, people may be compelled to take out loans, go into debt, sell assets or pursue other courses of action that make them either poor or more vulnerable to poverty. Hence, the costs (direct or indirect) associated with health care services may indeed push people into poverty, or deepen already existing poverty. When this happens, the health system itself becomes one of the causes of poverty. In order to tackle or avoid this problem, Member States are looking at the way in which essential health services are financed and are trying to ensure that the requirement to pay does not prevent the use of health services when needed. The analysis of the case studies in this cluster indicates that there is also a

Health systems confront poverty

need to look at how the health care system is structured and regulated, to ensure that the way the system operates is not interfering with people's jobs and livelihoods.

Two case studies illustrate interventions that address this problem. The French case study focuses on the health care system at the national level, where the costs of some services were not covered for certain vulnerable population groups, and for some services the procedure for claiming costs was so complex and/or stigmatizing that many were put off from making claims. The intervention involved changing the law and the national regulations. It should be emphasized that, although this intervention was originally triggered by concern for marginalized groups, it has also resulted in a change in policy that now benefits a much broader range of the population experiencing financial hardship.

The Kyrgyzstan case study addresses the problem of health care system financing, including payment of health professionals and patient fees – a widespread problem in many European Member States. This case study documents an attempt to lessen the problem of unpredictable costs of health care, in the form of “under the table” payments by patients, by introducing an explicit co-payment for inpatient care; this also increases the overall transparency of the system. Although the case study may still be considered an imperfect solution to the complexities of health care financing, it illustrates arrangements that tend to reduce the unpredictability of health care costs while providing extra resources for the very poor.

Initiatives that tackle the problem of a lack of cultural and/or geographical access to health services

Even when health care services are officially free, as is the case with many preventive services (such as those for controlling communicable diseases in most European countries), the services may not be provided in a form or manner that is culturally acceptable or geographically accessible to poor people in general, and marginalized groups in particular. Certain groups may be excluded from utilizing the services they need to prevent sickness and promote health and, over time, their health suffers, pushing them further into a cycle of ill health and poverty. According to the analysis of the case studies in this cluster, interventions to address this type of problem may include:

An analytical framework

- organizational adjustments that provide outreach services, by taking services to marginalized groups or hard-to-reach rural populations rather than waiting for them to come to the services, as portrayed in the German and Polish case studies;
- adapting the timing and staffing of services to fit in with religious or cultural practices, and training or employing staff with additional language and cultural–anthropological skills to overcome communication barriers, as described in the Croatian and Italian case studies; and
- professional development and equal opportunity guidance/regulations to improve the attitudes of professional staff towards poorer patients and to eliminate overt discrimination, as shown by the Hungarian case study.

Initiatives that tackle more directly the problem of poverty and the wider determinants of health

“Disease weighs heavily on economic development. ... But economic development requires more than just healthy individuals. ... Economic development is a multisectoral process, and the strategy for economic development must build on a broad range of social investments as well as strategies to encourage private-sector business investments.”⁵

If the conditions necessary for the fulfilment of a person’s capabilities (for example, employment, good housing and security) are not available, the health care system may cure patients only to have them return sick once again. But can health care systems contribute to economic development in its broader sense?

At first glance, it may seem to people working in the health care system that providing more financial resources for poor people or helping to find them jobs to increase their income is outside their sphere of influence. Some of the case studies collected, however, show that with creative thinking it is possible to conceive of ways in which the influence of the health care system can be important. Reducing poverty often involves linking up and forming partnerships with agencies outside the health sector.

Three case studies fall into this category. The case study “Fit for Work” in the London borough of Newham, United Kingdom is linked to a government

⁵ *Macroeconomics and health: investing in health for economic development. Report of the Commission on Macroeconomics and Health.* Geneva, World Health Organization, 2001.

Health systems confront poverty

policy initiative to reduce inequalities in health. Many local health authorities in the United Kingdom are realizing that, in deprived areas, the local National Health Service (NHS) is both a major employer and a major purchaser of goods and services. Local health agencies such as that in Newham have been making deliberate attempts to stimulate employment and provide job opportunities within the deprived communities that they serve – for example, by setting up “back-to-work” training schemes and by encouraging local recruitment to NHS job vacancies. They have also been using their considerable purchasing power to buy goods and services from suppliers in surrounding disadvantaged areas, thus helping to stimulate the local economy.

Again in the United Kingdom, the Blackpool case study provides evidence of some advantages in delivering welfare rights advice and debt counselling sessions in a primary care setting. In the United Kingdom, millions of pounds of state social security benefits go unclaimed annually. Studies show that the reasons can be related to people perceiving the procedures for obtaining these benefits as difficult. Elderly patients, in particular, do not like to ask for what they see as “charity”, even though they are entitled to the benefits under the law. Among other things, unclaimed benefits include income support, disability and invalidity allowances, and payments for carers who look after patients at home. To help patients assess their entitlement to state benefits and help them claim what they are due, trained welfare rights workers provide sessions in health centres. They also negotiate on the patient’s behalf with various statutory agencies if the patient has run into debt (for example, with the local housing department for overdue rent). In recent years, initiatives such as that described in the Blackpool case study have helped gain hundreds of pounds per patient and often, once claimed, these benefits go on for years. These types of initiative, therefore, are a very direct way of increasing the income of poor people while helping social programmes to reach their target populations. The impact of initiatives such as that described in the Blackpool case study is often not just confined to the very poor, but may also benefit middle-income people who are chronically ill and who may lose income – and become poor – because they have to pay for transport or for help to clean their home.

“The hanging gardens of St Petersburg”, Russian Federation describes another example of directly tackling the issue of poverty and its determinants. The case study shows that civil groups can help poor

An analytical framework

communities alleviate their food shortages and malnourishment by working in partnership with statutory agencies, nongovernmental organizations and local communities to improve access to supplies of fresh fruit and vegetables. In doing so, these groups are also creating opportunities for economic activity to flourish.

Initiatives that specifically tackle some of the “diseases of poverty”

A few diseases, such as malaria, HIV/AIDS, tuberculosis and childhood diseases, are considered to be key threats to the economic growth of many countries. At the same time, a number of effective health interventions exist for such health threats.⁶

Two case studies specifically target the so-called “diseases of poverty”. In Orel *oblast*, in the Russian Federation, a partnership between the health authorities, WHO, the Russian Red Cross, the International Federation of the Red Cross and Red Crescent Societies and others is implementing a social and nutritional support network for tuberculosis sufferers. Using the directly observed treatment, short-course (DOTS) strategy as a basis for treatment, the two-pronged approach is helping to increase the efficacy of the treatment, especially in the poorest part of the community.

The case study from the Republic of Moldova concerns the regulations governing treatment of sexually transmitted diseases (compulsory inpatient treatment and associated contact-tracing procedures), which often caused patients to lose their jobs and sometimes their homes, hence pushing them deeper into poverty. The intervention involved changes to the national practices, as well as new treatment and tracing protocols.

Clearly, there are several other possibilities for grouping the case studies, and the framework presented here is only a starting point. This publication invites the reader to become engaged in the candid testimonies that follow and to be inspired by the diversity of experiences in the WHO European Region.

⁶ *Macroeconomics and health: investing in health for economic development. Report of the Commission on Macroeconomics and Health.* Geneva, World Health Organization, 2001.

Case study 1

Tackling cultural barriers to health care service delivery in Croatia

Jelena Sedlak

The Roma community

They are called “gypsy” (which means man), “Roma” or “God’s children”, and they believe in fate and have faith in a better future. They “know” that their fate is not to be poor, disadvantaged or unemployed or to have a short life. They like to say that the most beautiful of them are “the colour of chocolate”. They believe in their traditions and many of them still live like nomads, with all of the advantages and disadvantages that accompany that lifestyle. Most of their villages are still without running water, telephones, sewerage or even electricity, and all of them live on land that belongs to someone else. Besides their disadvantaged social conditions and their dreams of a better future, they also have very large families. One of their dreams is to be healthy and live a long life in a community that is less poor than that of their parents.

The Roma villages are a special target group for vaccination and revaccination when there is suspicion of infectious disease in Croatia or neighbouring countries, and the response since 1997 has been very high. In 2001, following cases of poliomyelitis in Bulgaria,⁷ revaccination reached a very high rate and included 800 Roma children.

Because poverty and health are incompatible, initiatives for preventing communicable diseases must also look at ways in which this community can find a more prosperous life.

⁷ Information provided by the Međimurje County Social and Health Department. *See also:* Imported wild poliovirus causing poliomyelitis, Bulgaria. *Weekly epidemiological record*, 76(43): 332–335 (2001).

Health systems confront poverty

The Roma village when the initiative began in 1997



Međimurje County

Međimurje County, at 730 km², is the smallest county in Croatia. It comprises 3 towns, 21 districts and 129 settlements. The first results of the census of population, households and housing units, undertaken on 31 March 2001, show that its population of 116 225 (48.8% male and 51.2% female) has an annual increase of 0.68% (birth rate 11.3%; mortality rate 10.63%).⁸ The Roma population of the county is about 4000.

A health team visited three Roma villages in Međimurje County in February 2002: Sitnice (with 340 inhabitants), Piškorovec (with 600 inhabitants) and Pribislavci (with 522 inhabitants). These 3 villages are believed to be representative of all 16 Roma villages that surround Āakovec, the main town in the county. In all three villages, half of the population is under 15 years of age.

Compared with five years ago, when they lived in severely poor conditions, Roma villagers have seen some significant changes. Now, partly owing to

⁸ National Institute of Statistics, Zagreb (<http://www.dzs.hr/statinfo/stanov.htm>, accessed May 2002).

Tackling cultural barriers in Croatia

programmes on immunization, health and disease prevention, the Roma attitude towards health and protecting their children is changing.

Changing expectations

The Roma community is beginning to seek a better overall way of life and to expect improvements in health care and good health. This attitude is visible in some of their settlements. There are no more new earth cabins in this area, which was the dominant building type only few years ago, and the new houses are being built of brick. With the reduction in travelling and the establishment of more settled communities, personal conditions have improved and people have become more integrated into society.

More than half of all Roma people in Croatia live in Međimurje County. Their ancestors first lived there in the thirteenth century, drawn by the willow trees whose wood they used in crafts and tools that they sold to support themselves and their families. Although nowadays Roma people are believed to have other occupations, in practice most of them are unemployed. For this reason they are still the poorest minority group in a country where income per person is US \$4179 per year and the rate of unemployment is estimated to be 21.1%, with 357 872 people unemployed.⁹

Among the Roma people, the unemployment rate is estimated to be around 33%, although the exact figure is not known as there is no assessment by minority or national grouping. The income of a family in the Roma community is about a third of the national average, with most of the Roma families living on social assistance.

Communication

The Roma settlements occupy government and private land, and there are many difficulties in creating an infrastructure within these settlements. The county authorities, however, presented the Croatian Government with two projects aimed at alleviating the main problems of the Roma minorities: (a) legalizing the Roma settlements; and (b) tackling the poor communication between the Roma and Croatian communities caused by the absence of a common language. A group of Roma people are being trained as teachers who could help in overcoming the language barrier.

⁹ Data for 2000 provided by the National Institute of Statistics, Zagreb.

Health systems confront poverty

*Dragutin Lesar, President of the
Međimurje County Social and
Health Department*



Instead of teaching Croatian to the Roma villagers, they will teach Romany to those in the Croatian community who have contact with them. This approach maintains the Roma people's ethnic identity and helps to preserve the communities, as well as allowing some degree of integration into Croatian society. Persuading Roma children to stay in school at least until they complete primary school, which is currently uncommon, would be a major breakthrough.

The President of the Međimurje County Social and Health

Department, Dragutin Lesar, says that language and ethnic identity are extremely important:

Some people's idols might be Janica Kostelic [a champion skier], Dražen Petrović [a basketball player] or Davor Šuker [a famous football player], but these children need their own people to show them that they can also be successful, even the best. Why don't we have 20 Roma nurses, 10 Roma policemen? Why don't we have schools in their language? ... There are 900 children in elementary school and another 1000 preparing to start elementary school, just in our area. They should learn in the Roma language. But we don't have Roma teachers. We should encourage those children to finish their schooling if we really want the problem to be solved forever.

Lesar, however, does not believe that the system of social benefits is the answer.

Economic situation

In Međimurje County, 1557 families receive financial assistance equal to the social minimum, and 53% of these are Roma families. Although they comprise only about 3.4% of the population, their high rate of

Tackling cultural barriers in Croatia

unemployment means that they receive a disproportionately larger share of the county's social care funds. Up to the end of 2001, unemployed mothers with three children or twins received assistance, and of the 580 mothers in this category approximately 300 were Roma. Roma families tend to have between four and ten children. Some 48% of families receive social care that is equivalent to the social minimum.¹⁰

An example of one of these unemployed mothers is Natalija. She is 25 years old, has five children and has no profession. Although she used to live with the father of her children, they were not married; when he died last year, she was ineligible for the pension normally available to a widow. Natalija herself is one of ten children, and she remembers that her life, with its expectation of early death, was never easy: "I didn't understand why my sisters and brothers were disappearing. We rarely went to the doctor. Maybe it was because of communicable diseases, who knows? The doctors were far away, and a child would usually die before it got there." But commenting on her own situation as a new generation parent, she adds, "All my children are vaccinated, thanks to the doctors that visit our village, especially Dr Višnja [Smilovic, one of the members of the health team that established the Communication Initiative, see below]. But the previous generations didn't care much about immunization."



Natalija, mother of five children

Her neighbour, Nedjeljko, is 29 years old, had his first child when he was 17 years old and now has 3 daughters. The law in force until early 2002 enabled them to get social help for the third and each additional child, so large families attracted financial benefits. "It was very convenient to be 'traditional'," says Lesar. Although that law does not

¹⁰ Centre for Social Care of Međimurje County Council.

*Nedjeljko with his
three daughters*



exist any more, there are still large families and the main task is to keep them healthy.

Nedjeljko says that it is now possible: “My eldest daughter gets the vaccines in her school.” He adds, “The small ones are vaccinated here in the village, and it is a great help that the doctors come here. We don’t have a car and the clinic is more than 10 kilometres away.”

Commenting on his own experiences when young, he says, “I don’t remember that my parents knew of the importance of vaccination. On the contrary, they thought it was bad for us – the children. They still think there is no point in vaccinating children.”

Overcoming old attitudes

When the Communication Initiative started, the attitudes of the older generation still prevailed and the influence of traditional behaviour continued to be strong. Some of these traditions, however, were bad for individual and community health. Up to just a few years ago, the epidemiologists at the Medimurje County Public Health Institute had a difficult job in implementing the vaccination programme.

A factor that contributed to their difficulty was the last poliomyelitis epidemic in these villages, which occurred in 1983 immediately after a community vaccination programme in the Roma settlements. Four children from the village of Kuršanec contracted poliomyelitis after the primary vaccination. This reinforced some of the old prejudices against organized vaccination programmes.

As a result of this experience, Dr Smilovic explained some of the problems that she had to face when working with the community:

Tackling cultural barriers in Croatia

At the end of the epidemic in 1983, it was proved that the children did not get poliomyelitis because of the vaccination. But the Roma people believed that the children became ill because of the vaccination, and after that it was very hard to convince them to vaccinate their children again. We embarked on a difficult task.

Resistance was huge, especially in the village where the children had become ill 14 years previously. We were afraid of the possibility that something might happen again as a result of a reaction to the vaccine. Although we had taken precautions against something adverse happening, we were still aware of the conditions under which we were working. Sometimes, in a cottage, we just put a table cloth over some improvised place ... nothing like the conditions we have in the clinic. Once, I remember, a Roma child had a bad reaction – a rash all over her body – and the father simply wanted to kill me. I could not explain anything but took the child in the ambulance, hoping that we would all stay alive, and went to the clinic. Thank God, everything was fine in the end, but we might have lost our credibility again just because of one reaction.

Language as a bridge

When trust is lost one must think about the cause. But if the cause is not rational, as in this case, one must think about bridges to regain trust. The doctors' bridge was the Roma language, and the result was new trust.

The Public Health Institute team that visits the Roma communities includes four or five doctors, four nurses and technicians/ancillary workers. To communicate in a way that would build trust and overcome difficulties, the team learned the Roma language. Though they did not speak Romany fluently, it was sufficient to establish a real relationship with community members. Dr Smilovic recounts the initial breakthrough: "When I tell them to open their mouths, or to breathe or to swallow, or when I tell a teenage girl that she is beautiful, or speak to them as their mother would, I gain a little bit of trust. It is not too difficult to learn the Roma language. The doctors all have a home-made dictionary on sheets of paper that they keep in their ambulances."

Her Roma language teacher, Franc, was one of the community leaders in Sitnice, but many of the other villagers were also happy to help out in this effort.

Health systems confront poverty

Dr Smilovic, her “teacher” (Franc) and the children



Although the Initiative cost nothing and has made progress, there are still questions about its sustainability. The doctors say they do not have any intention of moving to another practice, but if they do their intention is to have their successors continue the Initiative. “The language is not difficult to learn and if you achieve such a goal the results are especially healthy for the children of minority groups,” says Dr Smilovic. The results (Table 1) are indeed impressive.

Table 1. Comparative vaccination rates, 2000

Vaccination type	All Croatia (%)	Medimurje County (%)
Primary	93.5	95.7
Secondary	94.3	97.6

Source: Croatian Institute for Public Health.

Background to the Initiative

According to the maternity department of the county hospital, many of the young in the Roma community are eligible for health care under the health insurance law, which provides free access for those under 18 years of age. These young people are subject to the national vaccination programmes.

Tackling cultural barriers in Croatia

Because of their lifestyle, social conditions and poor financial status, the Roma people are very susceptible to illness, particularly communicable diseases. Until recently, the children were only vaccinated unwillingly and irregularly. The Međimurje County Public Health Institute reports that 266 Roma children were vaccinated against poliomyelitis in 1994, 191 in 1995 and 404 in 1996.

In 1997, there were two suspected outbreaks of poliomyelitis within a few months, and vaccination programmes were instigated in response to both. In Međimurje County, the implementation of a special vaccination programme was considered a priority. This was the beginning of the Communication Initiative, when Dr Smilovic and the other members of the team started to learn the language of their Roma patients. The local Public Health Institute's Initiative resulted in an initial vaccination of 400 Roma children, followed by a small campaign in the Roma village of Drzimurec. This achieved a success rate of over 95% in children up to 15 years old – the very group whose vaccinations had previously been impeded by the traditional attitudes and fears of their parents.

On 21 October 1997, the Međimurje County Public Health Institute received a reported case of acute paralysis in a 14-year-old Roma girl from Drzimurec, just after the secondary vaccination had been carried out. Tick-borne encephalitis was diagnosed, and another campaign started. In this campaign, additional incentives were provided when the United Nations Children's Fund (UNICEF) office in Croatia donated 800 kg of baby food parcels and the Međimurje County Public Health Institute took the



1997 – UNICEF food parcel and the immunization information brochure

Health systems confront poverty

opportunity to distribute its brochure, *Protection of children from communicable diseases: when do I need to take my child for vaccination?* The brochure detailed the full schedule of vaccinations from 3 months to 19 years.

These food and information incentives to participate in the vaccination programme were readily accepted, partly because of the rapport that had already been established between the Romany-speaking health team and the Roma community.

Dr Smilovic says that in the two campaigns in 1997, “primary health care workers vaccinated 472 children and in ‘mopping up’ campaigns 418 children were vaccinated.” She feels that, although health services have a leading role to play in promoting health, cooperation between municipal authorities and other social structures that influence health, such as schools, social care, public services and nongovernmental organizations, is of the utmost importance. These are especially important among the vulnerable communities, such as those of the Roma.

“There are some problems that have still not been overcome,” emphasizes Ljudevit, a leader of a Roma village, Pribislavec. These problems are not directly connected to immunization of the Roma children, but can influence their health and their future in other ways, such as failure to complete their education. At present, only one in every ten Roma children completes the primary school course, and even fewer complete the secondary course. Ljudevit feels that if, like the doctors, schoolteachers were to use the Roma language, these poor statistics would change for the better.

Improving public services

Other poverty and health issues include the legalization of the Roma settlements and their connection to electricity and water supplies. Utilities will be difficult to provide because of the cost to this largely unemployed community.

Another issue being examined is that of health insurance. Among the people still outside the health care system, many are from the Roma community, where lack of health insurance is a big problem. For inpatient treatment, one known practice is to “borrow” someone else’s

Tackling cultural barriers in Croatia

documents, in order to be treated free of charge. But this can lead to many problems, including inaccurate health and social benefit records. In one instance, someone on “borrowed” insurance died in hospital and the real owner of the documents could not prove that he himself was not dead!

The President of the Medimurje County Social and Health Department, Dragutin Lesar, feels that actions such as the Communication Initiative should be a way of changing attitudes, as well as building trust between the community and health workers. He says, “Responsible parenting and health education of the Roma people are the key points on which we all have to work in the future. They must understand that they are responsible for taking their children to the clinic for immunization instead of waiting for the doctors to come to the village and bring them presents to let their children get the vaccines.” He feels that this approach can lead to irresponsibility. “The solution,” says Lesar, “would be to direct social security and unemployment money into health education, into schooling and into teaching Roma mothers how to cope with these problems.”

The future

The door to this Initiative was opened when a team of doctors first went into the Roma villages and convinced the people there to vaccinate their children. They did it successfully by learning the language of their patients, recognizing it as a way to overcome barriers to health service delivery. Natalija and Nedjeljko will not repeat the bad practices of their parents’ families; they already know how to protect the health of their children. Other problems could also be solved with the same recipe of trust and goodwill.



Children in the Roma communities are increasingly benefiting from the Initiative

Health systems confront poverty

The success rate achieved in immunization during 1997 continues, with Međimurje County still reporting higher vaccination rates than the national average (Table 1).¹¹

Social resistance to immunization and other public health initiatives is not restricted to the Roma community, or just to central Europe. Furthermore, investing in the health system alone is a simplistic solution. As Lesar and Smilovic point out, complementary steps in education and other investments in basic infrastructure (for example, safe water and sanitation) are also required.

In this particular case study, a specific intervention helped to ease some of the cultural barriers at the local level, increasing access to essential health services in poor and often isolated communities. The intermediary results achieved are visible and are expected to have a long-term effect by reducing the burden of disease, not only in the Roma community but also in the country as a whole. The initiative showed that public health programmes could be modified to include essential interventions, even in countries with limited public resources.

¹¹ *The Croatian Health Service yearbook 2000*. Zagreb, Croatian National Institute of Public Health, 2001.

Case study 2

Couverture maladie universelle: reaching the poorest in France

Frederika van Ingen

“Between 10% and 15% of my patients are in a situation of financial insecurity,” explains Dr Gilles de Saint-Amand, a general practitioner in a rural area. “There is no doubt that some of them are genuinely marginalized; they had difficulty obtaining treatment but now, thanks to *couverture maladie universelle* [CMU – universal health insurance], it’s easier for them to consult me. From a health point of view, this is clearly an advantage, while, from an administrative point of view, the procedures have been considerably simplified.” For social workers, CMU is also an advantage. “Since it was introduced,” explains Annie Dunant, a child care nurse in a state-run maternal and child health centre, “when we have to deal with children with health problems, it’s much easier for us to urge the parents to bring them to see a doctor, because we know this won’t cause them financial problems.”

Universal health insurance was introduced in France on 1 January 2000. The principle behind it is to offer every person resident in France basic medical cover, with additional cover available to people whose incomes are below a given ceiling. The aim is to offer “health insurance for all”, in order to give everyone equal access to health care.

In France, access to health insurance is based on a system of social security contributions by salaried employees and workers. This gives them and their families the right to partial reimbursement of their health expenses (basic cover). Patients are free to choose and consult their self-employed doctor (a general practitioner or a specialist): they pay the doctor for the consultation and are then partially reimbursed by the health insurance scheme. The same arrangement applies to drugs, for which patients pay pharmacists and are then reimbursed. A proportion of these health costs (known as the

Health systems confront poverty

“co-payment”) must be paid by the patients themselves, unless they take out a contract with a private insurance company or mutual association (*mutuelle*), which offers products that reimburse all or part of these costs. In 2000, 80–85% of the population had taken out additional cover that reimbursed them for at least part of their health care costs. This system gives a good proportion of the population satisfactory access to health care, but others are still excluded.

Before CMU, one measure was already in place: free medical aid, managed by the regional government (*département*) in France. Up to 1992, benefits were awarded to the very poor on request, each time they needed treatment. This system created inequities: not only did people in need have to apply each time they had a health problem, but they were also treated very differently from one *département* to another.

As of 1992, requests were still submitted to the administrative services of the *département*, but they were handled in cooperation with the local offices of the national health insurance fund (*caisses primaires d'assurance maladie*, CPAM). People in financial difficulties had to apply to the services of the local government authority (in the *département*) to obtain an entitlement for 1 year, for them and their families, rather than “one-off” aid. This was progress of a sort, but the problem of inequity between the *départements* persisted.

Moreover, the extent of poverty was increasing. According to sociologist Olivier Quérouil, a technical adviser to the CMU fund and a former adviser to the interministerial task force on the guaranteed minimum wage:

Between the 1960s, when 50% of the population were covered by social insurance, and the 1980s, when the figure had risen to 98%, we saw the total success of the social security system. But the existence of that last 2% was untenable. First, because this was unacceptable from a humanitarian point of view and, second, because we ended up with a system in which 60 million people's rights to health insurance had to be verified in order to reveal the 2% who were not entitled to coverage.

Since the health insurance system was established, entitlements have been extended to the families of workers (the beneficiaries), and a personal insurance scheme has been set up for people who do not contribute through their

Universal health insurance: reaching the poorest in France

workplace, but the system is still based on contributions. In the 1980s, we hoped to achieve full employment and thus health insurance coverage for all. But this did not happen. Between 1993 and 1998, the number of people in receipt of medical aid tripled (from 1 million to 3 million, or 5% of the population). It was no longer possible to go on talking about “residual vulnerable groups”. The social security system, which had become ever more generalized since its inception in 1945, had to respond to this problem, and a succession of political leaders began to seek solutions.

In 1997, a study carried out by the Health Economics Research Centre (*Centre de Recherche d'Etude et de Documentation en Economie de la Santé*, CREDES) highlighted inequalities in access to health care. Some 600 000 people did not have access to social security. In addition, 16% of the population did not have supplementary cover. Many of them did not seek treatment because they could not afford their share of the health costs.

The problem was aggravated by outpatient treatment being reimbursed under the basic coverage scheme at a lower rate (60–70%) than that of hospital treatment (80–95%). The result was that people who could not afford to seek treatment at an early stage, by consulting a doctor, hesitated to do so. As Etienne Caniard, Vice-President of the French National Federation of Mutual Insurance Companies, points out:

This shows that the basic health insurance scheme was not enough to guarantee access to care. This led to a question for Martine Aubry, the then Minister of Employment and Solidarity: in order to ensure equal access to treatment, would the system have to be reorganized in accordance with the resources available? Her answer was no, and she opted for a specific system whose primary philosophy is to avoid stigmatizing the least well off.

A revolutionary Act

In 1999, Parliament adopted an Act that set up CMU as an integral part of a broader act on measures against social exclusion. It has three components. The first component establishes basic CMU for all, with no contributions required from people with an income below a certain level (see Box 1). In other words, any person properly resident in France, who does not contribute through his or her employment and who is not a beneficiary, is automatically affiliated with the social security system. Another major innovation is that the burden of proof of entitlement is on the health

Health systems confront poverty

Box 1. Who is entitled to CMU?

CMU and supplementary CMU are available free of charge, provided an income ceiling is not exceeded. This ceiling was revised in February 2002. It is now €562 (US \$489) per month for a single person, €843 (US \$733) for a couple or a single parent with a child, €1011 (US \$879) for three people, €1180 (US \$1026) for four and €225 (US \$196) per additional person. This entitlement is awarded for one year, renewable after review of the insured person's situation. Since February 2002, people who no longer come under this arrangement, because their situation has changed, none the less continue to benefit from dispensation with regard to meeting medical expenses. Also, since that date, people whose income is in the band of up to 10% over the ceiling for benefiting from supplementary CMU are entitled to assistance amounting to €115 (US \$100) in order to take out supplementary cover with an insurer or mutual association. The contracts proposed by insurers or mutual associations guarantee them the same rates of reimbursement as supplementary CMU.

Source: CMU Fund.

insurance fund rather than the individual. People over 16 years of age can therefore join a fund with documents merely proving their residence and identity. People with no fixed abode must be registered with a recognized body in order to receive benefits. The local office of the insurance fund can question people and can ask for additional evidence that they do not come under a scheme for employed people, but they will be automatically entitled to basic coverage for one year. Subsequently, depending on their income, they will be required (or not required) to contribute to this system of basic coverage.

The second component of the Act is the establishment of supplementary CMU. Below a certain income ceiling, people receive this supplementary insurance free of charge, which meets health costs within the limit laid down by the social security system. This supplementary insurance covers the cost of co-payments, a daily tariff for non-medical inpatient costs (€10.67 or US \$9.28 per day), dental prostheses and spectacles (up to a limit of €396 or US \$345 per two-year period).¹²

¹² Full reimbursement of dental prostheses was introduced at the beginning of 2002. Initially, reimbursement of optical appliances and dental prostheses was limited to €396 (US \$345) per two-year period. This ceiling now remains only for optical appliances.

Universal health insurance: reaching the poorest in France

Doctors consulted by patients covered by CMU, however, make a commitment not to exceed the baseline rates laid down by agreement between the National Health Insurance Fund for Salaried Employees (*Caisse Nationale d'Assurance Maladie des Travailleurs Salariés*, CNAMTS), the Government and the medical associations. They may not set their own fees. Supplementary CMU is granted each time for a one-year period.

Individuals have a free choice of their supplementary insurer – which may be the health insurance fund itself, a private insurance company or a mutual association – from a list given to them when they register with the primary fund. If people choose a body other than the health insurance fund, the advantage is that they will be able, provided they do not exceed the CMU income limits, to take up a preferential offer of supplementary insurance (at a cost of €229 or US \$199 per year) after they leave the scheme. One essential point is that the CMU scheme does away with advance payments. Patients do not pay their doctor or the hospital; instead, the latter are reimbursed directly by the insurance funds and supplementary insurance bodies.

Finally, the third component of the Act relates to amendment of the arrangements for state medical aid. This is aimed at people in France whose



In January 2000, the "revolutionary Act" created a very large response. Many people were keen to register for CMU.



Health systems confront poverty

status is unclear but whose income is lower than the same ceiling used for CMU. Approximately 100 000 people are affected. They can submit a request for cover to the local health insurance fund office, to local or regional welfare service departments, or through nongovernmental organizations and charitable bodies. This component gives free access to hospital treatment for all, and to general practitioner care for people who have been in France for over three years (see Box 2).

The Act provides for rapid implementation of these measures, since it came into force on 1 January 2000. In the few months after the Act was passed in July 1999, the various bodies charged with operating CMU had to organize themselves to handle the recipients of this new service.

With regard to financing, a fund has been set up to finance the supplementary CMU scheme. Resources come from an allocation from the state budget and through contributions from complementary bodies (insurance companies and mutual associations), calculated on the basis of 1.75% of their turnover. In 2000, the fund's budget was €1047 million (US \$911 million). In 2002, it was due to rise to €1120 million (US \$975 million). When insured people choose primary insurers as their provider of supplementary insurance, their expenditure is fully reimbursed by this fund. If, however, they choose a mutual association or an insurance company, these bodies have their contribution to the CMU fund reduced by €228.67 (US \$199) per person registered per year. This sum, which is claimed to correspond to the average expenditure per person incurred by supplementary insurers, does not cover the management costs of the bodies that have agreed to insure them. Estimates show that the average annual health expenditure must be revised upwards to approximately €244 or US \$212 per person in 2001. Supplementary insurers are currently calling for an increase in their deduction or, indeed, full reimbursement of their costs, as is the case for the primary insurers. "There is a great deal of work to be done on the ground to reach out to people who could benefit from CMU but are not aware of it," notes Caniard. "This work could be done by mutual groups, in collaboration with welfare associations, but this would require additional resources."

A cultural shift?

"Introducing CMU has been a real cultural shift, at all levels," notes Marc Schlusshuber, the Director responsible for access to care at the

Universal health insurance: reaching the poorest in France

At the end of 2001, 120 000 people were in receipt of government medical aid (GMA), 70% of whom lived in the region of Ile de France (Paris and the surrounding area) and 44% in Paris itself. This aid is targeted at people whose status is "irregular" in one way or another. Not only is it "generous", it is a response to a public health problem. "Many of these people," explains Yves Carcenac, Inspector General of Social Affairs, "were developing communicable diseases, especially tuberculosis, but were afraid of being identified when they applied for treatment." One specific characteristic of this population is that it is especially difficult to assess how many people are involved. Since GMA was introduced, however, and after a slow start due to a certain degree of suspicion, 10 000–12 000 new people have been signing up every three months. Aid is granted mainly on the basis of a statement by the recipients describing their situation. Its introduction, however, has been more difficult than that of CMU, as is noted in a report issued by the General Inspectorate of Social Affairs (*Inspection Générale des Affaires Sociales*, IGAS). One reason for the difficulty is that the population concerned was not given enough information: one of the main channels for disseminating information was humanitarian organizations, since the government services have made no arrangements to do so. Another reason is that some primary insurance funds arranged for only one reception facility per region, which had the effect of stigmatizing these people who, according to the spirit of the law, should be able to "lose themselves" in the mass of insured people. The fact that access to general practitioner care is restricted to people who have been in France for more than three years creates complex situations. On the one hand, it is difficult for people in an irregular situation to prove that they have been in the country; on the other hand, it paradoxically "rewards" those people who remain in an irregular situation for longer periods of time. Finally, the IGAS report notes that budgetary management by the Government is "causing concern". For instance, the cost of €60 million (US \$52 million) provided for in the 2002 budget had already reached a level of €145 million (US \$126 million) in 2001.

Box 2. Medical aid to people whose status is "irregular"

Source: IGAS.

Seine-Saint-Denis primary health insurance fund. In this region close to Paris, which is severely affected by problems of poverty, the number of potential beneficiaries of supplementary CMU was initially estimated at 200 000. At the beginning of 2002, 146 650 people were entitled to benefits, after a peak of 177 000 in June 2001. In the first six months of the scheme, 87 000 people registered. Schlüsselhuber recounts:

Health systems confront poverty

For local insurance funds like us, we had to move from doing administrative work and applying mathematical formulae to carrying out a social role. The staff had to be convinced that, in the future, we would have a role to play in tackling poverty. As soon as the scheme was set up, we were inundated with applications. We had had a few months to prepare ourselves, 130 people were mobilized to tackle this issue, and we recruited about a hundred young people.

One of the main changes is that the insurance funds now have to prove people's entitlements, instead of the reverse. Schlüsselhuber recalls:

On 3 January 2002, a young man arrived to join the scheme. He had no job, he was in the process of applying for the guaranteed minimum income and he seemed to be in a "regular" situation. We therefore registered him automatically, without supporting documents. Clearly, we will ask for these documents at a later date and check his entitlements, but for us, as a civil service department, this was completely new.

Schlüsselhuber sees the same innovative approach for government medical aid: "In practical terms, when someone whose status is irregular comes to join the scheme, we try to ask them for all the supporting documents they can provide. But at the outset, especially in their cases, we have to be satisfied with statements made by them." In this *département*, GMA has meant that the number of people of irregular status who receive free medical care has risen from 3000 to 13 000. Schlüsselhuber continues:

We know that there are still people who do not dare to register because they're afraid that their illegal status will be discovered, but information about this new entitlement to social welfare coverage is gradually spreading.

CMU has improved the image of the health insurance system. The primary health insurance fund is now taking action against poverty. In Seine-Saint-Denis today, we are cooperating with the *département's* social workers, for instance by notifying them of people who have been refused CMU cover because their income is above the ceiling, so that they can be tracked and helped under other schemes. We are developing preventive action in households, associations and town halls, and we are offering a telephone hotline. In fact, we have re-established our dialogue with insured members of the public. Now we really have the impression of contributing something more

Universal health insurance: reaching the poorest in France

than just reimbursement. CMU is a system that requires everyone, throughout the whole process, to become involved in action aimed at strengthening solidarity.

Generally speaking, the introduction of CMU has completely changed the way in which primary health insurance funds operate. A study¹³ carried out by the Directorate for Research and Statistical Evaluation (*Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques*, DREES) at the Ministry of Employment and Solidarity highlights the difficulty of setting up a reception facility that is “normal”, in order not to stigmatize recipients of CMU, yet is also capable of responding appropriately to these particular cases. Initially, some local health insurance funds were not able to offer reception facilities to CMU beneficiaries on an equal footing with those of other insured people and had to make special arrangements. The deadline for registering for supplementary CMU, which by law must not be more than two months, has also created problems in some offices that faced technical problems when the system was set up.

In some places, waiting times at primary insurance fund offices have been avoided by making use of voluntary help, obtaining the support of mutual associations and insurance companies, and setting up reception facilities in hospitals, town halls and poor districts.

Recipients: 7.8% of the population

Almost two years later, on 30 September 2001, 1.2 million people were in receipt of basic CMU, according to the DREES study,¹⁴ while 4.7 million people or 7.8% of the population were covered by supplementary CMU. The number of recipients peaked in June 2001, at 5.3 million. This may be explained by the Act having provided for an automatic entitlement to CMU for people previously entitled to medical aid. The situation of some of these people, however, has changed, or they have not requested renewal because they have no need of care. Others can benefit from medical aid in a *département* where the income ceiling was higher than that for CMU.

¹³ BOISGUERIN, B. *Les bénéficiaires de la couverture maladie universelle au 30 septembre 2001*. Paris, Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques, 2002 (Etudes et Résultats, No. 158).

¹⁴ Ibid.

A young and female population

Another DREES study¹⁵ in November 2000 defined the target populations more accurately. Recipients of CMU are primarily women (55%) and young people (39% are under 20). Some 6% are over 60 and, among people of working age (20–59 years), 40% are unemployed. In 26% of cases, the reference person (that is, the person in the family who is registered for CMU and through whom the other members receive cover) is employed. Finally, 36% of recipients are in a household where the reference person is a worker, and 27% are in one where he or she is an employee. In 30% of the cases, the socioprofessional categories of reference persons are not defined, either because they have never worked or because they are inactive or are housewives.

Two years on, reimbursement figures serve as the main tool for assessing the health impact of introducing CMU. Statistics compiled by CNAMTS show that, in 2000, the health expenses of people covered by supplementary CMU amounted to 70% of the costs incurred by those insured under other schemes. By the beginning of 2001, however, the corresponding figure had risen to 85%. This may be explained by the target population for CMU being younger and thus in better health. While the health costs of people covered by supplementary CMU are lower than those of other insured people, they are initially focused more on primary care (general practitioners, drug costs) and seem to be growing gradually closer to the health consumption patterns of the population as a whole.

At the end of 2000, a study of a sample of beneficiaries showed that one in every two people covered by CMU said that, before joining the scheme, they had not proceeded with at least one treatment for financial reasons. This mainly concerned treatments that were poorly reimbursed by basic social security, such as dental care (31%), optical care (25%), dental prostheses (19%) and specialist consultations (10%). Since the introduction of CMU, 65% of those sampled said they had sought at least one of the treatments they had previously not taken up. Two thirds had “caught up” by initiating dental or pharmaceutical treatment and by consulting general practitioners or specialists. With regard to dental prostheses and optical care, only 40% of people had caught up with treatment previously

¹⁵ BOISGUERIN, B. & GISSOT, C. *L'accès aux soins des bénéficiaires de la CMU. Résultats d'une enquête réalisée en novembre 2000*. Paris, Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques, 2000 (Etudes et Résultats, No. 152).

Universal health insurance: reaching the poorest in France

abandoned. This may be explained by the existence of a ceiling on expenditure of €396 (US \$345) per two-year period. Abolition of the ceiling for dental care at the start of 2002 should help to enable people covered under CMU to initiate this treatment.

Another indicator of the effectiveness of CMU is the fall in attendance at health care centres operated by humanitarian organizations. These bodies were very much involved in discussions about introducing the Act and its enabling legislation, and they continue to closely monitor the impact of CMU and to refer their patients to the primary health insurance fund offices. “We are seeing a clear fall in the number of patients in our centres, since they now have easier access to general practitioners or hospital treatment,” notes Nathalie Simonot of Médecins du Monde. “Some centres in small towns have even closed down. There is still a problem of information, however, and we believe that many people who are entitled to CMU are not aware of the fact.” The same observation comes from the National Union of Private Health and Social Work Agencies (*Union Nationale Interfédérale des Oeuvres et Organismes Privés Sanitaires et Sociaux*, UNIOPSS), which notes a marked fall in attendance at health care centres. Nevertheless, it stresses the lack of information available to people who do not take the initiative of asking for it, as well as to the most severely excluded social groups, towards whom outreach activities must be directed if they are to be encouraged to take up the services available.

A major step forward in social terms

“Universal health insurance is a major step forward in social terms”, concluded a recent IGAS report.¹⁶ Yves Carcenac, co-author of the report with Evelyne Liouville, notes that:

Equal access to treatment, regardless of a person’s place of residence, and a single counter in the offices of local social security services seem to be generating a spirit of neutrality that was not always evident in the previous system. It’s still too early to clearly see a health impact, but we know that the measures taken under this Act, in particular the fact that people no longer have to meet their health costs “up front”, really makes for easier access to health care, and it seems that we are moving towards harmonization with the rest of the population.

¹⁶ CARCENAC, Y. & LIOUVILLE, E. *Première évaluation de l’application de la loi du 27 juillet 1999 portant création d’une couverture maladie universelle*. Paris, Ministère de l’Emploi et de la Solidarité, 2001 (Rapport No. 2001, 112).

Health systems confront poverty

Centralization at the national level, however, raises new problems. One that government offices are facing is the problem of control. “It’s the corollary of the spirit of trust embodied in the Act,” explains Carcenac. “We trust people by agreeing to base our action on their statements. The corollary is that we can check what they say. At the beginning, we were in a start-up phase. Today the CMU system has reached cruising speed, and steps must be taken to organize these checks.”

Another difficulty is that health professionals, on whom the operation of the CMU system partly depends (because they agree not to exceed the charges agreed), do not always “play the game”. Some of them, the IGAS report notes, refuse treatment to people covered under CMU, refuse to waive charges up front, or charge additional fees. One of the main reasons put forward is that some funds take a long time to pay out. These delays are not general, however, and they mainly concern doctors who do not have computers and who send in their claims for reimbursement by mail, rather than electronically. Other doctors, especially some dental surgeons, do not accept the rates laid down for payment of treatment. Instances of refusal to give treatment are relatively isolated, however, and the CMU system has greatly simplified administrative procedures.

The main criticism of the CMU system, however, concerns the “threshold effect”. People whose incomes are above the ceiling entitling them to CMU, even by €1, find themselves back in a precarious situation without the access to care that they had before CMU was introduced. Some people who are in receipt of allowances, such as isolated elderly people receiving the minimum old age pension or the disabled person’s allowance, have an income that is slightly above the ceiling, so they do not benefit from supplementary CMU. Compared with the estimated cost of health expenses per person for the supplementary CMU scheme (€238 or US \$207), the rate of contribution to a supplementary insurance policy is much higher for an equivalent sum insured. In addition, a dozen or so *départements* have set the ceiling for access to government medical aid higher than that for CMU. In theory this could mean that CMU downgrades them by preventing them from benefiting from this aid, but in practice successive postponements decided on by the Government – in order to avoid people who benefited from government medical aid having to make too sudden a change to a new situation without supplementary assistance – have meant that they did not have to leave the scheme until the end of 2001 or early 2002. Measures

Universal health insurance: reaching the poorest in France

giving support for subscribing to supplementary cover, which should be in place in 2002, will help them continue to receive care.

This is the next bridge to cross in the French health system's efforts to tackle poverty. The CMU scheme has made it possible to cover the health costs of a very large proportion of the poorest people. The only group left comprises those with incomes above the threshold that would entitle them to CMU.

For their part, the humanitarian organizations are proposing that, on the one hand, the income ceiling for CMU should be raised and that, on the other hand, regressive income-linked assistance should be introduced to help people with their contributions for supplementary cover. "If the supplementary insurance bodies want to maintain their monopoly," points out Jean-Claude Boulard, a Member of Parliament and one of the people involved in drafting the CMU Act in 1999, "they will have to come up with a system of modulated contributions starting at the CMU cut-off point." The IGAS report has studied various scenarios, ranging from raising the income ceiling to introducing benefits payable when people leave the CMU scheme. Ultimately, it has adopted the introduction of benefits, a move endorsed by the Government, which considers that raising the ceiling would be too costly and would only shift the problem of the threshold effect.

Despite some start-up difficulties and the emergence of the problem of a threshold effect, CMU none the less embodies undoubted progress, both for beneficiaries and for those involved in the health system. "The special feature of this Act," conclude Carcenac & Liouville, "is that, in addition to having been introduced under efficient conditions and to facilitating access to care for the least well off, it has also created a new frame of mind among most of those involved: people all have their hearts set on making it work at their level. Now, we have to consolidate." Further evaluations of the Act are planned at two-year intervals, which should allow the system to be fine-tuned if necessary.

Case study 3

The Mainz Model: bringing health care to the homeless

Sigrún Davídsdóttir

“You know, Herr Doktor, the pills you gave me really worked. I feel much better now.” Only rarely do doctors meet their patients in a tea room and hear comments like this, but for Dr Gerhard Trabert this is not rare. Unlike the usual practice of patients coming to him, he goes to them, and the tea room is one of the consultation places. His patients are the homeless and other socially excluded groups in Mainz, Germany. It is not just a German trait that a number of the homeless do not make use of health services; it is a general trait in many countries. Many public services are designed to be sought out, but many who suffer from much poorer health than the average person often do not go to the doctor. That is why Dr Trabert goes to them: in shelters for the homeless, in the basements of parking houses and on the streets. He knows where to find them, they know when he is around – and slowly he has gained their trust.

Dr Trabert started as a social worker, working in a hospital. Appalled by the medical care delivered to the homeless and by what he saw as the inertia of the health system to assist them, he read medicine. His doctoral dissertation in 1994 portrayed the health situation of the homeless.¹⁷ But research was not enough; he wanted to put his knowledge to practical use. He believed that efficient health care for the homeless could be provided only through carefully planned cooperation with the social services. The health care system could contribute medical expertise, but the social services should play an important role in reaching the homeless.

¹⁷ TRABERT, G. *Gesundheitssituation und Gesundheitsverhalten von alleinstehenden, wohnungslosen Menschen im sozialen Kontext ihrer Lebenssituation*. Bielefeld, VSH Verlag Soziale Hilfe, 1995.

Health systems confront poverty

His approach to bringing health care to the homeless has been called the “Mainz Model”. It is based on a combination of paid and voluntary work and consists of four modules:

- open consultation, with both a general practitioner (GP) and a nurse, at a refuge for the homeless;
- open consultation, with both a GP and a nurse, at a daytime shelter for the homeless;
- open consultation from a van (*Arztmobil*) fitted with a consultation “room” in the rear, in places in the city where the homeless are known to be; and
- medical and palliative care for the seriously/terminally ill in homes for the homeless.

The consultations are carried out at regular hours, so that the homeless know when and where the help can be sought. The fifth and much needed module on assistance for the mentally ill homeless is now being prepared, and would most likely start later in 2002. Every week the medical team sees about 50–60 patients, making 80–100 patient contacts.

Gerhard Trabert (left) and
Andreas Pitz



The health service for the homeless is embedded in the social services offered to the homeless. Dr Trabert and Andreas Pitz, who heads the department for service for the homeless on behalf of *Diakonisches Werk* (a welfare organization run by the German Lutheran Church),

both agree that the key to success in this field is close cooperation between health care and social workers. “The strength of the Mainz Model,” says Pitz, “is that we cooperate with all the institutions that work with the homeless. In order to succeed, this work must be interdisciplinary.”

In 1997, the association *Armut und Gesundheit in Deutschland* (Poverty and Health in Germany) was founded, both to raise funds for the Mainz Model

The Mainz Model

and to raise general awareness of the connection between poverty and health. Apart from raising funds and providing services to the community, the association organizes an annual conference on health and poverty and is rapidly extending links to other organizations in Germany and elsewhere. “The first reaction,” says Dr Trabert, “was that there was no poverty in Germany, so why should there be an association and a conference working in this field.” Now the attitude is different, in no small part thanks to the work of the association.

The success of this work is now turning into a problem that needs to be solved soon: the work is becoming too extensive to be dealt with only through voluntary help. The next step is to hire someone to run the service. A system to service the homeless, however, is not an end in itself. According to Dr Trabert:

Our final aim is to involve the municipal council and the state in the running of the service, making it a part of the existing health service. A health service for the homeless should not be separate but should be an integral part of current systems: [the health service] should include the homeless, not exclude them.

We now have a 10-year track record, which shows that the model works.

From words to deeds

According to official German statistics, there were around 700 000 homeless people in Germany in 1998, of which around 180 000 were single individuals on the move. The poorest of these – around 31 000 people, of which 3100 are women – live continuously on the streets. The statistics collected by Dr Trabert for his dissertation on the health of the homeless were shocking, especially considering that this group, in general, has a worse state of health than that of the average citizen.

It appeared that 80–90% of the homeless were in acute need of medical treatment, 60–70% had more than one disease and around 40% had three or more diseases. The homeless are mainly afflicted with diseases of the lung, intestine, heart and skin. Not surprisingly, there is a connection between the time spent on the streets and their state of health: the longer people have been homeless, the worse their health. Also, injuries related to violence are increasing, as violence against homeless people appears to be increasing.

In spite of their poor health, the homeless were seldom seen visiting health care institutions. Dr Trabert’s research showed that they have little faith in the system, have had bad experiences, are afraid of being thrown out and

Health systems confront poverty

often feel too embarrassed to visit regular health units – either hospitals or GP surgeries. Furthermore, they feel that the system is too bureaucratic, requiring many documents. Adding to these experiences, the homeless often have a reduced awareness of their bodily needs, and they simply feel that they do not need medical help, in spite of sometimes being quite ill.

Werner Schwarz, the treasurer of Poverty and Health in Germany, leads a day centre for the homeless in Bingen, close to Mainz, where a medical team visits regularly. He says, “There are doctors out there willing to attend to the homeless, but the homeless don’t want to go there, because they don’t like waiting in the waiting room. The homeless don’t go to the doctor until they are very ill and even then it can be difficult to convince them to seek treatment.” Schwarz knows that even under such circumstances his clients are prone not to show up, so he tries to accompany them if he can.

Health workers are invariably embarrassed themselves when receiving the often dirty and smelly homeless people, and show little understanding of their situation. Medicines to prevent diseases, or to prevent an illness from getting worse, often do not reach the homeless. Apparently, most homeless people come in contact with the health care system when brought in by the police, either because of accidents or because they have been found to be helpless.

While working on his research, Dr Trabert wondered how better health care for this group could be established. In recounting his experience, he says:

There were plenty of people ready to tell me that what I wanted to do could only be achieved by changing the whole health care system. But I couldn’t wait for that. I wanted to explore the possibilities at hand: how health care for the homeless could be constructed with what we had there and then. It is very important to search for new possibilities within the existing framework, in order to show that something can be changed. If that proves successful it can be used as an argument and pave the way for structural changes.

During 1993, his plans were laid out, and work among the homeless started in September 1994.

Placing new ideas inside the system

The German welfare system is traditionally a combination of governmental and church institutions, both the Lutheran Church and the Catholic

The Mainz Model

Church. In addition, the trade unions have their own welfare structure. Although the Mainz Model is a private initiative, it is embedded in existing welfare structures, within both the official system and the Lutheran Church system, thereby linking existing structures in a new way. In addition, there are voluntary work and fund raising.

At first, the service was offered at shelters for homeless people, both day centres and homes where they could stay overnight. But that still excluded those who never or hardly ever made use of these shelters and stayed exclusively on the streets. In order to reach them, it was obvious that a mobile surgery would be ideal. A van was bought with donations, was fitted with the necessary equipment and began operating in 1998. This proved to be the easy part of setting up the mobile service. The difficult part was that none of the institutions involved was willing to own it or run it.



Patients who live in containers, waiting to see the doctor in the Arztmobil

In order to provide the van with a legal owner, Dr Trabert and others founded Poverty and Health in Germany. The association now not only runs the van, but is also an active fund-raiser for the work as well as one of the several organizers of the annual Berlin Conference on Poverty and Health. The Conference and the association itself are playing an increasingly important part in pooling and distributing knowledge on poverty and health, not only in Germany but also in adjacent countries. The aim is to create a European network in the field. “There is so much financial cooperation in Europe, so it’s now time for some social cooperation as well,” says Trabert.

The association is also an important focal point for the work in Mainz, since it has members who not only contribute to the work of the Mainz

Health systems confront poverty

Model but also carry out work in other fields in a similar spirit, creating opportunities for those who are usually disadvantaged. For example, one of the members runs a hotel in Mainz, the *Inndependence*, where mentally and physically handicapped people are given the opportunity to work in a commercial setting.

One health system: not first- and second-class systems

Dr Trabert has a message he often repeats.

We don't want to create a special system for the homeless outside the regular health care services. We are not constructing special health care for the homeless, but demonstrating the need for it. The aim is not to have a well run separate system, but that the official system recognizes the need for taking the homeless and their special needs seriously, offering them the kind of service that is of use to them.

The structure chosen was a combination of paid and voluntary workers. The medical team consists of Dr Trabert (who is also Professor of Social Medicine in Nuremberg) and Ulrich Graeber, a retired and highly respected doctor.

Trabert and Pitz point out that, for a new initiative, the choice of co-workers is important. It is not only important to choose well qualified people but also to choose workers who bring respect and attention to the new initiative.

As a rule, and based on agreements with statutory health insurance funds, Dr Trabert can charge the funds for his work as a panel physician. In principle, health insurance directly or indirectly covers every citizen resident

in Germany in one way or another. Thus, the insurance funds normally pay for use of the health system. The costs for people in need and others who are not in the insurance system are met by the state (for example, by the social services); this also applies to asylum

Nurse Anke and Dr Trabert visit a patient who lives in a camping van



The Mainz Model

seekers. Illegal immigrants and other people not known to the social services are not covered in this way, but the Mainz Model team never denies medical care to anyone.

There are three nurses on the medical team. Sister Maria-Theresia and Sister Anegret, working for a Christian organization, are allowed time to work with the team; the other nurse, Anke, works with the team on a voluntary basis. Pitz and his colleagues provide social services within the shelters for the homeless.

The first barrier that Dr Trabert ran into when planning this drastically different kind of service was a law stemming from former times when quacks were a problem and, consequently, doctors were forbidden to practise medicine unless at a fixed setting. Dr Trabert's intention to seek out patients was hindered by this law, and it took some time before this could be overcome. Now, however, the Mainz Model is outside the ordinary health care system, though it benefits from Dr Trabert being able to charge the health care system for his services, like any other practising doctor.

An essential part of providing a first-class health service is documentation. Dr Trabert and his co-workers take a great deal of care to document their visits to each of the patients – in no less painstaking a way than visits within the health care system. This also wards off the criticism that the service being offered is in any sense inferior to that of the established health care system.

An important part of this documentation is the *Krankenpass*, a patient passport. The patients making use of the Mainz Model complained that it could be difficult for them to convince other doctors they might see that they had already been seen by a doctor. Others found it difficult to simply keep track of the treatments they had received from Dr Trabert's team. To meet these needs, a small folder of sturdy material was designed, listing vaccinations and other necessary health information.

Meeting the patients

“It is good that one can also be allowed to die here”, said a homeless man, often staying at a shelter for the homeless, when he heard that palliative care was now being offered to terminally ill patients. The gratitude of those using the service is obvious: “Oh yes, I make a point of being around when I know

Health systems confront poverty

that Herr Doktor is coming,” says a rugged-looking and weather-beaten man with long grey hair and a flowing beard at the container cluster, close to a social centre in Mainz. “Before, I never went to a doctor, even if I needed it. It is too much of a hassle, also because I’m on the move. But this is fine.”

The containers are set up in the autumn by the City Council and remain in place over winter, so that the homeless can sleep in them. They only come fitted with berths, but the inhabitants quickly furnish them with other necessary things. Some are quite cosy, with TV sets, bedspreads and rugs. While the containers are there, Dr Trabert visits them regularly.

When asked about his use of the health service being brought to him, a long, lanky man with thin hair down to his collar replies, “We know him. I feel I can trust him, and the doctor is nice. He knows us. The trust makes all the difference.”

A patient with Dr Trabert in a tea room used by the homeless



In the tea room for the homeless, Dr Trabert is obviously a well known face. As he shows up and goes around to announce his visit, some of those present start moving towards the van outside. Some just ask him simple questions, like the tall, bearded youngish man who needs to

know how to get rid of the lice in his sleeping bag, as well as those on his dog. Some of the others tell him that what he prescribed for them last time helped.

As soon as Dr Trabert is in the van, a queue forms outside. One after another the men climb into the van, explain what is wrong, get asked the relevant questions by the doctor and have the nurse measure their blood pressure and make other tests. It is easy to forget that the consultation is taking place in an unusual surgery. Everything but the surroundings is part of the ordinary process of going to a doctor.

“I come here when I need the doctor,” says a heavy set man, who says he has been sleeping rough for six months. This time his stomach is bothering him. He has been sent for a gastroscopy before, but did not show up. Now

The Mainz Model

he considers giving it another try, since his suffering has increased. He is an alcoholic and knows that drinking is the cause of his problems. The prescriptions given to the homeless include vitamins and regular medicine such as beta blockers, but never any medicine that could be abused, such as sedatives, painkillers or sleeping pills.

Sleeping rough is a hard way to live, and it often lacks human contact. It is obvious that the men like the care that the nurse gives them, such as massage and other almost “motherly” attention, all given as part of the service. Dr Trabert emphasizes that the team works on health issues, and not on resocializing the homeless. “We accept that people live on the streets, though we are keen to assist them if they want to settle down in a permanent place,” says Trabert. The acceptance of their way of life is undoubtedly part of the success experienced by the medical team and is an important factor in winning the trust of the patients. But this tolerant attitude demands a lot of patience – for example, perseverance in setting up appointments within the health system, which some patients often fail to attend.

Publicity: do good and talk about the good deeds

“The attitude towards good deeds is often that you should do good but not tell anyone about it,” says Pitz. “But in our work I claim we should do good and tell as many as possible about it.” From the beginning, publicity has been an important part of the Mainz Model, both because it raised the awareness of a problem that was not generally recognized and because the work has been dependent on donations.

The publicity is channelled through Poverty and Health in Germany. “It is important to make people aware that being homeless is not just due to alcoholism or unwillingness to work,” says Dr Trabert. “People can lose their way in life for all kinds of reasons, so don’t be too judgmental about the homeless.” Dr Trabert frequently visits schools in and around Mainz to talk about the health service for the poor, in order to create an understanding of the work. This is an important factor in creating sympathy, understanding and tolerance for the homeless among children and young people, especially now that hostility against the homeless seems to be increasing.

The publicity for the Mainz Model, in Mainz and neighbouring towns, has been instrumental in securing donations. When there are birthdays to celebrate, some of those willing to assist Poverty and Health in Germany

Health systems confront poverty

make it known to friends and family that, instead of birthday presents and flowers, money should be donated to the association. This is just an example of how well established the association and its work have become in Mainz. But money has also come from unexpected sources: the British pop singer Phil Collins donated €100 000 to the German welfare organization Caritas Verband, run by the Catholic Church in Germany. Out of this money Poverty and Health in Germany received €10 000 for the mobile surgery.

Most donations come from private individuals. According to Schwarz:

It's difficult to get companies to donate money or even goods to the homeless. Companies like their donations to be visible and it's not easy for us to provide that kind of visibility. The van has to stand out, so we can't very well plaster it with ads. And then there may be companies, like makers of luxury cars, who feel that their image doesn't fit well with the homeless. But individuals are often more than willing to donate.

Publicity, however, is not only instrumental in attracting donations and increasing understanding of the problem; it also paves the way for a change among policy-makers. Dr Trabert says, "Publicity is necessary not only to raise money but also to put pressure on politicians for action in favour of the homeless. The homeless tend to be ignored by politicians because they usually don't vote."

The price of success

The Mainz Model has proved to be a success in the sense that it reaches a target group who formerly would probably not seek assistance. There is now a growing demand from neighbouring towns and cities to extend the service to them, and also a demand from others for information so that they can profit from the experience of the group behind the Mainz Model.

Both Trabert and Pitz agree that the priority now is to get a full-time, paid worker. "We are rapidly reaching breaking point, where the service can't just be managed by volunteers and people doing a full-time job elsewhere," says Dr Trabert. "We are close to not coping with the operation any more," adds Pitz.

What is needed is someone who would be paid to oversee and organize the service, provide the necessary tools, service the van and synchronize the

The Mainz Model

publicity work. “It’s not easy to find someone who can be outgoing in informing and fund raising, as well as take care of the daily running of the service, but that’s the type we would be looking for,” says Pitz. “And this person has to be hired for a paid, full-time job. The service has become too extensive to be run from day to day just by us, who are actually doing full-time work elsewhere.”

“What we lack, for example, is the time to sit down now and go through our experience and discuss new working methods. We operate too much on short-term thinking, because there is too little time to think long term,” says Dr Trabert. The time tends to be used just for seeing the patients and keeping an eye on everything needed to operate on a day-to-day basis. The effort is now on securing the means to hire a coordinator: all in all a pleasant problem, since it is in a way a proof of the success of the Mainz Model.

Case study 4

Health care and social reintegration of the poor: exploring new pathways in Buda Hills, Hungary

Katalin Zoldhegyi

It is a magnificent 30-minute drive through curving hill roads and pine forests to Korányi Pulmonology and Tuberculosis Hospital and Sanatorium at the far western end of Budapest, bordering Budakeszi. The Hospital itself is more than 100 years old. It was founded by Sándor Korányi, the first Hungarian doctor to treat tuberculosis. The Hospital was funded by public contributions and it still serves all members of the community, taking in patients that health institutions in other parts of Hungary have been reluctant to admit.



*Korányi Pulmonology Hospital
in Buda Hills, Hungary*

There are at least 100 steps up one of the hills to get to Building L. This building houses a special unit that provides treatment for poor and seriously ill patients from Budapest and surrounding areas. It is a unit within the Tuberculosis Hospital run especially for homeless people. Homelessness is associated with many health problems, from low basic immunity to chronic illness and diseases such as tuberculosis. The patients in this part of the Hospital are also alcoholics. Recognizing the links between these medical

Health systems confront poverty

*Building L, the treatment unit
for homeless alcoholics
with tuberculosis*



and social problems, the Hospital introduced a comprehensive programme of treatment. When a tuberculosis patient is recovering and also, where necessary, undergoing therapy for alcoholism, the underlying problem of

homelessness is tackled with an innovative rehousing programme.

A series of visits to Korányi Hospital and, in particular, to Building L were made early in 2002 to find out about the services for this section of society.

Working with patients

Inside the single-story building, the route to the doctors' offices leads through a long corridor. The doors of the wards are open to the corridor and, although it is February, all the windows are open in the wards and passageways.

Dr Éva Salamon, a young doctor who is going to tell about the treatment programme, has been able to find only an hour of free time. It is not easy to find free time during the working day; the patients, resident for up to 12 months or more, want to talk, share thoughts and communicate with the doctors and other staff at almost every opportunity.

The special department was founded in the late 1980s by a senior professor at Korányi Hospital, László Levendel. By the mid-1990s, it was revealed that more and more tuberculosis patients were also homeless and suffered from serious drinking problems.

Three doctors currently work in the 40-bed department. In 2001, the department's doctors and 7 nurses treated 157 homeless tuberculosis and alcoholic patients. According to Dr Salamon, the special tuberculosis department achieves good results: only 17% of homeless patients get tuberculosis again.¹⁸ This number seems very high, but she adds, "It is also

¹⁸ The author is grateful to Professor Dezsó Kozma, Korányi Hospital, who provided most of the data quoted in this case study. Statistics were provided by the Methodology Department of the Hospital, from statistical yearbooks for 2000 and 2001.

Exploring new pathways in Buda Hills, Hungary

true that 83% of patients don't get infected again." Dr Salamon cannot follow the progress all of the patient's when they are released from hospital, but she is confident that the majority of them manage to find homes when they leave. Prior to discharge, one of the biggest tasks is to ensure that the patients complete their treatment. As Dr Salamon explains:

[They] lose patience or they don't want to take medicine regularly for six months or more, even if it is necessary. Unfortunately [some] patients escape [their treatment]. In these cases forced treatment is employed. The consequence of this [breaking the treatment] is a bacterium that doesn't react to ordinary medicine. ... If somebody is infected by this resistant bacterium their fate can be sealed, because it is very difficult to cure them.

Dr Ágnes Kádár is a part-time doctor in the department. She also works for the Budapest Addiction Institute. As the head physician, Dr Salamon is also responsible for another tuberculosis department in Korányi Hospital, which is where she is working during this visit. Dr Kádár started working for this special department four years ago. After she had completed her first year, two of her colleagues left Building L. This is a common administrative problem, because work with previously hard-drinking and, in many cases, drug-abusing and difficult homeless men and women is not an attractive prospect for newly graduated doctors.

On this particular Monday morning, Dr Kádár is very upset. Two of her tuberculosis patients left the Hospital during the weekend and, after four months of abstinence, both indulged in heavy drinking at a nearby pub. Although, as a rule, the patients are obliged to take a drug that induces sickness if mixed with alcohol, these two patients still consumed alcohol over the weekend and, when they returned to Building L, were in very bad condition. "These are the most difficult times for me," says Dr Kádár. "When patients escape to find alcohol, I think my work is totally useless. I am really depressed."

At this moment another patient enters the office, wanting to "negotiate" a leave from the department until the evening. An old friend has visited him and wants the patient to help him with his work in Budapest. Dr Kádár objects, but the patient doesn't drop the matter, imploring her let him go to the city and promising not to drink any alcohol. "I had an experience last time," he says. "It was more than enough. I drank two glasses of beer

Health systems confront poverty

and I almost died. I don't desire alcohol any more. I take the anti-alcohol pill. I know what it means to drink with it. I won't drink. I promise."

After listening to five minutes of begging and promising, Doctor Kádár gives the patient permission to leave. She explains her decision:

I had to let him go. He has been living here for six months. During one of his short weekend leaves, he had several beers and got really sick. So, I have to trust him now. You know we should also be good psychologists. I have to give him a chance to prove that he is reliable, that he is able to change. Otherwise, his attitude may turn negative during treatment, which may affect his chance for total recovery or may affect the atmosphere in his four-bed ward. I can't do anything, just pray for him and trust he comes back sober and with stronger self-esteem.

The atmosphere seems to be one of continual assessment and judgement on an individual level, deciding how much or how little trust should be given to these patients. All of them have had some degree of addiction, but all are undergoing treatment. It is a strange mixture of hope and disappointment, with some successes in between.

Tuberculosis screening

When trying to gauge the success of the Hospital, there are in general no statistics on the number of tuberculosis patients among the homeless, but Dr Kádár asserts that their number is increasing. The opening of this special department is in response to this increase.

In Hungary, if homeless people want to go to a shelter for the night, they have to go through pulmonary screening. If found to be positive for tuberculosis, they have to attend the tuberculosis dispensaries and are legally obliged to undergo treatment. But most of the hospitals refuse to take homeless patients. In theory they should accept all patients, but in practice they prefer to transfer the homeless tuberculosis patients to Korányi Hospital, because of the special Building L programme.

In Dr Kádár's experience, "Being homeless means being alcoholic as well," and being homeless and alcoholic almost certainly means contracting tuberculosis. She adds, "Ninety-eight per cent of our patients are hard drinkers.

Exploring new pathways in Buda Hills, Hungary

They are here for long months during the year. We only dismiss them if they are fully recovered both from tuberculosis and alcoholism. We have strong connections with aftercare institutions and civil organizations, which follow up on the future of the cured homeless patients.” But there is another disappointing answer when asked how many of the patients who recover from tuberculosis will be reinfected. If the question is applied to those who go back on the streets, homeless, Dr Kádár replies, “Almost everybody.”

The deputy head of Korányi Hospital, Professor Dezso Kozma, discussed the overall tuberculosis situation in Hungary. He says that tuberculosis was always the illness of poor people, but nobody could predict that, after the political transformation in the late 1980s, the number of tuberculosis patients would rise so steeply. Between 1990 and 1995, the increase was 20%, but levelled off by the late 1990s. According to the latest data provided to WHO in 2000, Hungary had 31 tuberculosis patients per 100 000 citizens.¹⁹ In 2000, 3073 new patients were registered. One year later, in 2001, the number of new cases had increased slightly to 3320. In the poorer eastern Hungarian counties, tuberculosis case notification rates are double those of western Hungarian counties (50 per 100 000 population).

“The main reason for the increasing number of active tuberculosis patients can be found in the socioeconomic changes,” says Professor Kozma. He adds:

Some parts of society live under worsening [economic] circumstances. There are more poor people than before, more homeless and more jobless people. There are significant differences between the territories of the country. The eastern counties, like Szabolcs-Szatmár near the Romanian border, and the Budapest region always had and still have higher numbers of newly registered cases. We consider homeless and alcoholic people the high-risk group for tuberculosis infection. Three years ago, we found that the incidence of tuberculosis among homeless people was 44% higher than in the normal population. In 2000, the incidence decreased. It is only 25% higher, but still very high.

In western Europe, the incidence is significantly lower (10–15 per 100 000) than it is in Hungary and in other post-communist countries, especially Romania, where the occurrence of tuberculosis is the highest in Europe.

¹⁹ Data from the Computerized Information System for Infectious Diseases (CISID) (<http://cisid.who.dk>, accessed 10 July 2002).

Health systems confront poverty

*Therapy session at
Korányi Hospital*



At Korányi Hospital, the special session of the week is about to start in the common room. Every Wednesday, all the homeless patients meet on a self-development training scheme. The session is led

by Géza Zánkay, a retired psychologist. Although he is over 60, he comes every week to meet homeless patients and has been working for the Hospital for 15 years. He starts the group meeting with routine questions about food and the cleanliness of the wards. Answering the general questions, some patients start by complaining about the quality and quantity of food, but the discussion soon moves on to their lack of freedom. This quickly leads to one of the central problems: prohibition of drinking.

“You want to serve two gods: sobriety and delirium,” Zánkay replies to a group of patients reminiscing about “old times”. When together with their buddies they share a “good and relaxing time with a bottle among friends”. In Building L, alcohol is forbidden, and under the house rules a drug that induces sickness if mixed with alcohol is required to be taken. The discussion continues: one patient criticizes people who impose on others’ kindness; another speaks about the lack of perspective in their institutionalized existence. But these discussions do not discourage Zánkay. He stresses that the major task is for all participants to tackle alcoholism as well as their tuberculosis. “If you don’t want to merge with the system, I can force you,” he says, referring to the 1961 Tuberculosis Law.

Zánkay asks one of the participants, Feri, to talk about his recently started weekend work at a school. This middle-aged man is in the secondary phase of treatment and has begun working outside the Hospital. It is an interesting introduction to rehabilitation and brings a note of optimism to the session. Feri says:

I had a flat and a job when I started to drink. I have been homeless for four years now. Now I receive a Ft 10 000 [US \$35] payment from the school. It made me

Exploring new pathways in Buda Hills, Hungary

think. Many people think that somebody else will help. It is false. We must help ourselves. Nobody will act for us. I had to queue a lot to get an audience with the mayor of Budakeszi. But he gave me one. And I got a weekend job. OK, the money is enough for now, as I am under treatment. But I feel I will have power to direct my future if I am totally recovered. I am positive and this is the big thing!

Unexpectedly, all the other participants applaud him. Zánkay reinforces the positive reaction by quoting the biblical proverb about not giving fish away but rather teaching others to catch them. The discussion continues on various matters relating to different aspects of their future.

Dr Kádár and Dr Salamon take part in a session with Dr Alíz Erdélyi, the department's psychiatrist. They let the patients speak, observing them and their reactions to each other. After the session Zánkay says:



Géza Zánkay, psychologist

I want to teach these homeless patients to struggle for their life again. I want them to believe that they can have a livelihood again and they can find a spouse again. They are very vulnerable and uncertain people. They use alcohol to ease inhibitions, loosen stress. This is a therapy session. In the group I have to find an issue that generates tension. I have to provoke them. I have to give them the feeling that they are able to handle their own conflicts by analysing, speaking out, communicating.

The easy approach would be for the Hospital to simply treat the illness and let the patient go, but these therapy sessions are a part of the more comprehensive approach taken at Korányi Hospital, where the interdependence of the problems means that all have to be treated.

Some of the patients have special counselling with Dr Erdélyi. This counselling is done in private, but after the 30-minute session Dr Erdélyi is free to speak about her experience with homeless tuberculosis patients. She explains:

Health systems confront poverty

They are generally unable to solve their problems by themselves. They run away from problems they are not able to face. My most important task is to motivate them. Most of them don't want to go home or back to the street, they don't want to work or undertake responsibility for their own future.

I have been working here for seven years. My biggest fear is what happens to them when they recover from tuberculosis and are dismissed from Korányi Hospital. Where do they go? Patients generally fall back unexpectedly. They don't know five minutes before that they want a drink. And after five minutes – they find themselves in a pub again.

András undergoing treatment



Korányi Hospital accepts tuberculosis patients from all over Hungary. They live in three- or four-bed wards for months. Each of them takes Esparal while resident, which is a procedure that in itself causes new problems. András, 28, drank spirits while taking the drug and now needs extra treatment. His story is one of consequential decline:

Unfortunately my marriage went wrong. I became homeless. My personal circumstances have totally changed. I was not averse to alcohol. I started to drink heavily, I started to sleep in different shelters and homeless doss houses, and I drank more. I never had problems with my health before.

My tuberculosis problem showed up when I went for a pulmonary screening, as shelters for the homeless require fresh documents every six months. I never had any problem before. But my latest examination showed that there are some lesions on my lungs. After several examinations, the conclusion is that I have a serious form of tuberculosis.

András's room-mate, Péter, is happy because he still has his family, who continue to support him during his treatment at the Hospital. Péter says, "I can't say I never drink. Sometimes I drink a wine spritzer but never too much. I am never drunk. I take care of myself, as I am a TB patient, but I have no money for alcohol and my family – who took me back – would scratch my eyes out if I drank again."

Exploring new pathways in Buda Hills, Hungary

Planning for the long-term future of her patients, Dr Salamon has founded an organization that helps cured homeless people integrate into society again. As President of the “Health and Alcohol-Free Rehabilitation Association” she raises money to help and support recovered patients.



A home and workplace for recovered tuberculosis patients

She succeeded in involving the Adventist Church and has set up a foundation that provides funds for housing up to 40 patients – all of them recovered tuberculosis patients, reformed alcoholics and formerly homeless. One of the foundation’s houses is in Budakeszi, three bus stops from Korányi Hospital.

Dr Salamon’s approach to teaching her patients is not just medical and social, but her humane attitude towards them is also part of their overall rehabilitation. She says:

Sometimes homeless people are really shocked when they see that they are regarded as human beings, because they have been stepped on, expelled and outlawed everywhere. The mere fact that they are considered a person is enough to gain their trust and start to work with them. ... But when it is time to say goodbye to them, from the medical viewpoint I always worry whether they will be strong enough to say no to alcohol and old buddies. I hope that in our protected houses and workplaces they will be stronger than they would be without support.

László, a recovered tuberculosis and alcohol patient, has not had any alcohol since 1994. He is at the front of the big house established by the foundation. He explains, “There are 40 ex-tuberculosis and alcohol patients and ex-homeless here. Everybody works. Working is compulsory in these fund houses. Jobs are obtained by Korányi Hospital’s special department, or Dr Salamon, or the Adventist Church. We have a strict rule: if somebody drinks alcohol, he must leave the house within 24 hours. This is THE RULE!”

The former homeless patients built the building. They laid the bricks and mixed the mortar. They did the carpentry and painted the walls. By using

Health systems confront poverty

László with a certificate for building houses for the homeless, given by the Minister for Youth and Sports

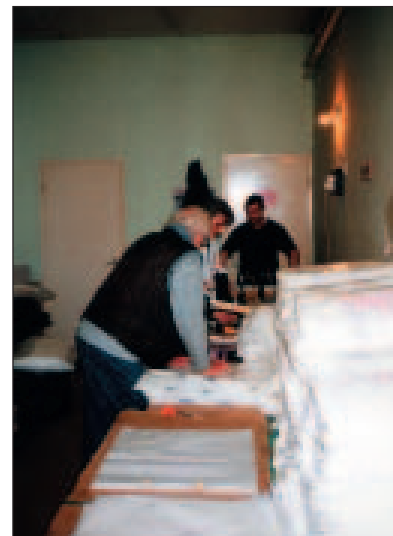


the skills of some of the patients and developing skills in others, the programme helps to prepare them for employment. The 40 recovered homeless people live in the building's many rooms for up to 2–3 years. During this time they save as much money as they can to start a new life when they leave. They work 6 or 8 hours a day, paying some money towards common household expenses such as heating, water and electricity, and keeping the rest for their own use. Most of them do gardening or school utility jobs, but some have trades such as carpentry or other building skills.

These working members of the Hospital's recovered community travel to different parts of Budapest for their work, while some of the older patients or those who are not so strong work in the building's own plastics workshop.

Mr Rudas is ready to leave the building. Last year, he applied to the foundation for help in getting a job and for shelter for three years. He

Work with plastics for recovered tuberculosis patients



Exploring new pathways in Buda Hills, Hungary

succeeded. He says he does not miss alcohol or his drinking buddies: “The foundation gave me a place where I can work. I like working and I am proud that I live in a house that I built with my own hands. I would like to write my story in a book. And, above all, I want to avoid my old drinking companions.”

Case study 5

From misinformation and ignorance to recognition and care: immigrants and homeless in Rome, Italy

Dario Manfellotto

In the Holy Year 1725, Pope Benedict XIII decided to build San Gallicano Hospital to provide assistance and care to the poor and the rejected, and to all the pilgrims coming to Rome affected by skin diseases, especially leprosy and scabies. A marble plaque on a wall of the Hospital records this in Latin.



The plaque

A few centuries later, at the beginning of the new millennium, the Hospital, located in the popular and traditional quarter of Trastevere, is still there although its name has changed to *Istituto di Ricovero e Cura a Carattere*

Health systems confront poverty

Scientifico San Gallicano (San Gallicano Institute for Hospitalization and Cure with a Scientific Approach). The poor and the rejected, however, are also still there, and the need for assistance and care for these people, despite social and economic progress, is still an actual and topical subject for the Italian National Health Service (NHS).

In modern Italian society, the poor may be characterized as people who live under conditions of particular disadvantage and who are bound to forms of dependence from welfare assistance. The poor also have difficulties in accessing the NHS and the social and public health networks. The weak and needy, immigrants, travellers and homeless must be considered overlapping groups, but there are also the elderly who live on a disability, social or old age pension.

Article 3 of the Italian Constitution states, “All citizens have equal social dignity and are equal before the law, regardless of sex, race, language, religion, political opinion, or personal and social conditions,” and Article 32 states, “The Republic considers health as a fundamental right of the person and a public concern, and guarantees free treatment for the sick.”

Italy and immigration

At the present time, mostly because of its geographical position and its initial lack of legislation on immigration, Italy serves as a gateway to Europe for thousands of immigrants.

In the last few years, Italy has begun to provide adequate legislative and operative instruments to regulate immigration. In 1995, Legislative Decree 489, *Urgent regulations about immigration, access and stay in the national territory of non-EU citizens*, laid out the right to health for all illegal or clandestine people, not only in terms of special access but also in terms of regular treatment. In 1998, Act 40, relating in particular to the health care system and services for migrant patients, was a confirmation that no one can be excluded from access to health care services. With the Consolidation Act, *Regulations concerning immigration discipline and rules on conditions for foreigners* (Legislative Decree 286/1998), which incorporates the above-mentioned Act 40/1998, remarkable advances in the efforts to overcome discrepancies and discrimination were made in relations between immigrants and the NHS. Both Presidential Decree 394/1999 (*Implementation rules of the Consolidation Act regulations concerning immigration discipline and rules on conditions for foreigners*) and Health Care

Immigrants and homeless in Rome, Italy

Ministry circular 5 (24/3/2000: *Regulations on health care assistance*) complete the reform and updating of the regulations that allow all foreign citizens, whether legally present in Italy or not, unrestricted access to preventive, curative and rehabilitative services under the NHS.

According to the official data on immigration in Italy, in January 2001 there were 1 388 153 foreigners with a residence permit. Some 245 000 of these were living in the Lazio region with 90.6% living in the province of Rome, which is where the majority of immigrants in Italy are concentrated, followed by Milan.

Taking care of people with different social and cultural backgrounds is not straightforward. There are language barriers, and often immigrants do not take advantage of preventive strategies, only turning to the social and health services in urgent cases or at an advanced stage of an illness when treatment is often much more expensive.

The Department of Preventive Medicine at San Gallicano, Rome

In recognition of the needs of immigrants, a Department of Preventive Medicine for Migration, Tourism and Tropical Dermatology (DPMM) has been operating at San Gallicano Institute since 1985. For years, DPMM has been the only public referral point, not only for assistance and treatment, but also for medical, epidemiological, social and anthropological research on immigrants and nomadic and homeless people.



Some DPMM staff with patients

Dr Aldo Morrone, a physician specializing in dermatology and venereology at the University of Rome, is the Director of DPMM. Under his leadership the service has expanded to a staff of four physicians, two social assistants, one administrative coordinator and two registered nurses, and enjoys the collaboration of many other professionals: physicians of various specialties, psychologists, epidemiologists, sociologists and statisticians.

Health systems confront poverty

DPMM has a medical–anthropological counselling service for finding and taking care of culturally disadvantaged people at risk of developing diseases. There is also a free legal assistance service for needy persons, a free ethnopsychiatry service and help from anthropologists from La Sapienza University in Rome, coordinated by Professor Gioia Longo Di Cristofaro. Every year, in collaboration with the Rome City Council and the Association “Casa dei Diritti Sociali”, DPMM organizes an International Course on Transcultural Medicine for sociomedical staff, public administrators, teachers and volunteers, with the aim of promoting interest, understanding and exchange of experiences about the complex reality of health care.

Since its inception, DPMM has provided services for all, Italians and foreigners alike. The services are particularly addressed to immigrants, the homeless, travellers and those without a health insurance card.

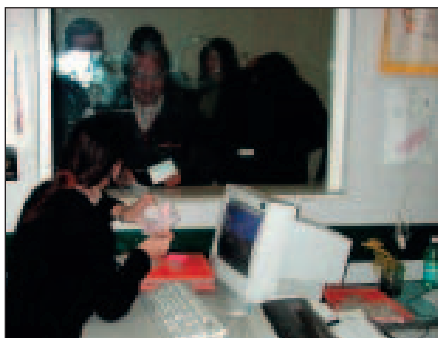
According to the present legislation, all Italian citizens and official immigrants may have free access to the services provided by the NHS, whatever their economic situation. A contribution towards expenses may be asked for certain services and drugs. Illegal or clandestine immigrants may obtain medical assistance from an NHS centre, provided they show identification and are registered as STP (*straniero temporaneamente presente*, which means temporary foreign resident). According to the regulation, a foreigner without an identification card has only to provide his or her name, date of birth and nationality to receive an STP number. The STP document allows free access to services and essential drugs when applying to a public hospital for assistance. The STP document must be renewed every six months.

Every morning, many people queue in front of the main entrance of San Gallicano Institute, waiting for the arrival of doctors. Along with the

People queuing to enter DPMM



Immigrants and homeless in Rome, Italy

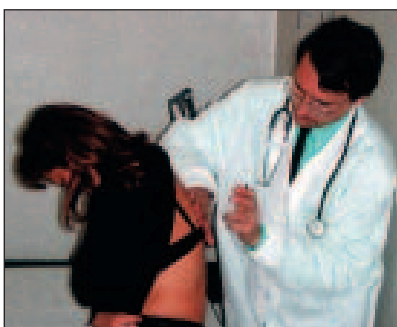


Office for registration and certification of young patient

Italy is a mix of patients of different cultures, religions, languages and colours. DPMM is open to tourists, missionaries and travellers from and to tropical countries, and provides specialized tests, consultations and updated information on the prevention of the most common diseases in tropical regions.

At the present time, between 150 and 200 people receive assistance daily. As soon as a patient arrives, he or she receives a first-stage evaluation by a team comprising a doctor (usually an internist), a nurse and a cultural mediator. They register the patient directly and, where necessary, make out an STP document. A further examination (and advice) can be requested on dermatology, allergology, oncology, plastic surgery, internal diseases, infectious diseases, neurology, tropical diseases, sexology, sexually transmitted diseases and AIDS. Recently, a service for odontostomatology was added.

Besides offering a daily service with free access to care, DPMM is also an observatory for studying and monitoring health conditions and health hazards in these particular groups. The data collected through this observatory are analysed and the statistical information is collated according



Clinical examination of patients

Health systems confront poverty

to a number of factors: country of origin, age, education, frequency of diseases, most prevalent diseases, substance abuse, sexually transmitted diseases, sexual activity, length of residency in Italy, legal status, family and social relationships, and behaviour and lifestyle.

Specialized treatment

Since 1996, care has been assisted by linguistic–cultural mediators, who welcome and explain the facilities to foreign patients in their own languages. They also facilitate cultural and interpretative understanding for diagnoses and therapies, to tailor the correct approach to the individual patient.

An example of the needs of Muslim patients during Ramadan demonstrates the type of sensitivities to which DPMM responds. Dr Morrone confirms, “In the beginning, there were a few misunderstandings. We were recommending all patients under cortisone treatment to take the drug in the morning ‘with breakfast’, according with the circadian rhythm of the natural hormone. We said this to a Muslim patient with severe diffuse dermatitis.” After several days the patient came back to the office with a worsening of the disease. “A cultural mediator,” continues Dr Morrone, “helped in explaining the case. Owing to Ramadan, the patient had not been eating breakfast, so he was not taking any cortisone pill. He started to improve when, contrary to the pharmacology and the circadian rhythm, he began to take the pills after sunset.”

A similar misunderstanding came to light after suggesting that antibiotics be taken for an infection after meals (breakfast and lunch). The patient was a strict Muslim and fasted completely during Ramadan: no meals (or drugs) during the day. Acknowledging this particular need, DPMM now remains open during the night, to allow for treatment after sunset. Intravenous lines are also used at night, to allow infusions of fluids and/or drugs, and injections and other drugs are given after sunset. For diabetics, instead of an injection of insulin before each meal, two doses (one before dawn and the other after sunset) are planned.

The people attending DPMM have almost all experienced war, poverty, marginalization or loneliness. During a business trip to Rome, S.H., a 45-year-old businessman from Somalia, was informed that, owing to the war in his country, he was not able to return home. His bank accounts had

Immigrants and homeless in Rome, Italy

been blocked, and he was not able to get financial support. His family was in Somalia, and he could not contact them easily. Until then he had been a rich man; suddenly he was poor, homeless and unemployed. He started to sleep under the bridges on the Tiber river, or in the central railway station.

As Dr Morrone remembers, S.H. had never had health problems before, but owing to malnutrition and housing problems he started to have fever, infections, a recurrent cough and bronchitis. He often had to consult doctors for a strange feeling of burning in his mouth and pain in the throat. “An examination by our ear, nose and throat specialist easily discovered the cause: a carcinoma of the larynx,” says Dr Morrone. “We admitted the patient, and he underwent a total laryngectomy. His clinical condition was very compromised. Moreover, owing to the operation, he had lost the ability to speak, and he had to write all his needs on a sheet of paper.” In a short time, the disease became terminal. He asked Dr Morrone to help him bring the family together, to see his wife and three sons before he died. DPMM covered the expenses for the flight of the family to Rome, and a friend of one of the doctors lent his house to the patient so that he could live the last part of his life with the support and love of his relatives.

Not all endings are sad, and Dr Morrone remembers many stories with happy endings. A young woman from Belgrade was spending a period in Italy to improve her knowledge of Italian history and literature, when the conflict in the former Yugoslavia erupted. She had to remain in Italy, with an inactive credit card and no possibility of contacting her family. She started to work in Genoa general market; then, she was obliged to prostitute herself to survive. She decided to escape from the streets of Genoa and left for Rome, where she asked for an examination at DPMM. She had contracted a sexually transmitted disease, which was immediately diagnosed and completely cured. The woman was very well educated and spoke perfect Italian, and it was proposed that she be employed as a cultural mediator for Balkan people in the Department. She remained in Italy until the end of the conflict, returning at last to her country to rejoin her family.

The linguistic-cultural mediators speak many languages in addition to Serbian/Croatian: French, English, Spanish, Portuguese, Arabic, Kurdish, Lingala, Swahili, Tigrinya, Amharic, Bantu, Filipino (Tagalog), Tamil, Bangladeshi, Bulgarian, Polish, Russian, Romanian and Albanian.

Health systems confront poverty

Two young patients



Between 1 January 1985 and 31 December 2001, 49 701 illegal and clandestine immigrants made their first visit to DPMM. Of these, 19 252 (38.7%) were female and 10% of those seen were children, whose number is increasing with time.

The percentage of Italian patients consulting DPMM has increased with time, from 5% in 1985 to 25% at the beginning of 2002. This group is composed mainly of the homeless (about 90%) and the elderly (about

10%). This may be explained in part by the increase in the percentage of Italians (13.1%) under the poverty threshold. They find it difficult to access the NHS and the social and public health network, where complete coverage of their needs by the NHS is not yet fully available to them. These people consult DPMM for many kinds of help, especially social, and also for simple procedures such as intramuscular injection of drugs.

Migration and health

Dr Morrone explains that migration is a cause of stress and health hazards, because it involves a reorganization of life and uprooting from a familiar environment. A large number of studies suggest that migrants who decide to leave their country of origin have a basically sound health record and a good level of education – to secondary or higher level (18% have a degree and 86% can speak a second language well). Until recently, migrants arrived in good health and diseases were only contracted after entering Italy. But now that phenomenon (known as the “healthy immigrant effect” owing to a kind of autoselection before leaving the country of origin) is only partly true. According to Dr Morrone, the journey itself is now the first health hazard for an immigrant. When 80–100 people are packed in boats designed to hold a maximum of 20–30, and sail for days with no sanitation and little food and drink, there is a substantial risk of getting ill.

The health record of a new immigrant can also be rapidly damaged by a series of factors, such as diseases present in the host country, psychological problems, no income due to unemployment, housing difficulties, absence

Immigrants and homeless in Rome, Italy

of the family, and change of climate and eating habits. The time interval between arriving in Italy and first requesting medical help, the “healthy interval”, has dramatically decreased from 10–12 months in 1993–1994 to 3–4 months in the last few years. The diseases resulting from this situation can be defined as stress- and poverty-related.

In Dr Morrone’s DPMM, the main pathology observed in immigrants is not very different from that observed in Italians. A number of so-called poverty-related diseases, such as tuberculosis, scabies, pediculosis and some viral, mycotic and venereal infections, have been observed. Though not specific to immigrants, they are indicative of a state of extreme marginalization, such as homelessness. In other words, immigrants do not present problems of tropical diseases or different pathologies that are more serious than those of native Italians, but they lack basic health safeguards and the subsequent prompt diagnosis and therapy that allows native Italians to recover faster. It can be very difficult, if not impossible, to help such people when they ask to return home because their condition has become pre-terminal, and often they die alone.

What has been achieved?

It is difficult to measure quantitatively the true impact of the type of services provided by DPMM. But the benefit for the thousands of people who now have a better life owing to the work of dedicated and interested health personnel is very clear. Furthermore, by keeping data and analysing trends in the “invisible” population (the illegal immigrants), DPMM is building a solid base of scientific evidence on the medical and social conditions that afflict the poor.

This unique experience has been reported to have influenced the development of modern Italian legislation on the care of migrants. This legislation allows, at least from a legal standpoint, access to the NHS by all foreign citizens officially or illegally present in Italy.

Moreover, DPMM was recognized in 1998 as a centre of reference and consultation for the Lazio Regional Government and for the NHS, for educating and training health personnel devoted to the care of migrants. The Department for Health Promotion Policies of Rome City Council has also designated DPMM as a clinical–epidemiological observatory for the health of the homeless, immigrant and travelling populations in Rome.

Health systems confront poverty

Since December 2001, DPMM has been a member of the International Centre for Migration and Health (ICMH), a WHO collaborating centre.

This experience appears to be economically cost-effective, in addition to being ethically sound. The cost for the management of the Department is around €300 000 a year, including the cost of drugs and other materials freely provided to all patients. But the impact of this service is believed to have a clear additional value. The care of immigrants' health is of the utmost importance and feeds back to preserving the health of Italian citizens – for example, limiting the spread of communicable diseases. Moreover, the preventive and screening activities performed by the staff of DPMM allow the prevention, prophylaxis, detection and treatment of diseases at an early stage, thus limiting and controlling their progression to more severe conditions that would be expensive to treat.

Case study 6

Mobilizing resources for health: the first phase of Kyrgyzstan's co-payment policy

Jen Tracy

The buildings of the main hospital in Kyrgyzstan's Issyk-Ata district in Chui *oblast* are structural nightmares. Some of the foundationless buildings are due to be demolished, while the others are a patchwork of half-hearted repairs that should be condemned. The heat escapes through the poorly insulated walls and dilapidated windows; a combination of tape and plastic attempts to hold rusted heating pipes together, and the smell of dust and mould pervades.

But for three young male patients crammed into one of the hospital's small rooms, health care isn't nearly the nightmare it used to be only a short time ago. Before, they had no idea what informal costs awaited them on admission, or whether or not the hospital would be able to provide the necessary medicaments. In particular, they say they have benefited from the co-payment policy and the patient certainty it has brought.

Gasanov, a 28-year-old patient, eagerly sits up in bed to say that he is satisfied with hospital conditions under the new system. "The situation is better now," he says. "The payment is official and I was aware of it before I came, plus I'm getting all the drugs I need and I don't have to go the pharmacy myself to get them. It's all included." He sits up further in bed to point out all the remodelling going on



Gasanov and his two roommates in the main hospital at Issyk-Ata

Health systems confront poverty

around him as an indication that reforms are working in other areas as well. His two companions echo his opinion, saying that the quality of service seems to have improved and that they are all getting three meals a day.

In Bishkek, though, where the co-payment policy is not scheduled to be implemented until July 2002, people are less satisfied. "You never know what you will pay when you go to the hospital and everyone's so afraid of getting sick," says a middle-aged Bishkek taxi driver who asked that his name not be used. "Removing your appendix might cost as much as \$100 but no one really knows, and if you don't have the money, forget about the operation," he says.

The link between health and economic survival in Kyrgyzstan, with a predominantly agricultural economy and the majority of the population living below the poverty line, is direct. For these people, one family member's illness means one less breadwinner. And for those who must seek medical treatment it also means informal payments that the average family can ill afford. Sickness is a nightmare and increases poverty among those communities that are already the poorest.

Much like in other former Soviet republics, the health care system in Kyrgyzstan suffers from an excess of hospitals that are difficult to maintain, even with the assistance of international donors. In theory, it is a system that offers free health care to all citizens. In reality, it is a system in which patients have to pay for ostensibly free drugs and surgical operations, and in which medical workers are so poorly paid that they sometimes feel compelled to supplement their meagre incomes by coercing payments from patients.

One of the pervasive problems has been the absence of drugs in hospitals, requiring patients or their relatives to search for drugs outside the hospital, paying for them directly. Not only has this been a serious financial burden, but it has also jeopardized the health of patients who required emergency treatment.

The most horrifying response to the shortcomings of the country's health care system has come from the poorest segments of the population. Unable to pay for their health care, many turn to home remedies and go without any medical treatment at all. And it was the poorest people that Ainagul Isakova, Director of the Family Group Practice Association (a

The first phase of Kyrgyzstan's co-payment policy

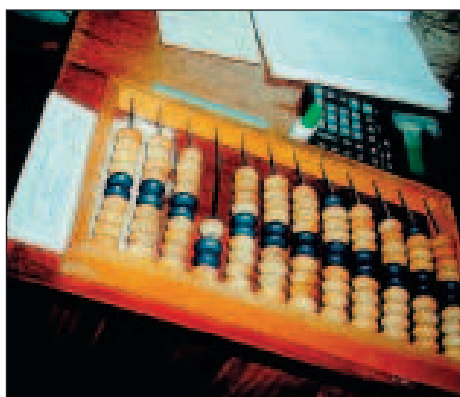
nongovernmental membership organization of primary care providers) was thinking about when she said: “We do not want health care to become a distant memory.”

The co-payment policy – part of the 10-year MANAS Health Care Reform Programme that aims to improve the efficiency and effectiveness of the Kyrgyz health care system – is one reform that is working towards ensuring that health care is indeed not a “distant memory”. The policy was introduced in two *oblasts* (regions) in March 2001. Since then, it has helped to reduce informal payments to medical staff and for medical supplies, to generate an additional source of income for hospitals, to slightly raise meagre staff salaries, and to make health care more affordable. It has also provided a specific fund to pay for the health care of the poor.

“Overall, this policy is part of a package of measures that relate to the funding provided by local government authorities ... for the health sector in their *oblast*,” says Joe Kutzin, Senior Resident Adviser, WHO Health Policy Analysis Project.

A visit to the main hospital in Issyk-Ata in mid-March 2002 provided an example of how the co-payment policy is working. The head doctor of the district's two hospitals, Emen Isakov, was more than eager to show evidence of what he calls success. In the hospital's main building, a sign on the door of a small office reads “Co-payment Cashier”.

Here, with an abacus and a pile of receipt forms, a hospital administrator registers patients one by one, checks their documents to determine their insurance or exempt status, collects the appropriate co-payment fee,



“Co-payment” – the office sign and the abacus on which it is calculated

Health systems confront poverty

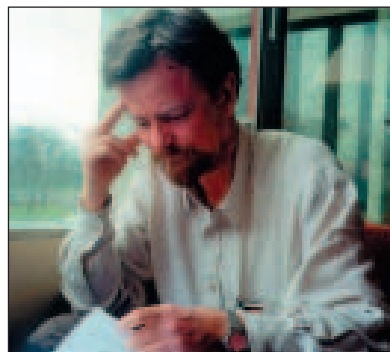
provides a receipt and then ushers the patient off for treatment. After that, the patient pays for nothing else. “Overall,” says Isakov, “the payment is less in the absence of informal payments and other unknown costs. Most importantly, it is more convenient for the population because now they know exactly what [and if] they will pay.”

*Dr Tilek Meimanaliev,
the Kyrgyz Minister of Health*



The Kyrgyz Minister of Health, Dr Tilek Meimanaliev, testified in a recent interview to the success of the co-payment policy. He says, “I am pleased with the experience of the policy to date. In particular, I feel that this has demonstrated that we can reduce corruption in the health system and enable health workers to increase their salaries through legal means. This system has also empowered patients by giving them a good understanding of their financial responsibilities as well as their rights.”

*Tobias Schüth of the
Swiss Red Cross, Bishkek*



Tobias Schüth, the coordinator of a Swiss Red Cross health project in Kyrgyzstan, describes the policy as an overall success:

My general view is that the policy is a very good attempt at introducing official user fees. It is done in a way that is generally acceptable to people and has definitely the potential, on the hospital level, to reduce informal payments to insignificant levels plus generate local funds for the hospitals – if on a macro level, the Mandatory Health Insurance Fund [MHIF, the organization responsible for providing public funds to health care providers] can ensure the funds it is entitled to.

Ninel Kadyrova, Deputy Director of MHIF, also says the co-payment system has produced positive results. She says, “The single payer system started in March 2001 and we have only early results, but they show us effectiveness in improving access of the population to medical services.”

The first phase of Kyrgyzstan's co-payment policy

Evidence from the first phase of the national reform

On its implementation in March 2001, the co-payment rates for inpatient care ranged from zero to 1890 soms (approximately US \$40), with five different levels of payment. A series of different analyses of the policy were sponsored by WHO's Health Policy Analysis Project in Kyrgyzstan. The first findings on the policy – from rapid appraisal studies conducted in May and October 2001 led by the Swiss Red Cross – showed that the majority of people interviewed, after receiving care under the new system, “perceive the co-payment policy clearly as an improvement over the previous system”. The general conclusion of the preliminary findings, presented by Schüth, was that: “At present the co-payment policy fulfils partially its major function of replacing all other hospital-related expenditures of patients.” Indeed, all patients interviewed in Issyk-Ata and Bishkek attested to the policy's current and potential success.

The two rapid appraisal studies led by Schüth's group show a positive picture overall. The first study shows almost no payments made by patients beyond the co-payment fee, while the second study shows that about 40% paid something beyond the official fee – mostly (88%) towards treatment and very little (5%) in the form of informal payments to medical workers.

In Schüth's opinion, however, the differences do not reflect a failure of the co-payment system, but instead reflect delays in hospital financing.

The hospitals do not get all the funds they are entitled to from the MHIF because the MHIF itself gets only a fraction of what it is supposed to get from the Social Fund. So, while in the beginning hospitals tried to strictly follow the rule of not asking patients for extra payments, later reality forced them to do so anyway and they asked patients to buy what the hospitals could not provide. [In the end], 40% of patients making payments beyond the co-payment does not mean that the co-payment does not work on the hospital level, but rather that its conditions on a macro level are not set to allow it to work as it is supposed to.

In addition, two surveys of patients were sponsored to provide a quantitative assessment of the effectiveness of the policy. The first baseline survey was made of patients discharged in February 2001, just prior to the implementation of the co-payment policy. A second survey was made of patients discharged in July 2001, the fifth month of implementation of the

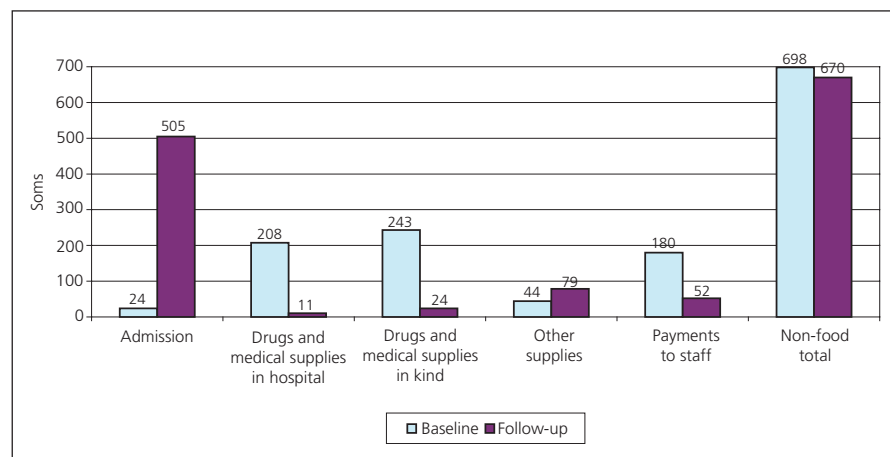
Health systems confront poverty

policy. The data from these surveys largely confirm the more qualitative conclusions of the rapid appraisal studies. According to data from the surveys, the share of total patient spending for drugs and medical supplies – both in and out of the hospital – was dramatically reduced. Particularly in Issyk-Kul *oblast*, there was a dramatic shift in the composition of patient payments from informal expenses to the formal co-payment for admission to the hospital (Fig. 1).

The data also indicate, particularly in Issyk-Kul, that the extent to which informal payments were being made directly to health workers was reduced. Such payments were particularly frequent when surgery was needed. For surgical patients in Issyk-Kul, however, the frequency of making payments directly to the surgeon dropped from 50% of cases in February 2001 to only 9% in July (Fig. 2).

Consistent with this, the survey data also show that insured and uninsured surgical patients paid noticeably less under the co-payment policy than they did under the old system, while uninsured medical patients ended up paying, on average, more than they had previously. For insured medical

Fig. 1. Mean expenditure by all surveyed patients in Issyk-Kul hospitals, weighted by actual utilization distribution



Source: WHO surveys of discharged hospital patients carried out during February and July 2001.

Notes: The baseline survey interviewed 2917 patients nationwide, including 381 patients from Issyk-Kul hospitals, representing 11.5% of February cases. The follow-up survey interviewed 3731 nationwide, including 560 patients from Issyk-Kul hospitals (16.3% of July cases).

The first phase of Kyrgyzstan's co-payment policy

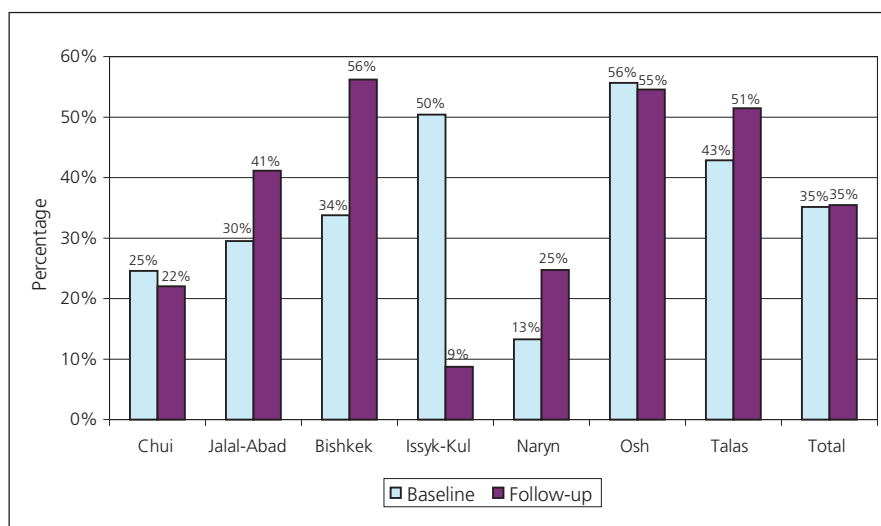


Fig. 2. Patients paying surgeons directly in Issyk-Kul and other oblasts, demonstrating the effect of the co-payment system

Source: WHO surveys of discharged hospital patients carried out during February and July 2001.

Notes: See notes to Fig. 1.

patients, the payment remained about the same. “In short,” says Kutzin , “the fixed co-payment led to some convergence in the total amounts paid by insured medical and surgical patients, who are more differentiated now by their insurance status than by the costliness of the condition that they have” (Fig. 3).

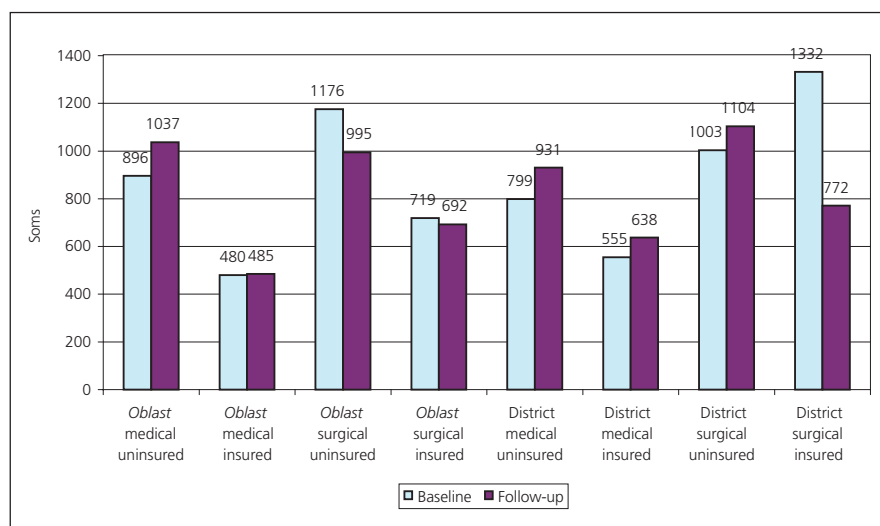
Putting revenues to work

“The advantage of formalizing the payments is that they are then open to redistribution throughout the hospital, whereas the previous informal contributions were not subject to the management control of the hospital,” says Kutzin.

Isakov says that the co-payment contributes an estimated 10–15% of the hospitals’ budgets in the region. “But that money,” he points out, “is very important because it is ‘real’ money that we receive and that goes directly into our bank account. Budget money is not always provided on time, but co-payment money is always there.” According to the doctor, most of the co-payment revenues go directly towards patient treatment, with about 20% going towards staff salaries. The result, Isakov says, is that the expenditure on patient treatment has tripled.

Health systems confront poverty

Fig. 3. Total patient non-food expenses, medical and surgical, for patients in Issyk-Kul regional and district hospitals, demonstrating convergence in payments following introduction of the co-payment system



Source: WHO surveys of discharged hospital patients carried out during February and July 2001.

Notes: See notes to Fig. 1.

Co-payment revenues have so far resulted in increased daily funding of drugs and medical supplies, by 1.9 times in Chui *oblast* and 2.7 times in Issyk-Kul *oblast*, according to data from the Ministry of Health (2001).

The policy has worked to increase daily food expenditures in Chui and Issyk-Kul *oblasts* by 1.8 times and 2.2 times, respectively. In both *oblasts*, co-payment revenues have also been used to increase staff salaries by 2.8 times for doctors and 2.5 times for nurses. The average monthly salary for medical workers is slightly less than €10. Isakov confirms that, “Today, our salaries are the highest in the Republic. For instance, a nurse here receives as much as a medical professor at a university.” It has yet to be confirmed how far this situation can be extended to other hospitals.

The co-payment system has allowed for greater overall transparency, with most patients now being given receipts for their co-payments. According to Kutzin, “Prior to the co-payment policy in Chui, about 13% of patients paid something for admission to the hospital,” though they should have been charged nothing. Of those, Kutzin says that about 25% received a receipt for the full amount of their payment. The follow-up survey data show that about 34% of patients reported paying for their admission (the sample including many who were exempt from the co-payment), and about

The first phase of Kyrgyzstan's co-payment policy

66% of them received a receipt. In Issyk-Kul *oblast*, Kutzin says that about 22% of the patients paid something for admission in February 2001 with about 20% of them receiving a receipt. In July 2001, under the co-payment system, that had changed to about 38% paying for admission and 86% of them receiving a receipt.

Health care for the poor

Experts initially feared that the country's poorest people would be alienated by the co-payment system and would choose to avoid treatment altogether. Schüth, however, says that the results have proved otherwise: "What we found, surprisingly, is that probably isn't the case. The differences between richer and poorer patients' opinions weren't very large. Around 70% of both – only slightly more for richer patients – saw an improvement in the new policy." He attributes this largely to a "back-door entry" that was designed into the co-payment policy to protect the poor and ensure their access to health care. Poorer patients can get a letter from their village administration that certifies their inability to pay. "That is widely practised," says Schüth, "and certainly is a reason why we didn't come across more people who couldn't go to hospital because of the co-payment."

According to Minister of Health Meimanaliev, "By making the payments formal, we are able to implement specific policies aimed at protecting access to care for low-income or otherwise needy persons. This is done through our policies on exemption from payment and on the

hospital 'reserve fund' that sets aside money to provide free drugs for poor patients." The Ministry of Health has instructed hospitals in both *oblasts* to set aside 10% of co-payment revenues for that reserve fund. According to the Ministry's instructions, each hospital has a special committee to decide who this reserve fund will benefit. According to Meimanaliev, in 2001, the first 7 months of the co-payment policy benefited 1700 poorer patients by providing them with free drugs from the reserve fund.



Patients lingering in the Issyk-Ata hospital grounds

Health systems confront poverty

MHIF's Ninel Kadyrova says that less than one year later, the number of people who have been treated without a co-payment fee thanks to the reserve fund policy has increased to 2500. Furthermore, Kadyrova says that MHIF is working very closely with the Ministry of Labour and Social Protection to improve access under the reserve fund. Isakov says that his hospitals treated around 180 poor people using the reserve fund in 2001 and that most of the beneficiaries were homeless people.

Taking the nightmare out of health care

The co-payment policy has also reduced people's uncertainty about the costs of inpatient health care, allowing treatment for some poor members of the community who previously could not risk unpredictable, excessive costs. The unofficial nature of most payments that people had to make for hospital care meant that most patients had no idea how much they would end up paying for their treatment. According to patient surveys, only about 23% of those admitted to hospital had any prior knowledge of what they would be paying in total, and only about 18% had an idea of what they would be paying in official fees.

Data on both the initial and incoming results of the co-payment policy show that the overall effect has been a positive increase in patient certainty (Fig. 4).

"This time I knew in advance what I would have to pay, and I know that I'm paying what I'm supposed to pay and nothing more," says 30-year-old patient Isaev, from his bed in Issyk-Ata's main hospital. Isaev, Gasanov and Madinov all say they learned of the co-payment policy from their Family Medicine Centres and were prepared to make the payment when they checked in. The survey data show that in Issyk-Kul and Chui *oblasts*, patients' awareness of their financial obligations increased significantly, whereas such awareness was largely unchanged in the rest of the country.

A patient at Bishkek's outpatient Polyclinic 6 said she was eagerly awaiting the July implementation of the co-payment policy in her area and the certainty it would bring her about hospitalization. "Right now I'm lucky enough to need only outpatient care. I have children and I need to be home. But if I ever need inpatient care, I'm scared because I don't know how much it will cost or if the necessary drugs will be there," she said. The health and income of her family could depend on the development of the

The first phase of Kyrgyzstan's co-payment policy

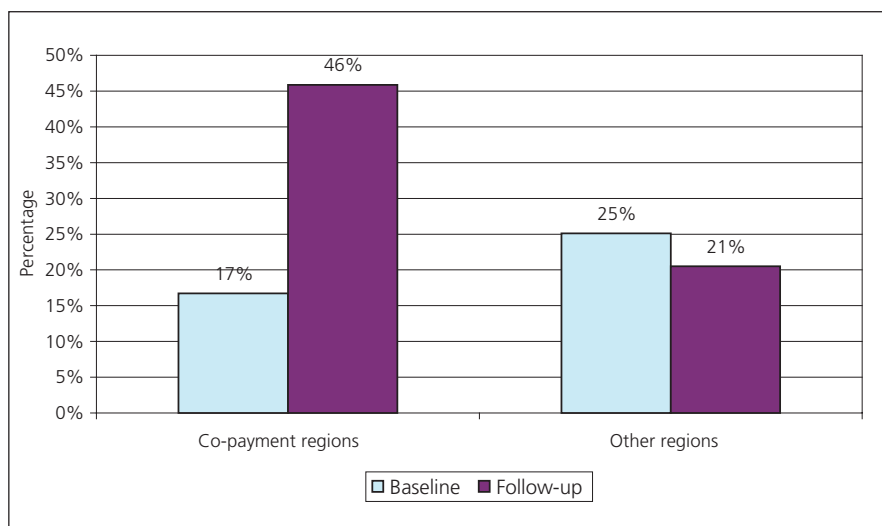


Fig. 4. Percentage of inpatients reporting that they had prior knowledge of their health costs

Source: WHO surveys of discharged hospital patients carried out during February and July 2001.

Notes: The survey included 2917 cases, representing 7.4% of February cases. The follow-up survey included 3731 cases, representing 9.9% of July cases.

co-payment scheme. She continued, “My relatives in Issyk-Kul have told me about the co-payment policy ... I hope it comes to Bishkek soon.”

Informing the public

To benefit from the co-payment and free access scheme under the reserve fund, the community had to be informed of its availability, and to communicate with the poorer communities who would most benefit, an alternative to mass media was necessary. The WHO surveys indicate that the most effective method of informing patients of the new system is via local Family Group Practices, as well as via polyclinic and hospital staff. Only a small percentage of patients reported having received their information from newspapers, and no patients identified television or radio as their source, according to WHO's Kutzin.

According to Isakov, the population's opinion of the co-payment policy depends largely on how well it is explained. He says, “Their first reaction is negative, but further explanation of the details convinces them that it is much more convenient.” Family Group Practices Director Ainagul Isakova says that her association uses visual aids, discussion groups and community meetings, as well as the mass media, to increase the public's awareness of the new policy. But she admits that it wasn't at all an easy task: “In the

Health systems confront poverty

beginning, we weren't properly prepared to explain the co-payment policy to them, and their opinions weren't as positive. After some time, though, the population started to understand the benefits of the policy, and now they can definitely plan their hospitalization."

Dr Isakov says that his experience at the onset of implementation was similar and that some people admitted for care were unaware of the new policy. He says, "They would turn around and leave. But by May and June, our information campaign turned that around and people started coming back. By the end of the year, practically no one was unaware of or had negative views on the policy."

Changes in hospital admissions

Hospital admissions in Chui and Issyk-Kul *oblasts* decreased by 6.9% in 2001. Many in the Ministry of Health saw this as a positive development, given the hospitals' historical tendency to provide unnecessary inpatient care, but there were fears that some people were not getting the medical care they needed because they could not afford the co-payment. Kutzin says there was little evidence to support either of these conclusions. He adds, "It will be extremely difficult to determine the effects of the co-payment versus the myriad of other changes going on that might affect admissions."

According to Kadyrova, MHIF's Deputy Director, the number of hospital admissions declined in the first three months and then began to increase again. She says that it is likely that the number of admissions was reduced mainly in the area of "planned hospitalization", which could be treated on an outpatient level anyway. "To make sure that patients are still receiving necessary treatment at the outpatient level", says Kadyrova, "MHIF implemented the Additional Drug Package with reimbursement for drugs on the primary care level for the insured population." A visit to Bishkek's bustling outpatient Polyclinic 6, where all necessary outpatient drugs are provided and minor surgery is performed, served as testimony to that.

Isakov says that, for hospitals in Issyk-Ata, the co-payment policy as well as the Additional Drug Package has definitely helped to reduce unnecessary admissions and the financial burden that accompanies them. Isakov adds, "There were many illnesses that could be treated at a primary care level – such as hypertension and less serious cases of anaemia that plague the region – that were instead being treated at a costly inpatient level."

The first phase of Kyrgyzstan's co-payment policy

Lessons learned

The first phase of the implementation of this policy has shown that greater transparency in health care financing is possible and that there is room for measures that improve health care access for the poorest part of society. Addressing the issue effectively, however, requires a comprehensive approach that goes beyond simply establishing fee levels. It has to be linked to concurrent policies on how hospitals are paid and on how to improve the management of drugs and supplies. It also has to be linked to efforts to inform and educate hospital staff and the population.

According to Isakov, the combination of serious managerial restructuring, capacity downsizing and the co-payment policy has mitigated successful reform in his hospitals. But efforts to inform the population – at all levels – have been imperative throughout.

Although the Ministry of Health is pleased with the preliminary results of the co-payment policy, it also recognizes that there is always room for improvement, as was shown by the variations in success in the two *oblasts* included in the first phase.

Meimanaliev describes the importance of persuading local government of the need for reform.

Selling this reform to local government is essential. The success of our ... reforms depends on the contributions that local government makes to the single pool of funds for health care managed by the *oblast* affiliate of the Health Insurance Fund. The main problem that we faced in the first year of implementation was that some local authorities contributed far less than was planned. However, we were able to convince them to increase their contributions and the problems were resolved.

The Ministry has included local authorities and the central government in targeting its information campaigns, to maintain awareness and support for the co-payment scheme at all levels, and has engaged in intense negotiations with local authorities to maintain funding levels.

But it is this macro-level management that worries the Red Cross's Schüth. He says, "I have heard that ... *oblast* administrations withhold budget funds for the hospitals on the grounds that they now receive money from

Health systems confront poverty

patients. This of course could threaten the whole idea.” It would seriously reduce the levels of funding for the poor, as they depend on a proportion of the overall income for their free access. While there was an attempt to reduce this funding, particularly in Chui *oblast*, the Ministry of Health ultimately won. “This issue,” says Kutzin, “does remain a threat to the Kyrgyz model, however, and needs continued attention.”

Before the reforms, health represented about 25% of local government spending and was a major financial responsibility, as well as a source of hierarchical power. With the single payer reform – of which the co-payment is a part – local authorities are being asked to maintain that 25% but to relinquish control. This is perceived as a real challenge for the reforms.

In Schüth’s opinion, the greatest determinant of the co-payment policy’s future success is holding on to the public’s trust. He says:

The promise that the co-payment policy makes to patients is: pay this amount and nothing else. People may lose trust in the system, or fail to gain it in the first place, if they see that this promise does not hold. In my view, the challenge is not in selling this to people as it is designed, or making it work on the hospital level. The challenge is to deliver it on a macro level as it is designed.

The especially successful case of the Issyk-Ata hospitals also demonstrates how much reforms depend on the individual hospital’s willingness to work with the system.

Overall, the first phase of the co-payment policy is perceived as a success. The challenge is the successful scaling up to the national level. Such a step would place Kyrgyzstan further down the road of reforms thanks to the efforts of the Ministry of Health. Schüth adds, “The driving force of the reforms is the Minister himself who had been Head of the Department of Health Reform before his appointment as Minister. The whole Ministry of Health is committed to health reforms. There is a great amount of innovative thinking and openness to new ideas.”

Success in the next phases will depend on the factors mentioned here and many other variables, which the team in the Ministry of Health is carefully monitoring.

Case study 7

Primary health care in homeless shelters in Łódź, Poland

Steve Turner

In Łódź there are four homeless people's refuges with 264 places, and two one-night shelters with 138 places. There are 122 places for women (in two refuges and one one-night shelter) and 280 places for men (in two refuges and one one-night shelter). At present, these facilities fulfil the needs of the homeless in Łódź.²⁰

Doctors and nurses visit the refuges three times a week under the special "Palma Initiative", which provides primary health care to all shelter inhabitants regardless of their eligibility under the Polish health system. For medical examinations and more specialized medical care, the homeless are referred by the visiting doctors to Palma's outpatient clinic and hospital.



Consultation room at St Albert's shelter

In 2001, the Palma Initiative provided the following services free of charge:²¹

- 5200 consultations by a general practitioner
- 720 specialist consultations
- 380 dental consultations
- 100 eyesight examinations
- 1205 diagnostic examinations.

²⁰ Data provided by the St Brother Albert Society of Social Assistance.

²¹ Palma is more formally known as the Health Care Management Unit for Schools of Higher Education.

Health systems confront poverty

Hospital inpatient treatments, also free of charge, totalled 18 in 2000, 12 in 2001 and 8 in the first three months of 2002.

Of the homeless refuges in Łódź, the two that provide shelter for men were chosen to start this Initiative. It is hoped that treatment will soon be offered at the shelters for women, but, as they house many pregnant women and young mothers (who are entitled to primary health care), the priority was to start the initiative in the shelters that housed the larger number of inhabitants excluded from primary health care provisions.

The current health care system is administered through the 16 *voivodships* (provincial administrations). They distribute the funds available for the hospitals and clinics according to the number of registrations at a hospital rather than the actual treatment required by their patients. Thus, if a hospital has a small number of people registered with it, but its patients have a high demand for health care, it would still receive lower funding per consultation than a hospital with a larger number of registered patients whose demands for medical services are less. The national annual expenditure on primary health care is currently Zł 100 (US \$25) per person.²²

The cost of the Palma Initiative, which directly benefits those who are not eligible for health care and indirectly benefits the community at large, is borne by the general budget allocated to Palma Hospital, calculated on its number of registrations.

The writer (S.T.) visited the city of Łódź in mid-February 2002 to meet the people involved in this Initiative.

Municipal Department of Public Health

Maria Lewicka is the Director of the Municipal Department of Public Health. The Department is active, working through the various hospitals and health institutions in the region to provide a comprehensive health programme. The city is active in WHO's Healthy Cities project and several other proactive initiatives. "The Initiative at St Albert's was instigated by Dr Kowalski," says Maria Lewicka, "and it is unique to Łódź. There are other city schemes, but not providing regular care as this does." She and others in

²² Source: Łódź Municipal Department of Public Health.

Primary health care in homeless shelters in Łódź, Poland

the Department are proud of the scheme, but are concerned about funding, which so far comes from their stretched health budget. She confirms that most people in the shelters are not eligible for primary health care: “In general, if you are not working, or are registered as unemployed, you are not entitled to health care except in an emergency.”

Dr Michał Kowalski is the Director of the Health Care Management Unit for Schools of Higher Education – known in Łódź as “Palma”. His enthusiasm for this project is a reflection of his general interest in socially oriented initiatives, several of which he has instigated since becoming Director at Palma. He comments, “It is only sensible to help people if they need help. This is our job. I work not just for the homeless in this shelter but for poor people generally, and invalids and children and families. The problem in central and eastern Europe is more acute than in the west.” In the case of health care for the homeless, the Initiative was instigated under his supervision – his Hospital supplying medical services, visiting doctors, inpatient treatment and other medical specialties as required.



*Dr Michał Kowalski,
Director of Palma*

To help fund this and other socially oriented projects, the Hospital’s Marketing Department has been given the task of finding extra revenue from sponsorship, the sale of goods and fund-raising activities. This too is an innovative step for a hospital, raising cash and contributions from suppliers.

The people involved in the Initiative are concerned about providing and maintaining good standards of health in the shelters. They find that most of the medical problems suffered by the general public are also experienced by the refuge inhabitants, who in addition have particular medical conditions relating to their homelessness. Because of Poland’s geographical and political position as a gateway to western Europe, Dr Kowalski is aware of the international nature of the illnesses his hospital has to tackle. “Łódź is the geographical centre and the centre for trade. It attracts homeless people from the former Soviet Union and even as far away as China, where people see Poland as an entry point to the west. This migration causes big

Health systems confront poverty

epidemiological problems. Among [illegal immigrants] arrested here there are a variety of diseases – some almost forgotten in central Europe.” It is felt that the homeless are the first to contract some of these uncommon diseases, carried by illegal immigrants: “Some [inhabitants] at the homeless shelter are in contact with these immigrant communities through their other home – prison.”

In 1999, Poland hosted 1280 asylum seekers and processed 2864 applications for asylum.²³ The Polish Government contends that a high number of abandoned applications in recent years indicates that most asylum seekers only filed applications as a stopgap measure while attempting to reach points further west. Doctor Kowalski says:

We have to treat these transit immigrants ... and some of them stay in the homeless shelters. Their needs are just as much as [those of] the long-term refugees. Their “passing through” status doesn’t mean they don’t need medical treatment.

We also have many students coming to Poland from all of the former Soviet Union, and in Łódź we have the national language institute for all of Poland. So, we have students from Asia, Africa, the United States and the Russian Federation coming here also. Our general health situation is under a wide potential threat, and our homeless shelters must not become a breeding ground for diseases.

Dr Kowalski recognizes that all these minority groups are in need of health services and works towards providing care for all people, based on need. The homeless do not just have medical problems; they also suffer from psychological and dysfunctional problems within their family and social groups. Dr Kowalski says:

Our idea is to help these people. Medical intervention is expected to act quickly, but we would also like to see preventative projects and health education. Many of the [refugee’s inhabitants] are X-rayed for tuberculosis, and they are educated and informed about the results. Out of 200 examinations, 2 cases of tuberculosis were found and treatment established. We feel this is a direct example of the positive outcome from the scheme.

²³ US Committee for Refugees. *Worldwide refugee information. Country report: Poland*. Washington, DC, US Committee for Refugees, 2002 (<http://www.refugees.org/world/countryrpt/europe/2000/poland.htm>, accessed March 2002).

Primary health care in homeless shelters in Łódź, Poland

Looking to the future, Dr Kowalski feels that more international aid is needed and that:

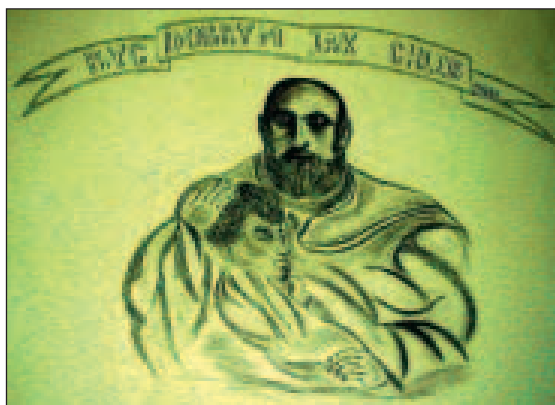
Central government should be responsible, not local government. It costs too much for the municipality. There are lots of changes connected with immigration. Poland is geographically central to the region and change is accelerating movement, especially among the poor who are travelling, looking for better opportunities. Łódź will attract more and more people wanting to come to western Europe as transport and other travel systems make it a crossroads. And it is the poorer people, the homeless, who will be travelling illegally or will arrive without any qualifications for health provision. Poverty and health problems really are an international issue.

The ideal model he would like to see is for the health care units that deal with homelessness to be made public.

Another scheme for the poor of Łódź, initiated by Dr Kowalski, is the free daily distribution of bread for those who cannot afford to buy it. A local bakery provides up to 300 loaves of bread, free of charge, each day and the Hospital distributes them from a known point at its rear entrance. Before leaving the Hospital, the writer was invited to witness that day's distribution. Approximately 100 people of a wide range of ages gathered around the doorway. Jostling just a little, they seemed to know from experience that the large amount waiting to be handed out was sufficient to ensure that they would each be given their daily bread.

St Albert's shelters

"To be good, like bread" is the inscription above the drawing of the patron at St Albert's. The drawing is by one of the shelter's inhabitants and was made on the wall of the common room in the shelter. This shelter is one of the two run by the St Brother Albert Society of Social Assistance and is located about a 30-minute drive away from Łódź city



A refuge inhabitant's drawing of St Albert, patron of the shelters for the homeless

Health systems confront poverty

St Albert's shelter for the homeless



centre. It is located away from the main highway and is reached by turning down a potholed road, driving further down another lane and then past a deserted driveway with rusted iron gates. Sitting in the middle of a snowy field is the shelter for the homeless.

To visit a shelter for the homeless on such a day, when the snow blows almost horizontally across the open field, highlights some of the basic practicalities of homelessness. But after entering under the *Patronat* sign

over the main doorway, the warmth inside is immediately evident, demonstrating success in what must be one of the most pressing issues of homelessness in the winter months. Along with the warmth, there is also the stale air of a heated building housing damp inactive people who spend their day waiting. The

Entrance to St Albert's shelter



normal policy at the shelter is for inhabitants to leave during the day, only being readmitted after 4 p.m. But because of the bad weather, this house rule has been relaxed.

Jerzy Czapla directs the two St Albert's shelters. The regular visiting doctor assigned to both shelters under the Palma Hospital Initiative is Dr Pashinska.

The shelters try to operate as transitional centres rather than as permanent homes, helping their transient inhabitants to find employment and new

Primary health care in homeless shelters in Łódź, Poland

homes in the longer term as well as offering short-term refuge. The average stay is less than a year, with most inhabitants expected to leave in half that time. In 2001, 50 men were returned to the community after rehabilitation aid from the shelter, and are now either renting accommodation or living again with their families.

Approximately half of the inhabitants of the shelter are without work or any official status, and it is they who most benefit from the Palma Initiative. At the time of the visit there were 35 unemployed homeless people, all of whom were receiving primary health care only because of the Palma Initiative.

Dr Pashinska attends this shelter and the larger one where the main administration and catering are carried out. She sees up to 20–30 patients during each visit, sometimes dealing directly with their problems herself and at other times referring them to specialists or for inpatient treatment.

When the homeless first arrive at the shelter their typical ailments are predictable, considering their situation: ulcers, especially of the legs, coronary disease, lichen planus, frostbite and exposure, vitamin deficiency, dermatitis, high blood pressure, scabies and lice. But there are also cases of tuberculosis and other infectious diseases.

The shelter is “dry” and does not allow any alcohol, but alcoholism is a condition that Dr Pashinska has to tackle. It is difficult to separate cause



Inhabitants of St Albert's shelter



Dr Pashinska and Jerzy Czaplak

Health systems confront poverty

and effect when dealing with homelessness and alcoholism.
Dr Pashinska comments:

Treatment for alcohol abuse is only given on a voluntary basis, whereby the patients decide to attend an outpatient centre. Sometimes alcohol is the cause, sometimes the result, but it nearly always needs special treatment. When there is someone who is an alcoholic, I can send him to a group clinic for treatment. But one of the problems is when the patient seems to recover and gets a job – then he spends his new-found money again on alcohol.

Social area at St Albert's



Other than alcohol abuse, illicit drugs and other substance abuse are uncommon among the shelter's inhabitants, mainly because they are beyond the financial reach of most of them.

A number of consultations are available to the shelter's inhabitants. A recent service is the psychiatric consultation. Specialist care is also provided by visits from dentists and opticians. The consulting room at the centre is equipped with a dentist's chair and

instruments, and can also double as an optician's surgery.

Funding

Where a patient is eligible for primary health care through the existing health system, Palma Hospital is able to recover some of its costs through this patient's registration, but where this is not the case Palma bears the cost from its overall budget. If spectacles are needed after an ophthalmic examination, the cost is borne by the shelter.

The shelter's income comes from three main sources:

- Łódź City gives 60% – for the building and one meal a day;
- inhabitants who work during the day make a contribution to the shelter; and
- marketing – painting exhibitions, events and sales of work – adds to revenues for the general operating expenses.

Primary health care in homeless shelters in Łódź, Poland

Dr Pashinska has been visiting the shelter for two years. When she was first approached to take on the role of visiting doctor, she wasn't sure about the job, feeling some fear of the homeless people she encountered in the city, "...but Dr Kowalski asked me to do it, so I did. Now I am used to them and we get on. If I meet some of the patients in the city we say hello and talk." Some she gets on with better than others, and some have become her "friends". The manager of the shelter adds, "They couldn't live without Dr Pashinska."



Patient, Dr Pashinska and nurse in consulting room

Her overall assessment of the project is positive: "Some people would have remained ill – become worse – and in the end needed emergency treatment as inpatients in the hospital. So although the hospital is paying for the costs of the scheme it is also saving money later." Within this overall system, where preventive health care is good economics, the Hospital itself is one of the beneficiaries of its own Initiative.

But like Dr Kowalski, Dr Pashinska can see much room for improvement: first, removing the need for a special initiative altogether by extending the health system to include primary health care for all. This would formalize the additional costs of provision and lead to official funding. More importantly, it would allow this local Initiative to be extended to all those in need. With regard to the administration of the scheme, other benefits could be gained by having visiting surgeons, more health care materials (such as bandages, test equipment and syringes), more resources for drugs and more frequent visits from the medical team.

Dr Pashinska feels that the health care scheme would benefit from a central administration. "The need continues for this Initiative while the patients are outside the health care system, because of the law excluding those who are not registered. The project is good, but needs money to maintain, support and expand it – the other [women's] shelters are not totally without need."

Health care is an integral part of the overall recovery process: "With adequate medical treatment the [refuge's inhabitants] feel more respected

Health systems confront poverty

and useful and want to rejoin society. They often return to the outside world when they get a job, although this can be a critical time, especially when they have had a drinking problem.”

But health care is only a part of the problem of homelessness. Dr Pashinska says, “If all they needed was health care, some could leave the shelter quite soon, but although some become healthy they are still without other resources to re-enter society. We have started the psychiatric service to try to help with some of these problems, but it has not been running long. Other assistance could be [creating opportunities for] getting work. There is still some work to be done.”

The St Albert’s Shelter Director, Jerzy Czaplą, is aware of the contribution made by the Palma Initiative in rehabilitating the homeless. He says:

Many of the [shelter’s inhabitants] arrive here very ill. It is part of being homeless. Usually there is a link: either they are ill because of their homelessness or, being ill, they are without work and money and are therefore homeless. In the past, for those not covered by insurance, they would only be able to access emergency treatment, which in practical terms meant waiting until we call for an ambulance.

For Czaplą, the main function of the shelter is to return people to society, and good health is crucial for this: “A return to health is not just advantageous but can be the reason for success. Thanks to Palma we can help everybody who gets ill. We have a lot of people who have been able to move out and get jobs after being treated by Dr Pashinska, whereas before they would simply have become worse.”

From sickness to employment

Arriving at the shelter after 12 months of living on the streets, Sławomir’s experiences illustrate many of these issues. Some years ago he was a partner in a small electronics business. It was fairly successful, providing him with a higher than average income and a lifestyle he was pleased with. Following a dispute with his partner, he was arrested for what he says were charges fabricated by his partner, in order to have him removed from the business. Sławomir was imprisoned for a year.

When he was released, his house had been taken over, he had no work and he was not able to support himself. At first he lived with friends, but soon

Primary health care in homeless shelters in Łódź, Poland

after release from prison he started to drink, and this led to his leaving them quite soon. He started to live on the streets. His drinking continued and he developed stomach and kidney problems. Sławomir ignored his symptoms for a long time, simply by drinking more and by refusing to acknowledge his poor health. By the time he did accept that he had to look for help, he knew he could not go to a hospital because during his time on the streets he had become one of the marginal citizens in society, without registration or the right to hospital care. For shelter, rather than specifically for health care, he came to St Albert's.



Sławomir recalls his experience of homelessness

When the first admissions procedure had been completed he was referred to Dr Pashinska, who treated him for his kidney and stomach problems and introduced him to an outpatient centre where he attended a programme for alcoholism. When recounting this story, Sławomir felt that the alcoholism was not a major problem, but was the result of his overall circumstances of losing his job, his business, his house and his health. While overcoming his alcoholism, however, he acknowledged the help provided by the counselling sessions.

“I wasn't sure at first if he would stay for the counselling sessions,” says Dr Pashinska, “as he was still upset from his experiences and didn't seem ready to respond.” But he did work through them, and also responded to the treatment for his other ailments.

About six months after entering the shelter, Sławomir felt that he was ready to consider leaving, but when looking for work he said that the stigma of having been to prison was now a barrier to his finding a job: “This experience [with my partner] was still with me, and I couldn't lose the fact that I had been to prison. My job was as an accountant, and employers are not happy to employ someone from prison in this job.” But, at the same time that Sławomir was looking for a job outside the shelter, St Albert's was in need of someone to look after the accounts and administration. Sławomir

Health systems confront poverty

put himself forward for the job and is now working for the shelter under a proper contract of employment. A month before meeting the writer, Sławomir had moved into his own apartment. He is very happy to have returned to a state of self-sufficiency, pleased with his job and his home. He says, "The other [inhabitants] from the shelter help me with my apartment, decorating and fixing it."

In the longer term, he may move on to another accountancy job, although he says his prison record will always present problems in this respect. But his treatment in the shelter, and particularly the health treatment he received under the Palma Initiative, have led him from being a drain on the health and social system to becoming a contributor to the community in which he lives and to the shelter that saved him from the bleak prospect of increasing ill health and homelessness.

Homelessness in Poland and the costs of scaling up

The number of homeless people in Poland has not yet been fully researched (a full census will take place in 2003), but estimates can be made by looking at the number of registrations and the number of people who moved but did not register again for some time. The use of this methodology has resulted in an estimate of the number of homeless of between 300 000 and 350 000. In addition, illegal immigrants and foreigners in transit, according to Dr Kowalski, could add another 50 000.²⁴ If the annual expenditure on primary health care remained at the average of US \$25 per person, the annual cost of extending primary health to all these homeless people, regardless of registration status, would be approximately US \$10 million. This figure, although an approximation, suggests that scaling up access to essential health services for the homeless is not beyond reach.

Lessons learned

The Palma Initiative offers solutions that could be useful to other municipal centres. Nevertheless, it has not been reported outside the local press and, with the exception of the Polish Healthy Cities project, there appears to be little contact among urban districts to facilitate the exchange of such experiences. The Palma Initiative was not known among the people the writer spoke with while in Warsaw, where the issue of homelessness is also apparent.

²⁴ Estimates were made with the help of Mrs Lucyna Nowak, Director, State Statistical Office. Poland's population is 38.7 million (December 2000 estimate. *Source*: The Economist Intelligence Unit).

Primary health care in homeless shelters in Łódź, Poland

Beginning with one person's mission to "help people if they need help", the next step was to encourage the existing health workers to embrace such work. Dr Pashinska's initial reluctance, because of the "intimidating" nature of homeless people, changed to one of friendship and professional interest for the people she cares for in the shelters. Development of similar skills and an open attitude towards the poor and homeless could be one of the first steps in the provision of similar initiatives elsewhere. The selection of where to start was not accidental: two shelters were chosen based on the fact that the necessary resources were available and the results could be assessed. They were the men's shelters, and not those for women, because this was where there was the greatest need. The effectiveness is apparent and the extra financial costs, which could have been a burden, are in part borne by the Marketing Department at Palma, which is raising additional funds for the Initiative. Though not the most obvious source of sponsorship, sales of work made by the shelter's inhabitants and donations of materials have contributed to funding the project and to an attitude of self-help and self-sufficiency.

The experience in Łódź suggests that expenditure on primary health care, rather than emergency care, could be an effective step towards improving the health of the homeless, improving the general public health and reducing one of the factors that make people poor.

Case study 8

Prevention and social acceptance: managing sexually transmitted diseases in the Republic of Moldova

Jen Tracy

Pregnant and infected with syphilis, 22-year-old Radika is relieved that today she can receive treatment for her disease without losing her right to employment for the next five years, without being hospitalized under police guard, and without the fear that her husband will be taken from their home by force for the same inhumane treatment.

Radika is being treated at the State Dermato-venereology Dispensary in Chisinau under terms of strict confidentiality. She was not asked to give any type of personal identification or to register her address or any information related to her previous partners. “Only my husband and I know of my disease,” she says.

Less than 10 years ago, Radika would have been forced at all times to carry a certificate of her registration as suffering from a sexually transmitted disease (STD) – a certificate that would have kept her from getting a job or travelling freely. And instead of informing her



*Examination room of the State
Dermato-venereology
Dispensary in Chisinau*

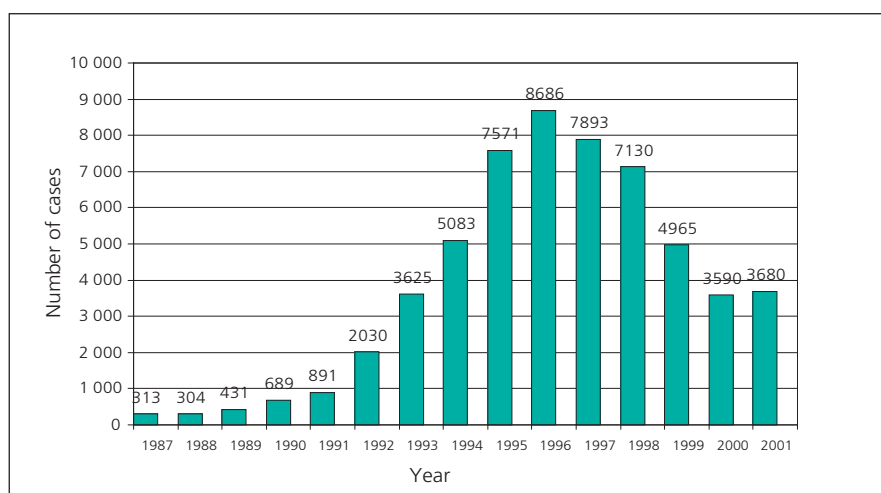
Health systems confront poverty

partners herself, a police investigation would have done it for her. The new system, which has undergone slow but continual implementation since 1996, has worked to remove the previous system's fears of seeking treatment for STDs and to motivate people to present themselves to clinics – a highly significant factor in stopping the further spread of disease.

In the Republic of Moldova, as in some other countries of the former USSR, the 1990s saw unprecedented economic stagnation combined with steadily rising inflation. The social situation worsened dramatically, and the rise of STDs and HIV infection hit epidemic proportions. Human insecurity – particularly with regard to economy and health – became acute and all parameters of the quality of life sharply worsened. The burden of economic reform fell quickly on the shoulders of the country's poorest – those most in need of social protection.

In the early 1990s, the incidence of syphilis (see Fig. 5) increased 10.6 times in the Republic of Moldova, reaching a peak in 1996–1997 of about 200 cases per 100 000 people, according to data from the Ministry of Health. From 1997 on, the incidence of syphilis began to decrease and then stabilize somewhat, with 97.4 cases per 100 000 in 2000 and 111 cases per 100 000 in 2001. Gonorrhoea and HIV infection have also followed the same epidemic course, levelling off in the latter part of the decade. In 1997,

Fig. 5. Annual incidence of notified newly diagnosed syphilis cases in the Republic of Moldova, 1987–2001



Source: WHO health for all database (data for 1987–1999).

Notes: Data for 2000–2001 received directly from the national health authorities.

Managing sexually transmitted diseases in the Republic of Moldova

new cases of HIV infection rose alarmingly (Fig. 6). Today, the Ministry of Health says that there are 1482 reported cases of HIV infection and 39 reported cases of AIDS, 83% of which are related to intravenous drug use.

An impressive 354-page situational analysis prepared on behalf of the Ministry of Health attributes a number of transitional changes to the spread of disease, including migration issues, sharp changes in sexual behaviour, an alarming increase in drug use, a severe lack of sexual education and trafficking in women.

Furthermore, the Republic of Moldova is undergoing a severe demographic crisis, with an annual decrease in the population of between 12 000 and 14 000. The Ministry of Health worries that the crisis is being further aggravated by the STD and HIV epidemic. The report also states that poverty is not only one of the main causes of the epidemic, but is also the “ball and chain” that makes eradication extremely difficult.

According to the situational analysis:

Economic security is an important factor in human security and sustainable human development. Related to basic human needs such as food, shelter, health, etc., economic security presupposes a favourable environment that

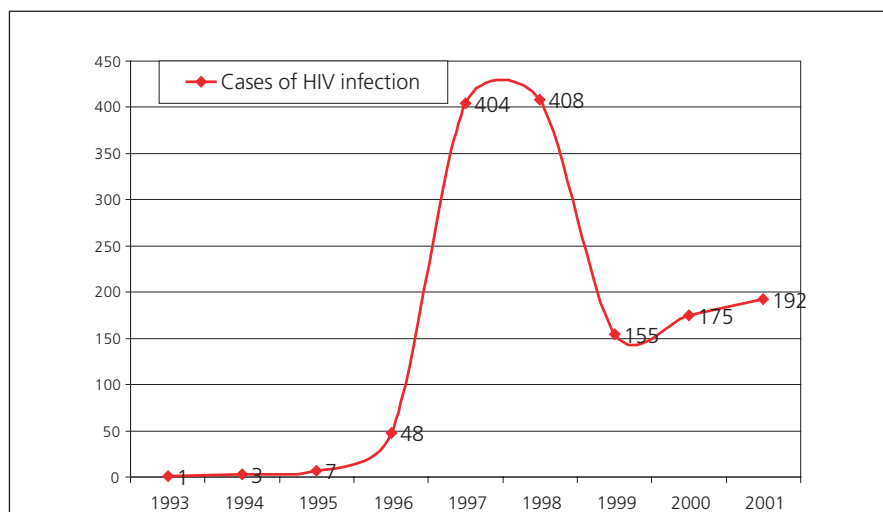


Fig. 6. Annual incidence of notified cases of HIV infection in the Republic of Moldova, 1993–2001

Source: EUROPEAN CENTRE FOR THE EPIDEMIOLOGICAL MONITORING OF AIDS. *HIV/AIDS surveillance in Europe. End-year report 2001*. Saint-Maurice, Institut de Veille Sanitaire, 2002.

Health systems confront poverty

would lead to decent living standards. ... Characteristic of the Republic of Moldova is a rather insufficient level of economic security that has an adverse impact on human development.

The end result, the analysis concludes, is that Moldovans have become more sensitive and vulnerable to socioeconomic threats, including STDs and HIV/AIDS. Instead of being concerned about dangerous health issues, people are forced to be preoccupied with simply earning an existence. During the first part of 1999, salary as a source of income constituted only one fifth of disposable income. Today the average national salary is less than €20 per month. The Ministry of Health fears that the country's poor economic situation means not only that people are much more vulnerable to infection and disease but also that they are not seeking or receiving education on these issues and are instead focusing solely on economic survival.

Confidentiality and anonymity are only one aspect of reform in the Government's strategy to halt the epidemic. The Ministry's first national programme for dealing with the rise in STDs and HIV/AIDS lasted from 1995 to 2000, and was fairly successful in ensuring confidentiality and switching from expensive inpatient care to more affordable outpatient care, as well as providing free-of-charge screening and treatment for patients with syphilis, gonorrhoea and HIV infection. According to WHO's Dr Alexander Gromyko, these changes must be considered "revolutionary".

On 18 June 2001, the Government began implementing a second national programme – this time centred on prevention. The programme includes eight concrete strategies for prevention among intravenous drug users and young people, and it ensures safe blood transfusions. It also provides medical assistance and social support to people infected with HIV and their families, and provides epidemiological surveillance and state monitoring of these diseases.

Although the first national programme met with commendable success, continued progress will depend on the country's economic stability, the Government's full support, and continued and intensified assistance from international donors and local nongovernmental partners. The Ministry recognizes that the HIV/AIDS and STD epidemics are accompanied by challenges that are "too diverse and complex to be tackled by the

Managing sexually transmitted diseases in the Republic of Moldova

government and NGOs [nongovernmental organizations] alone. It raises socioeconomic, legal, ethical and human rights issues that all need to be adequately addressed if the fight against the epidemic is to be successful.”

Social aspects: confidentiality, trust and prevention

For a solemn and serious 23-year-old man seeking counselling and check-ups at Chisinau’s National Centre for AIDS Prevention and Control, an anonymous one-night fling at a Black Sea resort in August 2001 is cause for lifelong regret. The young man, who asked that his name not be used, tested positive for HIV in January 2002. He says, “When I found out, I didn’t know what to do, what to think. But this Centre offers very good counselling. Without their help, I couldn’t have gone through all of this.”

Now, as a graduate medical student himself, this HIV victim’s goal is to use his experience to help educate and counsel other young people on the dangers of HIV/AIDS and STDs. His goal is the same as that of the Ministry of



Blood-testing laboratory at the National Centre for AIDS Prevention and Control

Health – quell an epidemic of disease that is without precedent in the country. The hope is that it will not take a positive test to get people to recognize the urgency of the situation.

Intensive education of the population is the key to changing risky behavioural patterns that have spiralled out of control. In its 2000 situational analysis, the Ministry of Health presents an extensive study of the sexual behaviour of both teenagers and adults, with more attention paid to youth as a group more vulnerable to the country’s transitional social changes. A focus-group study, conducted by the Swedish NGO CIVIS, showed that the biggest concerns teenagers have in the Republic of Moldova are related to economic instability.

Health systems confront poverty

In general, the study showed that most young people possess a rudimentary knowledge of STDs and HIV/AIDS and their causes and consequences. Some young people said that taking precautions against STDs or HIV/AIDS was pointless, as it is all simply the luck of the draw. But behavioural choices in case of infection showed a lack of clear understanding of the urgency of the situation. According to the study, most teenagers said they would try to treat themselves before going to a doctor if infected with an STD. The main reason for this was “shyness” and issues of confidentiality.

According to the Ministry of Health, the social development of the Republic of Moldova is characterized by a transition from traditional to urban principles of sexual culture. For that reason, intensifying health education for young people – and working to change patterns of sexual behaviour – is imperative. As stated in the situational analysis:

The opening of frontiers facilitates personal contacts, human communication and, at the same time, simplifies the conditions for the spread of HIV/AIDS and other diseases, which were never before encountered by our society and health system as a mass phenomenon. ... [Though young people express a general knowledge of these diseases], the level of mentioned knowledge and the degree of its putting into practice before first sexual contact and during the entire sexual life is evidently insufficient [as proven by the statistics].

The Ministry, with the help of many local and international NGOs, has prepared and begun to implement a multifaceted educational programme that promises to change all of that. The wide variety of literature, television and radio programmes, hotlines and travelling seminars attests to the Ministry's eagerness to target prevention. Dr Stefan Gheorghita, Director of the National Centre for AIDS Prevention and Control, says that education and prevention are the keys to the Ministry's new national programme. As partial evidence of those efforts, the doctor produces three textbooks from the Joint United Nations Programme on AIDS (UNAIDS) that have been translated into both Russian and Moldovan and distributed in schools nationwide. Furthermore, he says that special seminars are being held to train teachers to teach health education classes that stress the urgency of the STD and HIV/AIDS problem.

Managing sexually transmitted diseases in the Republic of Moldova

The AIDS Centre itself is quite impressive, with energetic and dedicated doctors, laboratory technicians and counsellors. With the help of such international organizations as the United



National Centre for AIDS Prevention and Control – packages and information for drug users

Nations Children’s Fund (UNICEF), the United Nations Development Programme (UNDP) and UNAIDS, the clinic has modern equipment, and the staff are proud to say that it operates at internationally accepted standards in every way. Counselling for patients, as attested to by the young HIV victim interviewed, is of the highest quality.

The clinic is also trying to stop the spread of infection by providing drug users with clean needles, condoms and disinfectant – all wrapped up in a package full of literature on prevention. The clinic carefully monitors the distribution of these packages, and clean needles are given in return for used, which the clinic then sterilizes.

The young HIV victim at the AIDS Centre agrees that the effort is increasing, but there is still much work to be done. He says, “It’s improving and people are becoming more aware, but we need to keep informing and educating them on how to protect themselves and how to help and support those who are infected, because these people are very lonely.” He adds that there should be much cause for concern among the gay community, because “not one of them that I’ve ever talked to believes that there is a need for precautions.”

Although prevention is widely considered to be the Ministry’s most important focus, reforms geared at replacing harsh, fear-driven treatment of people with STDs with options of confidentiality and anonymity have also been very important and highly successful. These reforms have served the

Health systems confront poverty

The State Dermato-venereology Dispensary in Chisinau



important functions of convincing people to present themselves to clinics and encouraging trust in the state health care system. “Today we offer anonymous and confidential services – no investigations, only treatment,” says

Dr Viorel Calistru, Director of the State Dermato-venereology Dispensary in Chisinau.

WHO’s Dr Gromyko describes the dramatic change that has occurred:

People can now freely go to the health care facilities if they suspect they have been infected. Before, they would try to avoid treatment. Police officers would be standing at the doors of the hospitals, and patients weren’t allowed to leave. The police would even go to their homes. If a husband tested positive for an STD, the police would go and take the wife by force for a clinical check-up and treatment.

And there were other social implications as well, such as forced unemployment, which increased the already chronic poverty.

Under the new system, 50% of syphilis patients and 40% of gonorrhoea patients received anonymous treatment in the course of 2001. Dr Calistru says, “It is very important that people trust the state services so they don’t avoid treatment and continue to spread disease. We couldn’t have imagined this kind of system less than 10 years ago.”

The burden of informing partners at risk now lies with the patients themselves. To that end, Dr Calistru says that clinics are trying to make things easier for patients and are counselling them on the urgency of informing any partners they may have had. Each patient receives a card containing an encoded patient number, but no names, and the address of the clinic where treatment is being carried out. On the bottom of the card,

Managing sexually transmitted diseases in the Republic of Moldova

the clinic guarantees complete confidentiality. Infected patients are given as many cards as they need to distribute, either secretly or in person, to their partners. So far, however, there is no way of monitoring the success of this programme. And much of its success will depend on the continued education of the population, urging them to inform their partners of the risk of disease.

“The idea,” says Dr Calistru, “is that we are all in this together, that patients work together with us. All of our actions have been centred on the interests of the patients, and that is a much more effective way of doing things.”

Providing free screening and free treatment for syphilis, gonorrhoea and HIV infection has been an important part of that plan. Dr Calistru elaborates:

If you look at the patients, 80% have unstable work, and it is not possible for them to get treatment unless it is free of charge. All of this has a direct link to lessening the burden of poverty for our country. The poor must have free access to treatment or there will be no end to the STD epidemic, and people will continue to spread disease and be forced into deeper poverty, because of their inability to work and even [owing to] death in the family of a breadwinner.

Medical aspects: restructuring and sustainability

While the Republic of Moldova’s second national plan focuses primarily on prevention and health education, the first programme, which lasted from



*Dr Viorel Calistru,
Director of the State Dermato-
venereology Dispensary*

Health systems confront poverty

1995 to 2000, concentrated largely on restructuring the health care system to better deal with the STD epidemic.

The restructuring is said to be economical for both patients and medical facilities alike, as patients are offered screening and treatment free of charge, and hospitals are saving money with the shift from expensive inpatient care to more affordable outpatient care. According to Dr Calistru, one of the most important first steps was the centralization of screening for STDs and HIV infection. Last year, he says, 470 000 people across the country were screened under the new programme, free of charge. Those screened included all hospital patients and pregnant women, people whose profession requires it, blood donors and couples seeking to be married. Today, says Calistru, all hospitals and clinics are able to begin treatment of infected people within 24 hours of screening – an important accomplishment that has helped to reduce the period of non-treatment and lessen the further spread of disease.

A recent decision to switch from diagnostic testing to syndromic case management²⁵ also promises to lessen the time between screening and treatment. Earlier in the reform process, a 1997 WHO report on the situation addressed concerns that doctors in the Republic of Moldova showed resistance to the syndromic approach. Despite the delay in treatment caused by diagnostic tests, some doctors still felt that for the patients those tests were an indicator of the quality of service. Dr Calistru says that resistance is no longer a factor today, and the Ministry of Health has already ordered a shift to the syndromic approach. The Ministry is now working to train doctors and is providing detailed instructions to all staff on how to use the new method. Though it is still in the implementation stage, Dr Calistru says that doctors have been prepared and are ready and willing to make the change. A shift away from expensive laboratory diagnosis will also lessen the financial burden on hospitals and clinics.

²⁵ The traditional approach to the diagnosis and management of presumed STD is through laboratory diagnosis to determine the etiological agent(s). This approach is expensive, both in terms of diagnosis and laboratory infrastructure maintenance, and results in delays in diagnosis and, often, in treatment. The syndromic approach uses clinical algorithms and the constellation of symptoms and clinical signs to determine antimicrobial therapy. The advantages of the syndromic approach includes expedited care, treatment at the first visit, cost savings by not using laboratory tests, and increased patient satisfaction with the care delivered. The main disadvantage is the cost of diagnosis and overtreatment when multiple antimicrobials are given to the patient with no (or only one) infection.

Managing sexually transmitted diseases in the Republic of Moldova

The Republic of Moldova has made considerable progress towards making outpatient care the primary mode of treatment for syphilis and gonorrhoea. According to Dr Calistru, with the exception of pregnant women, neurosyphilis cases and the uncontrollable homeless population, all STD patients are receiving treatment as outpatients. “This new system is much more attractive to patients,” he says.

Inter-hospital training on methods of treatment and prevention has also been a focal point of the Republic of Moldova’s first and second national programmes for eradicating STDs. Not only are doctors and other medical staff required to attend a variety of courses on new methods of treatment and prevention, but they are also required to spend six hours each month working towards prevention – usually in the form of school and university lectures targeting young people.

Where it concerns prevention, the Ministry of Health has also recognized the necessity of teaming up with local NGOs that have more time and experience working on a grassroots community level. Dr Calistru’s clinic trained the workers of the local NGO Youth for the Right to Live on how to answer people’s questions about STDs and HIV/AIDS.

The Ministry’s situational analysis clearly identified the Government’s need to form as many of these partnerships as possible: “The vision ... is to expand the number of partners



The office of the Chisinau NGO Youth for the Right to Live

involved in the national response. It will do this by focusing activities in critical areas for the greatest effect on preventing the expansion of the epidemic.”

Dr Calistru says that, by offering free treatment to STD patients, the new programme is working to reduce the burden of poverty on the country’s

Health systems confront poverty

poorest population. Before the programme's implementation, patients were usually required to procure their own drugs – which generally ranged from 100 lei to 300 lei, (between €6 and €8) – at their own expense. The cost of treatment itself was additional.

In a country where the average salary is less than €20 per month and where 80% of the population have unstable incomes owing to salary arrears, payments in kind and growing unemployment, the cost of such treatment is prohibitive. If the system fails to treat enough people, Dr Calistru says, the epidemic can never be tackled, and only treatment that is free of charge can attract people to the clinics.

Although treatment of syphilis, whether at the inpatient or outpatient level, is now ostensibly free of charge, there are some instances – though by no means the norm – of doctors asking for small, under-the-table payments for their services. Eighteen-year-old Olya and twenty-two-year-old Radika, both pregnant and infected with syphilis, said they were asked to pay a small sum for their treatment at the state clinic. “As I understand it,” says Olya, “our first 20 days are free of charge, but the next 10 days will cost 100 lei (about €6).”

The situation is indicative of the enormous burden of poverty on all levels of society. Doctors generally earn a meagre €17–20 per month and, like most of the rest of the population, they are also doing whatever they can to survive.

Dr Calistru, for his part, assures that this incident is not a common phenomenon when it concerns the treatment of patients for STDs, and all patients are treated fully, regardless of the “individual initiatives” of certain doctors.

Although providing free screening and treatment for STD patients is necessary in order to attract enough infected people to clinics and stop the spread of disease, it is also an additional financial burden on the already impoverished health care system. And sustaining these successful national programmes and “revolutionary changes” is yet another challenge for one of the poorest countries in Europe. “But at the same time,” Dr Calistru says, “if you lessen disease, you increase your resources.”

Managing sexually transmitted diseases in the Republic of Moldova

Dr Gheorghita warns that sustainability will depend on a number of factors, including the success of reforms in other sectors of government. “This is not just a medical issue,” he says. “This is a serious economic and political issue as well.”

Lessons learned

If there is an overall lesson learned during the Republic of Moldova’s struggle with the STD epidemic, it is that prevention is the only way out – a lesson that is being learned the hard way.

At the onset of the epidemic, the Government’s first national programme targeted, first and foremost, medical restructuring, with prevention taking a back seat to other reforms. The second national programme, begun in June 2001, corrected this situation: all eight steps of the detailed strategy concern prevention at all levels.

“People have been so involved in testing for the past 10 years, when they should have been thinking more about prevention,” says WHO’s Dr Gromyko. “But in the last few years that has started to change. They have finally understood that primary prevention is the most important aspect.”

The change in strategy was evident in the plethora of brochures, textbooks and other literature available at all clinics and distributed to schools, universities and travelling seminars. Both Dr Calistru and Dr Gheorghita expressed a serious commitment to educating the public on the dangers of the epidemic.

With the Government’s limited resources, increasing prevention is easier said than done. But it is here, Gromyko says, that another important lesson has been learned: “The Republic of Moldova has discovered how important a role NGOs can play in prevention. They are very good supportive tools. This is one of the nicer developments of the past few years.”

The Ministry of Health is experiencing some success in the fight against STDs and HIV/AIDS, but continuing success will depend on government resources that have already been stretched to the point of exhaustion. Without a clear demonstration of support from the country’s highest authorities, and assistance from many more local and international partners and donors, today’s progress could easily become tomorrow’s tragedy.

Health systems confront poverty

Only four years ago the STD and HIV epidemic was raging out of control. Today – seemingly because of the Ministry of Health’s ambitious efforts – the epidemic appears to be under control. But the Republic of Moldova is not out of the dark yet. Dr Gromyko says that the Republic of Moldova’s success story may be the harbinger of a miraculous message for the rest of the world: “Maybe what this means is that it is, after all, possible to stabilize such an epidemic with the proper support and quick action. Maybe it’s not true that AIDS is unmanageable.”

Case study 9

Poverty and tuberculosis: a pilot partnership in Orel, Russian Federation

Susan Poizner

A mother with a bulky coat and fur hat holds her daughter's hand as she crosses the central square in the city of Orel in the Russian Federation. The little girl giggles and kicks a small pebble out of her way. On the other side of the huge square, two round elderly women stroll arm-in-arm towards the local pharmacy. It is Sunday morning and this city of almost 341 000 inhabitants is certainly not bustling. But life in this predominantly rural and agricultural region, 382 km from Moscow, is never very fast-paced.

The square is flanked on all sides by large, dignified-looking buildings. On one side, the once obligatory statue of Lenin still stands tall, adorned with a bouquet of wilting red flowers. The imposing "White House" stands behind Lenin. There, local government officials legislate not only for Orel City but also for the entire *oblast* (region) of the same name. Orel *oblast* occupies 24 700 km². It is divided into 24 administrative districts, includes the cities of Orel, Livni and Mtsensk, and has a population of 900 000.

One of the major problems the Orel administration has to deal with today is a surge in the number of cases of tuberculosis after the end of the Soviet Union. Increased poverty and homelessness in the post-Soviet era, shrinking health budgets and erratic supplies of anti-tuberculosis drugs are among the reasons for the rise of tuberculosis in Orel and across the Russian Federation. In Orel *oblast* in 1990, 41.4 out of every 100 000 people suffered from tuberculosis. Two years later the number had risen to 50.4 per 100 000. In 1996, when 65 out of every 100 000 people had tuberculosis (Table 2) and that number seemed destined to continue to increase, the Orel administration realized that something had to be done.

Health systems confront poverty

Table 2. Tuberculosis cases per 100 000 population in Orel oblast, 1990–2001

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
41.4	39.3	50.4	48.3	51.9	52.3	65.0	66.6	71.3	71.2	81.0	77.1

“The reason tuberculosis was a particular fear for us is that one person can infect dozens of others,” says *oblast* Health Commissioner Mikhail Vladimirovich Shirokov. “And [lack of] the treatment is relatively expensive – not just due to the number of deaths that may result, but due to the possibility of an increasing number of invalids in society. We realized that this is a serious threat to the health of our people. And we decided that something had to be done to eliminate or at least minimize the problem.”

With an already overstretched budget and frequent shortages of anti-tuberculosis drugs, it was clear that Orel could not conquer the disease alone. In 1999, therefore, health officials forged a partnership with WHO and started implementing the directly observed treatment, short-course (DOTS) tuberculosis control strategy. Later, the Russian Red Cross and the International Federation of Red Cross and Red Crescent Societies also became involved, implementing a social and nutritional support network for tuberculosis sufferers.

This two-pronged approach, combining social support and medical treatment, helps to increase the efficacy of the Orel DOTS scheme, especially among the poorest in the community. The scheme recognizes that it is the poor who are most likely to contract tuberculosis, so food packages are distributed to patients every time they come in to take their medication. Not only does this encourage people not to abandon their treatment before it is complete, it also helps ensure that even the poorest sufferers will not go hungry. And a healthy diet is one of the ways to help all tuberculosis patients overcome the disease.

General context of poverty and health

The road from Orel to neighbouring Mtsensk is potholed, and the scenery is varied. A row of rotting wooden pre-revolutionary peasant houses is followed by a development of sturdy brick “New Russian” mansions. The expansive subdivided fields are where the city dwellers have their modest *dachas* – simple summer homes with small gardens. Here people grow and preserve their own vegetables, to ensure that they will have enough healthy food to get them through the winter months.

A pilot partnership in Orel, Russian Federation

But not everyone has the luxury of having a *dacha*. And not everyone has the luxury of having enough healthy food to eat. “This man who we are going to visit has struggled with tuberculosis for two years,” says Mtsensk tuberculosis doctor Alexander Nicolaiovitch Malachov. “And no wonder he can’t beat the disease. He lives in a tiny room in a communal flat where there is no running water. Even in the coldest winter months he has to go outside to wash or use the toilet.”

Inside the run-down apartment building, Dr Malachov greets tuberculosis sufferer Victor, a ghostlike man who spent most of his working life in a factory. His room is dilapidated, with peeling wallpaper and a single bed that he shares with his wife. He has access to the communal “kitchen” equipped with a rusty cooker and not much else. A small tub for bathing hangs on the kitchen wall.

Victor is typical of the people who get tuberculosis in the Russian Federation, where approximately 70% of civilians who are affected are low-income earners, pensioners or unemployed.



Victor, a tuberculosis patient

The link between tuberculosis and poverty is clear. In addition to infections being greater among the poorer communities, once contracted the disease increases the chances of falling into relative poverty because of loss of income. In the Russian Federation, official employers do pay employees during sick leave, but sufferers will not get sick pay at any unofficial jobs they may be doing to increase their income – a practice that is increasingly common in the poorer communities.

Owing to the WHO/Red Cross programme in Orel City, which combines improved medical treatment with social and nutritional support, Victor is better off than he would be if he lived elsewhere in the Russian Federation. Like all other civilian patients in Orel, he receives a food parcel each time he takes his medication, encouraging him to complete his treatment and giving him the nutritional boost he needs to help combat the disease.

“Good food is essential for patients,” says Dr Malachov. “It helps them build up strength so that they can fight the disease.” The doctors at the

Health systems confront poverty

Orel Tuberculosis Dispensary decide which patients will receive aid, based on the patient's financial situation and social circumstances. Priority groups are the more vulnerable, such as alcoholics, drug addicts, ex-prisoners and the very infirm and elderly.

All inpatients get three meals a day at the Orel Tuberculosis Dispensary



While the general population is vulnerable to tuberculosis, the country's prison population is much more likely to get the disease. In 2000, among an estimated one million prisoners in the Russian Federation, 10% were diagnosed with active tuberculosis,²⁶ while in the general population the rate was around 90 cases per 100 000.²⁷

Reasons cited for the high rate of infection include overcrowding, poor-quality food and poor living conditions. But with the budgetary crisis, those who run the prisons feel there is little they can do to improve the situation.

Victor Fyodorovich Gerasichev, Deputy Head of the tuberculosis hospital in Orel City's Detention Centre (SIZO), and his staff of 9 doctors and 23 nurses, try to keep the situation under control. Prisoners with tuberculosis from SIZO and the *oblast's* five correctional colonies are sent for treatment to the tuberculosis hospital. At the moment the hospital, which officially has 50 beds, is treating 200 prisoners out of a total prison population of about 6000. Here, too, nutrition is recognized as an important factor in the overall treatment – tuberculosis patients receive food of better quality to help strengthen the immune system. But the help is modest. "Each day our patients swallow their pills with a glass of water," Gerasichev says. "It would be nice to give them juice instead so they could have a bit of extra vitamin C, but that's something we just can't afford."

There are 19 inmates locked into the women's ward. The budget does not extend to prison uniforms so they wear brightly coloured sweatpants,

²⁶ *Communicable diseases 2000: highlights of activities in 1999 and major challenges for the future*. Geneva, World Health Organization, 2000 (document WHO/CDS/2000.1).

²⁷ Computerized Information System for Infectious Diseases (CISID) (<http://cisid.who.dk>, accessed 10 July 2002).

A pilot partnership in Orel, Russian Federation

sweaters, skirts and other ragged pieces of clothing brought from home. The room they share is small, and there is little room to move around. Ten bunk beds, a roughly cordoned-off toilet area and a grimy coffee table take up most of the space. There are no cupboards in sight. The women hang their extra clothing off the upper bunks, completely obscuring most of the lower beds.

Tuberculosis is highly infectious, spreading through the air when a tuberculosis patient coughs, sneezes or spits. So, do prisoners get the disease as a result of living in these cramped prison conditions? Not always, according to Gerasichev: “About 30% of those sent to prison in our *oblast* are already affected with tuberculosis. We know because all new inmates are thoroughly tested when they arrive. We cure people, but they often develop the disease again owing to boredom and stress in prison, and the tight living quarters mean that others may catch it as well.”

But why do such a high percentage of inmates come to the prison already suffering from tuberculosis? Again, poverty plays a role. “Those who end up in prison are generally not the richest of people. This is clear. These are often people who don’t have family or relatives. They can’t support themselves, so they commit crimes and end up here. They live in poor conditions. They eat poor food. That’s why they’re more likely to fall ill with tuberculosis,” says Gerasichev.

The WHO programme in Orel *oblast* has helped Gerasichev and his staff improve tuberculosis treatment, by supplying drugs for patients and by funding the transition to the DOTS programme. The programme includes information on methodology and statistical recording (with a supply of standard patient monitoring forms) and financial incentives to hospital staff who incur more work as a result of the programme. Moreover, other international aid is helping the prison programme, with the United States Agency for International Development (USAID) funding a service of legal and psychological support to help ease prisoners’ transition to civilian life when released.

Objectives of the programme

Part of the DOTS programme is the “direct observation” carried out at the Red Cross office in Orel. At 10 a.m., the women are waiting for their patients to arrive. Soon, a few men gather at the front door. One by one

Health systems confront poverty

they approach the Red Cross nurse, who looks at their forms, gives them their medication and watches as they swallow a number of pills. Once the patients have taken their medicine, both nurse and patient sign a form and the nurse hands over a daily food package. The package has different products every day. Today it's a bag of *pelmeni* – Russian meat-filled dumplings – and a carton of yoghurt.

Once the patients have taken their medicine, the nurse hands over a daily food package



At 11 a.m., Red Cross nurse Nina Prividentzeva sets off to deliver some more of these food packages to tuberculosis sufferers who are unlikely to come into the office to take their pills. They may be very elderly, infirm, ex-prisoners or alcoholics.

Katya, a 22-year-old single mother, is one of those people. The pale but beautiful young woman lives in a tiny flat with her 3-year-old daughter, Inna, her grandmother and her brother. But sometimes there are days when Katya is too drunk to come into the Red Cross office and Nina delivers the daily food parcel – but only after she has seen Katya take her pills.

The social support side of the Orel programme goes further: twice a month, patients who take their pills are also given “family food parcels”, a large cardboard box containing rice, *kasha* (buckwheat), sugar, flour, oil and other essential foods. And every two months the Red Cross gives patients a package with soap, shampoo, washing powder and other household goods. The daily food packages cost about 30 roubles (US \$1), the twice-monthly family food packages some 120 roubles (US \$4) and the two-month packages about 60 roubles (US \$2).

There are about 700 new cases of tuberculosis each year, and about 150 of those patients are helped by the Red Cross for between two and eight months, depending on the response to the treatment.

What, then, is the objective of the tuberculosis programme in Orel? It is more than implementation of the DOTS strategy.

A pilot partnership in Orel, Russian Federation

- It ensures that all tuberculosis patients, wherever they are and whatever problems they may face, will take their medication as prescribed. The food parcels encourage the patients to come to the health centre to take their pills for the entire 6–8-month treatment period.
- It gives a boost to the effectiveness of DOTS by giving poorer patients some social support.
- It boosts patients' immunity by providing them with some healthy food.

Process and methodology

If a resident of Orel *oblast* goes to a doctor and complains of fatigue and a persistent cough, the doctor will refer the patient to a tuberculosis specialist. The specialist will request a sputum sample for laboratory testing, and within a day or two the results will be clear. Sputum smear microscopy is a quick and effective way of identifying infectious cases of pulmonary tuberculosis. The patient will then be admitted to the Orel Tuberculosis Dispensary for immediate treatment. Often, the disease can be identified and treated before the patient infects anyone else.



The use of sputum smear microscopy to diagnose tuberculosis – a key element of DOTS

The use of sputum smear microscopy to diagnose tuberculosis is one key element of the DOTS strategy – the medical side of the two-pronged tuberculosis control programme in Orel. It contrasts with the previous method, which called for each citizen to have a chest X-ray once a year to detect the disease. That approach did result in a gradual reduction in the incidence of tuberculosis, bringing it down to the lowest level for 25 years at the end of the 1980s. But the system was too expensive to sustain, and the disease was not always diagnosed and treated in the early stages.

Health systems confront poverty

The appropriate implementation of DOTS ensured a regular and uninterrupted supply of all necessary first-line powerful anti-tuberculosis drugs, funded by both the Russian Government and international donors. Short-course chemotherapy means that the patients take 4–5 drugs for a period of 6–8 months, of which only the first 2 months are spent in hospital. Previously, patients would stay in hospital for two years or more. Such long periods of inpatient treatment can increase or even cause poverty, besides dramatically increasing costs. Shorter inpatient treatments and an earlier return to noninfectious conditions, where patients can return to gainful employment, have a smaller adverse effect on a patient's financial situation.

Without the help of the local, *oblast* and federal governments, DOTS could not be implemented and government cooperation is therefore an essential component of the strategy. The new programme uses the *oblast's* existing well developed tuberculosis control infrastructure and its experienced specialists, retrained in some of the new tuberculosis treatment and diagnosis techniques. Education programmes and campaigns were established to increase public knowledge of tuberculosis and to encourage those with symptoms of tuberculosis to report to their doctors immediately. Public awareness campaigns are vital when implementing DOTS.

The DOTS strategy calls for a standardized recording and reporting system that allows for documentation of assessment and treatment results for each patient, and of the performance of the tuberculosis control programme. Not only does this help health workers monitor and evaluate patient progress, but it also allows them to plan and maintain adequate drug stocks.

The DOTS strategy has been employed elsewhere in the Russian Federation. By the end of 2001, the Russian authorities had established 19 pilot projects around the country. In some of these there was an element of social support; but, again, what makes the Orel project special is that such social support is integral to the programme and that it receives substantial funding.

Wieslaw Jakubowiak, WHO Tuberculosis Programme Coordinator in the Russian Federation, says the Orel experiment was created as a way of dealing with a high default rate in some *oblasts*: "In some of the *oblasts*,

A pilot partnership in Orel, Russian Federation

such as Ivanovo, the default rate was above 30%. This is quite high. So together with our donor USAID we tried to find a way to deal with the difficult group of people who abandon treatment before it is complete.”

WHO and USAID approached the Red Cross, a highly experienced and respected organization in the Russian Federation, to help them work out a mechanism to deal with potential defaulters – most often ex-prisoners, homeless people, alcoholics or drug addicts. The food package incentive seemed like a good way to encourage this often impoverished group to continue treatment.

“We have been getting good results even though it’s very difficult to work with this group of patients,” Jakubowiak says. “In fact, the programme has been so successful that we are working with a high-level working group, including senior officials from the Ministry of Health, the Ministry of Justice and the Academy of Medical Sciences, to bring the project in on the federal level.”

Main lessons learned

Boris Yakovlevich Kazeonny, Chief Doctor at the Orel Tuberculosis Dispensary, is a very busy man. As the person in charge of overseeing the Orel project, he is often called out to meetings with government officials or WHO and Red Cross representatives. At the Dispensary, there is often a queue of doctors and nurses waiting outside his office, hoping to catch him for a few minutes to discuss a patient or ask his advice.

Once his job was simply managing the 470-bed Dispensary where tuberculosis patients are treated. But Kazeonny does not regret the extra workload that has come with the Orel project. In fact, if the project came to an end, Kazeonny says Orel’s doctors would continue to use the DOTS techniques, but adds that the social support is what makes the Orel project stand out.

“The role of the Red Cross has been very important,” he says. “Because of our joint activities, our results in Orel have been very good and our default rate has gone down to 2%, 3% or 4%. And of course, alongside chemotherapy, one of the most important ways to treat tuberculosis is to make sure the patients have a good diet, and the food packages are helping to improve the diet of those with tuberculosis.”

Health systems confront poverty

This initiative benefited from international funding to help pay for drugs, food packages, retraining and publicity campaigns. The extra social support from the international community to patients with tuberculosis has been considered to be an investment that has ultimately saved money for the government in many different ways. Lives are being saved, and sufferers have a better chance of recovering their health and capacity to work.

Low-income patients who continue to fight the disease have one thing less to worry about: each day they take their medicine, they know they will have something substantial to eat. But what will happen once they are cured?

Case study 10

The hanging gardens of St Petersburg: improving nutrition and food security in impoverished urban settings

Susan Poizner

Alla Sokol climbs the narrow steps up to the attic of her nine-story apartment block on Pulkovskaya Street in St Petersburg. The attic's ceiling is low, so she has to double over. A few metres away is a ladder. The youthful looking 64-year-old pulls herself up rung by rung and squeezes through the small door that leads to the roof.

During the spring and summer months, Alla and other residents will make this trip up on to the roof almost every day. For them, the beautiful view of St Petersburg is a bonus rather than an incentive. Instead, they come to work on the roof garden where they grow high-quality vegetables that they cannot afford to buy in the shops.

“For pensioners and low-income families, vegetables are expensive, especially in the winter. But all of those in the building who work in our roof garden can help themselves to vegetables in the summer for free. We also have elderly women in our building in their eighties who can't work on the roof, so we give them free vegetables too,” Alla says.



Alla Sokol, founder of St Petersburg Urban Gardening Club

Health systems confront poverty

The idea for a roof garden began in 1991, when Alla attended a lecture on the subject by Martin Price, an agricultural adviser with the Educational Concerns for Hunger Organization (ECHO) based in the United States. This was a time of severe food shortages in the Russian Federation. To Alla, roof gardening seemed like a perfect way to help the people in her building to survive this hard time.

She invited a number of other residents to help her set up the St Petersburg Urban Gardening Club (UGC), and by 1994 they had established a roof garden with the help of ECHO and the non-profit Center for Citizen Initiatives (CCI). This was, and remains, the city's only residential roof garden.

The economic problems of that time that spurred the establishment of UGC still persist, and Alla and her colleagues are working to help other urban communities set up rooftop gardens. They are also working with research institutes to introduce new, cheap and easy-to-grow vegetables to the Russian population.

The UGC members believe their work will eventually make fresh produce more affordable and accessible to all residents of St Petersburg. This is especially true for low-income groups, where an increase in the consumption of fresh fruit and vegetables would improve the population's health.

General context of poverty and health

With its wide tree-lined streets and breathtaking cathedrals, St Petersburg is perhaps the Russian Federation's most aristocratic-looking city. But the beautiful architecture barely disguises its poverty. In 2000 it was home to 4.6 million people, with roughly a third living below the poverty line.

Many Russian low-income workers believe it is economical to fill up on inexpensive starchy foods like potatoes and bread, or fatty foods like butter and meat, while avoiding more expensive fresh fruit and vegetables. But, like the members of the UGC, experts say this is a mistake that leads to poor health.

“A diet high in saturated fat, combined with low consumption of vegetables and fruit, contributes an estimated 30% of the cause of heart disease,” says WHO Regional Adviser for Nutrition Aileen Robertson. And a high-salt

The hanging gardens of St Petersburg

diet can make things worse. “In the Commonwealth of Independent States, because of the tradition of preserving vegetables and meat, the intake of salt is probably much higher,” she says.

A high meat intake has been linked with colon and breast cancer, while high vegetable consumption is said to help protect the body from strokes, high blood pressure and obesity. It is estimated that that up to 40% of cancers could be prevented by increasing the intake of vegetables, fruit and fibre.²⁸

It is recommended that the Russian citizen consume five servings or 400 grams of fruits and vegetables (not including potatoes) every day.²⁹ But consuming that amount is difficult in this north-western region of the Russian Federation, where imported or greenhouse products are expensive and the local growing season is just four months long.

For residents of St Petersburg, it is all a matter of economics. Low-income families earn less than 1500 roubles (US \$50) a month. Renting a modest flat can cost 300–500 roubles (US \$10–17). So, when faced with a choice of buying a kilo of bread for 8 roubles or the same amount of green salad for 19 roubles, most low-income families will opt for bread.

During Soviet times, the local *sovkhozi* (state farms) produced a wide range of affordable vegetables year-round. But in post-Soviet times these farms were privatized. The cost of energy soared and, to minimize energy use, the farms closed down their greenhouses, concentrating instead on growing cheaper vegetables such as potatoes, beets and carrots. The few companies that continue to use greenhouses make the consumer pay the price.

Once, the Russian *dacha* would have been the perfect solution. Today, more than half of the residents of St Petersburg have access to a *dacha* in the summer months, where they can grow their own vegetables. But according to Oleg Maldakov, an agricultural researcher and a member of the UGC, up to 8% of those who own *dachas* are now leaving them unused. He explains the reason for this:

²⁸ *CINDI dietary guide*. Copenhagen, WHO Regional Office for Europe, 2000 (document EUR/00/5018028).

²⁹ *Urban and Peri-urban Food and Nutrition Action Plan*. Copenhagen, WHO Regional Office for Europe, 2001 (document EUR/01/5026040).

Health systems confront poverty

The problem is that these *dachas* are 30–100 kilometres from the city and it takes up to three hours to get there by train. Transport has become more expensive. For a family, it could cost 250 roubles to get to the *dacha*. For that money they could buy 25 kilograms of potatoes. Then there's the additional expense of buying seeds, pesticides and compost. So poorer families may decide not to use the *dacha*.

The local authorities are aware of the problem of poverty and lack of food. “We have a well developed network of humanitarian aid,” says Svetlana Konovalova, Head of the Municipal Authority of Zvyozdnaya where the UGC is located. “About one third of our 56 000 residents are poor, but we recently distributed ten tons of food products from the United States.” But what was inside these food packages? Families and individuals received butter, sugar and milk – but no fresh vegetables or fruit.

Objectives and main activities

Nataliya lives in a pretty two-room flat in Alla's building. She has leafy house plants on every window sill. Nataliya used to work in an accordion factory, and her husband Leonid was a boat mechanic. During Soviet times Leonid spent much of his time at sea, so the couple never bothered to purchase a plot of land for a *dacha*.

*Nataliya has leafy plants
on every window sill*



Today, Nataliya and Leonid receive 750 and 1200 roubles a month, respectively – well under the 1500 roubles subsistence wage. Leonid earns some extra money working as a security guard, but it is Natalya's work in the roof garden that ensures that in the summer they will have plenty of vegetables to eat.

The primary objective of the UGC is to help low-income earners like Natalya and Leonid have access to fresh produce. Another goal is to do this in an environmentally friendly way. In 1999, the programme expanded to establish a composting station in the building's basement, to process the building's organic waste by placing it in black bins filled with red worms.

The hanging gardens of St Petersburg



Nutrient-rich compost is produced in the basement

The worms eat the waste and excrete a nutrient-rich compost, which UGC members sell or use in the roof garden.

Creating new employment is another outcome of operating the UGC. By 1999, running the new composting station and the garden became too much for volunteers to handle alone. With a grant from the American-based Gagarin Fund, Alla was able to hire two single mothers to work on the project full time.

But the point of the UGC is not just to have one single working roof garden in St Petersburg. Instead, it is to inform, advise and give others the help they need to set up similar projects. The members publicize their work through the media, have published a reference manual and are developing a training course to help similar schemes. Because it is an officially registered club, it is also able to develop political support to help expand the project.

Scope of the initiative

Anna is not ashamed to tell you that she has only 15 teeth left – after all, she is 82 years old. But Anna is not the type to complain about the ailments that accompany old age. “Of course things hurt sometimes,” she says dismissively. “But you also get aches and pains when you’re younger. You just have to learn not to dwell on these things.”

Anna also does not dwell either on the fact that her pension of 1500 roubles a month means that she is teetering on the edge of poverty. “It’s enough for me,” she insists. “It’s not enough for those who waste their money on vodka or cigarettes. But I can buy what I need.”

One thing that helps Anna is that she is a resident of 9 Pulkovskaya Street and the UGC gives free vegetables to five of its most elderly residents, even though they are not physically able to work on the roof. The building has a

Health systems confront poverty

total of 287 flats and is home to 540 people. Any resident willing to volunteer to work for the project will reap their reward in vegetables.

Methodology

Alla Sokol's professional training is as an agricultural engineer, and she had to use her expertise when designing the garden to convince the residents and the city administration that the roof would hold the weight. She calculated the load and proved that with the use of light soil there was no danger of the roof collapsing.

In 1993, CCI gave Alla seeds as part of a humanitarian aid package. "We then took some of those seeds and bartered them for soil and boxes," Alla says. By 1994, UGC had been registered as a non-profit public organization, and Alla and her team were ready to start setting up the roof garden by planting the remainder of the seeds.

In 1994, CCI started paying Alla 1500 roubles a month to encourage her to continue to manage the project, and the following year it also donated fertilizers, hoses, boxes and plastic sheets to use on the roof.

The roof garden is designed to be self-financing



The composting project was established in 1998–1999 with some funding from the European Union programme TACIS. "They paid for everything, including renovating the basement. We couldn't have done it without them," Alla said. In 1999, the grant for

full-time employees followed and the scheme was well supported.

Now that the infrastructure has been established, the roof garden is designed to finance itself. Some 70% of the 300-m² garden is devoted to producing flower and vegetable seedlings that can be sold in a shop on the first floor of the building. The UGC also sells its home-made compost, and in 2001 earned 30 000 roubles (US \$1000).

The hanging gardens of St Petersburg

“We hope to be able to earn three times as much in the future,” says Alla. “That would be enough for us to pay for two full-time employees. We have much more room on the roof, but to expand the project we need guaranteed buyers. So we would need a large order for seedlings from a company who could pay some of the cash in advance.”

The main obstacle to the expansion of urban gardens in St Petersburg is that only those who live in communal buildings like Alla’s can be sure to get permission: “We needed to get the permission of all our residents, because we collectively own the building. Some of the owners of other St Petersburg buildings may not be so forthcoming in granting permission.”

Svetlana Konovalova is Head of the Zvyozdnaya Municipal Authority, which owns many of the other buildings in the neighbourhood. According to her it is more complicated than that. As she explains it, “We like this programme. But this type of project is very complicated. The roof garden could leak into the flats below. It’s expensive to prepare a roof for this type of garden. We need plenty of documents proving that the building is capable of taking the load. And honestly, why pay money to establish gardens on the roof when we don’t even have enough gardens on the ground?”

Roof gardens are still a new concept in the Russian Federation, although with the help of the UGC similar projects have been established at the “Rubin” shipbuilding enterprise, at Secondary School Number 42, and at the infamous “Kresty” remand prison, home to 10 000 inmates.

This overcrowded prison has created rooftop and ground-level gardens to feed the inmates, which have so far provided three harvests of vegetables. According to rooftop garden enthusiasts, the vegetable gardens of Kresty prison will yield rich harvests every year. The gardens of the city prison produced crops of greens that were sufficient not only for use in the summer but also for drying for winter storage.



Alexander Gavrilov (right) shows Kresty inmates how to garden

Without encouragement and funding from the local authority and from international organizations, it is unlikely that rooftop gardening will develop in the Russia Federation quickly enough.

Lessons learned and the future

The main lesson UGC members have learned is the importance of teaching Russians what constitutes a balanced diet. “Its not just the poor who have a problem with food here,” says ecologist Alexander Gavrilov, who worked closely with Alla to establish the UGC. “Very few people seem to know what foods are healthy to eat.”

Gavrilov would like to see a citywide campaign that teaches Russians about the links between diet and health. “We need to devise an inexpensive food plan to show that even low-income people can actually afford to eat healthy food – maybe by replacing cakes and biscuits with more nutritious foods,” he says.

*Alla shows Nataliya
how to grow bean sprouts*



This type of educational campaign could also introduce people to vegetables that can easily be grown in the winter months when fresh produce is scarce. One example is witloof (also known as Belgian chicory), which can be grown in complete darkness – in a building’s basement, for example. The UGC experimented with this vegetable

in 2000, growing it and giving it out to residents. The problem is that the seeds are imported from the Netherlands and are therefore expensive. But solving this problem would not be difficult, since the city’s Vavilov Institute has a collection of 200 varieties of witloof seeds.

“What we need is to develop a culture of eating witloof,” says Vavilov researcher Olga Zverev. “Then we could easily produce large amounts of it cheaply.”

Bean sprouts are another option, but while they are found in most supermarkets in western Europe there is still no demand for them in the

The hanging gardens of St Petersburg

Russian Federation. Alla has produced a leaflet on bean sprouts and has shown some of her residents how they can grow them in a jar at home. But she realizes that they need to be introduced to the country on a larger scale.

This she could do in partnership with the St Petersburg Agrophysical Research Institute. “Every sprout has a wide selection of nutrients,” says researcher Vitaly Sudakov. He describes a plan to expand the use of sprouts:

While we have developed the technology to produce large amounts of sprouts safely, we don't have the funding to do so. The plan is to create a Living Food Centre at the Institute to introduce nutritionists from schools, hospitals and other institutions in the city to bean sprouts and witloof. The hope is that this type of education would create a demand for both types of produce.

Alla also says that this self-funding centre could be equipped to produce large quantities of sprouts, but it would call for an initial investment of US \$26 000, which would keep the centre running for two years. For another US \$17 000, the UGC could also work with the Vavilov Institute to produce inexpensive, large amounts of witloof to sell to hospitals, schools and other institutions.

All these plans are ambitious. But so was the plan to establish St Petersburg's first and only residential roof garden. Alla Sokol and her team are determined to keep working to achieve their goals and are certain they will help improve the nutrition of the neediest people in society – thereby also improving their health.

Case study 11

Combined social support and health care in deprived areas: the Citizens Advice Bureau in Blackpool, United Kingdom

Sigrún Davídsdóttir

For decades the coastal town of Blackpool, on the Irish Sea, was a favourite summer resort in England. However, with charter tourism the number of people travelling to foreign countries for their holidays increased, the town lost some of its appeal and gained some familiar symptoms of economic decline: reduced numbers of visitors; declines in seasonal trade, guest houses, hotels and other tourist facilities; and services closing down. The resident population of 153 000 still notices a difference between the quiet winter season and the buzz of high summer, but the new experiences of poverty and deprivation tell the story of the decline in the local tourist industry – the backbone of the town's economy.

Many of the inhabitants have moved to Blackpool from other parts of the United Kingdom, still seeking seasonal work, but there are far fewer opportunities than there used to be. According to John Dempsey, who is a General Practitioner Project Worker at the Blackpool Citizens Advice Bureau, the town also attracts a lot of unemployed people. "It's more pleasant to be unemployed here by the seaside, rather than somewhere else in a less attractive environment," he says. But this means that Blackpool is attracting the social problems attached to unemployment, such as drug abuse and alcoholism, as well as poverty and deprivation.

Identifying the causes of illness

The relationship between stress and health is a common phenomenon that is not limited to deprived environments. Many general practitioners (GPs)

Health systems confront poverty

in Blackpool, however, felt that much of their time was being taken up trying to address symptoms that had an underlying non-medical cause. When talking with their patients, they were time and again faced with conditions such as sleeplessness and depression stemming from worries over debts or other social problems. They could cure or reduce the symptoms, but the underlying cause would still be unresolved.

“GPs are not trained in non-medical areas such as debt counselling, hence they do not feel they can offer the most up-to-date advice,” says Carol Goodier, Primary Care Development Manager at the North West Lancashire Health Authority. That, however, does not mean they ignored the problems.

The doctors’ observations led to an attempt to find out how the non-medical causes of health problems could be reduced or removed. After carefully considering many options, including setting up an advice unit within the British National Health Service (NHS), it was decided to team up with the local Citizens Advice Bureau (CAB), a well established British charity that specializes in independent advice on any issue that clients bring up. “After working for 30 years in advice work I still come across questions I have never been asked before,” says Dempsey.

For the patients, the benefits were that the advice offered on issues that were troubling them helped remove many of the causes of their health problems. For the GPs, the benefits were that they could focus on the health issues instead of having to deal with issues that were not their specialty. This invariably led to more time and care being given to patients on health issues. As Goodier points out, “Owing to demands on the NHS, it is often difficult to find money within the health service to fund a non-medical project. Apart from making more time available for the GPs to do their work, the cooperation with CAB has had a preventive effect.” The NHS is now funding the project with £56 579 per year, which covers salaries for three workers as well as limited travel and associated costs.³⁰

³⁰ *Citizens Advice Bureau (CAB) workers in GP practice*. Blackpool, North West Lancashire Health Authority, 2001. All other data were provided by Carole Sharrock, Project Manager, Blackpool Primary Care Group.

One-stop shopping: covering financial, medical and psychological needs

The Blackpool initiative, offering advice on social issues, signals a growing awareness among health workers that medical symptoms and social problems, especially among the poor, are profoundly related. In 1997 the Health Authority in Blackpool turned to local GPs, asking what could be done to lessen the pressure on their work. It turned out that the GPs not only were concerned with shortcomings of the health service but also felt that a lot of their time was being spent on patients with health problems that had non-medical causes. The GPs often had to help patients with tasks such as applying for social benefits, even though they felt they were not well qualified to do so.

The problem seemed to be that, although advice on financial or social issues such as benefits was offered in many places, both by the social system and by other groups, many vulnerable people were not seeking this advice – in spite of their acute problems. Instead, sometimes through ignorance, sometimes because of the supposed stigma of seeking financial help, the social problems led to health problems, which led to the GPs. The GPs could see the problems were serious, but were not in a position to resolve them.

Within the health system there is (understandably) reluctance to fund non-medical projects. This initiative was initially piloted within two of the most deprived areas of Blackpool and reviewed by the University of Central Lancashire. Based on evidence from this initial pilot, the Blackpool Primary Care Group (PCG) of the North West Lancashire Health Authority extended the service to cover four central areas and two large council estates, which were the areas of greatest deprivation within Blackpool. The service reflected a “one-stop shop” approach to medical, social and psychological needs.

There is, however, quite a difference between pointing out that a GP’s time is taken up by social instead of health issues and designing a suitable and useful service that can help to resolve the causes of the patient’s problems. Several options were considered, but in the end PCG decided to cooperate with the local branch of CAB and worked with it on the specific role it would play in resolving these non-medical problems.

CAB is a national network of advice bureaus, which like most charities used to be run by volunteers. To meet the ever more complicated issues of their

Health systems confront poverty

clients and to ensure greater consistency and reliability of service, paid workers are now felt to be essential. CAB involvement in the Blackpool scheme is funded by PCG. At CAB, clients can expect to get free, confidential and independent advice. The first aspect is essential since patients are often unable to pay for professional advice. The last aspect is rare: as Dempsey points out, not many services offer advice that does not serve someone else's interests. In general, people turn to CAB mostly with problems related to debt and benefits, and the problems handled by CAB in Blackpool are no exception.

The reason for choosing CAB as the partner in this initiative is that it is a well respected, long established organization with great expertise in the issues that the GPs felt were in need of attention. For CAB, which in Blackpool was a relatively small organization, the challenge was to move away from operating in an overcrowded and outdated office, where its work had changed little over the previous 20 years. This initiative offered CAB the opportunity to offer its services in different surroundings and to target people who, although they had a clear need for advice, had not previously used them.

Another benefit for CAB was that it expanded its funding in Blackpool from predominantly one source (the local council) to a significant new partner (the NHS). From the beginning, it was obvious that this partnership not only would expand the expertise within the local CAB but could also be of interest to other CAB services across the country. All of this meant that, instead of just giving advice, CAB could expand to include one full-time and two part-time paid advisers.

Meeting people's health and social needs

This service is rather different in practice from CAB's original aims. CAB was originally intended to offer a "signpost" service – not trying to resolve issues, but pointing out where advice and help could be found. In this situation CAB offers a seamless, inclusive service, meeting as many needs as it can. The reason for this increased service is that clients found it difficult to have to go from one organization to another with their problem. This led the CAB staff to change their approach and follow their clients' problems through to conclusion.

CAB staff can be consulted at several GP surgeries in Blackpool. The clients are mostly referred to CAB by the GP or the nursing staff. In this way,

The Citizens Advice Bureau in Blackpool, United Kingdom

people who have not used the CAB service before are now encouraged to do so, not only broadening the expertise of CAB but also bringing in clients from the most vulnerable parts of society who previously would not have attended.

The reasons for the previous reluctance seem to vary but the most important appears to be that, for many people, there is a stigma attached to using CAB's main office. In the past, many were unwilling to be seen going there, but now that the CAB worker is located in the GP's surgery it is not obvious that this is where the "patient" is going. Carol Sharrock, Project Manager for the Blackpool PCG, states, "Patients will be in familiar, safe surroundings and could be waiting for the GP, the practice nurse or the CAB worker; in other words, there is anonymity. The fact that the doctor has suggested that the person see the CAB worker gives legitimacy to the service – in other words, it must be all right; doctor says so!"

Awareness of this stigma influences the way CAB and PCG announce the services. "There is no use in just putting up posters to announce the service, because many will not want to be seen reading them. It's much better to distribute leaflets in more discreet places. The CAB workers have found that the toilets are a good place to put them," Sharrock says with a smile. CAB is able to share its experiences of targeting, to develop its services with agencies throughout the area.

From a pilot project to a fully fledged service

The project, started in late January 1998 as a pilot, was planned to run for a year. To begin with, the "CAB in GP surgeries" service was offered in five surgeries in Blackpool as nine two-hour sessions. The North West Lancashire Health Authority commissioned a review of the project, and Professor Alan Gillies managed the work on behalf of the University of Central Lancashire. His review provides a useful insight into all aspects of the service, as does the information report produced by Blackpool PCG. The review is very favourable, and no particular problems or shortcomings were encountered.

With the positive review from Professor Gillies and favourable comments from health workers, it was decided to extend the service. The two main concerns were to reach those most in need and to manage the cost of the service. The service is now being offered in 9 surgeries in Blackpool with

Health systems confront poverty

17 2-hour sessions. The new contract runs for a 3½-year period from 1 October 2000 to 31 March 2004, and PCG is funding the project with £56 579 a year. This covers salaries for three people, one of whom is full time, as well as training, office costs, reference materials and some travel.

Debt and the “benefit jungle”

“Debt is the most common problem,” says Dempsey. He elaborates by pointing out that banks and financial institutions have for years been more than generous with loans and credit cards, making it easy to build up debts very quickly.

A patient who comes to the doctor complaining that he cannot sleep may not be suffering from anything physical but could easily be kept awake by the thought of the bailiff knocking at his door. In such cases, the GP may discover the cause of the problem but not be able to help. In those Blackpool surgeries that include the CAB service, however, the GP can refer the patient to the CAB staff and follow up on progress to see if the patient is able to sleep soundly again when the threat of the bailiff is removed.

Another major source of economic difficulties is claims for social benefits. In the United Kingdom, potential benefit recipients are often “means tested”, and this has led to increasingly complicated forms and a myriad of available benefits – if a claimant knows where and what to look for. This benefit jungle requires a high level of expertise and knowledge, often beyond the capability of the average claimant. CAB staff working in surgeries spend a lot of their time assisting people in identifying and claiming the right kind of benefits.

From left to right, John Dempsey (CAB), Carole Sharrock (PCG) and Carol Goodier (Health Authority)



The Citizens Advice Bureau in Blackpool, United Kingdom

According to Dempsey, the service claimed about £150 000 on behalf of its clients in 2001. In its first year of operation the project had 215 clients, resulting in enquiries on 1233 issues and recovering £106 000 for the clients. From April 2001 to March 2002 there were 3554 client contacts. These figures forcefully demonstrate the popularity of the service.

According to clients' replies to questionnaires, the project is making a great difference to their lives. When they answer the questionnaires, some even add words of gratitude to named CAB staff, such as "Always sociable at all times" and "I have had several reasons for using your services and every problem had a positive outcome." When asked if there was any improvement to the services the client could think of, one answer was: "No, I think what you are doing now is a very high service and I don't have complaints about anything." When clients were asked if they felt the service could be recommended, one answer was: "Well, they give you help and advice like they say they do and help solve the problem."

Dempsey points out that, while most of the referrals come from the GP surgeries, many clients are advised to attend by other clients: "We now get many members of the same family, so that points in the direction of satisfied clients." He adds with a smile, "We are even described as having magical qualities." Dempsey and his colleagues, however, are not resting on their laurels but are thinking of how the service could be improved. One idea being pursued is to add a "buddy" service: when clients need to go elsewhere they are accompanied, so that they are not left on their own without support.

The NHS has awarded the service "Beacon Status", which means that it has been chosen as a "best practice" service. It is at present one of 11 projects to be presented on the NHS's Web site. Sharrock points out that since the service was awarded Beacon Status, PCG has invited health organizations, CAB workers and social workers to Blackpool to attend workshops on the subject. Inviting about 20 people at a time, PCG has held 4 workshops to date and a number of other events, such as a publicity stand and lecture at a recent national conference on primary care. The publicity has particularly targeted organizations working in deprived areas (as defined by the British Government), other PCG groups, primary care trusts and CAB. It has also been presented at NHS events.

Lessons learned

“Service of this kind could be set up everywhere in the United Kingdom and make a difference,” says Dempsey. Apart from good preparation, the key to success has been the carefully orchestrated cooperation between CAB and health workers. GPs felt that such services were needed and appropriate.

When asked what others should keep in mind when setting up a service of this kind, Dempsey, Goodier and Sharrock agree that the slow start was a bit of a surprise to them. It took a while before the clients started coming in. Once that happened, however, the increase was steep and now GPs have been asked to consider their referrals carefully so that they only refer those who can benefit from CAB advice.

Publicity has been taken into consideration since the beginning. It was important to publicize the project locally, so that possible clients were aware of the service. “Local radio and local papers are important to start with,” says Sharrock. Then there are the leaflets, so that people can learn how the service functions and how to access it. From the beginning, there has also been an interest in publicizing the service among other groups who could be inspired to do something similar.

“Working in cooperation with PCG means that CAB can take the service where it is most needed, particularly to those people who do not traditionally seek help, such as the elderly,” says Dempsey. This flexibility seems essential for reaching those most in need.

Case study 12

“Fit for Work”: linking city regeneration and health in Newham, London

Sigrún Davídsdóttir

On stepping out of the train at Stratford Station in the London Borough of Newham, it is not immediately obvious that Newham is one of the country's most deprived areas. Yet its income levels, unemployment rate, debt, poor housing and homelessness are among the worst in England. Newham also has the second largest proportion of families with young children in the United Kingdom: over 32% have children under 16 years of age. More than 13% of the inhabitants are pensioners. Considering the strong link between poverty and unemployment on the one hand and ill health on the other, it does not come as a surprise that the general level of health is poor in Newham.³¹

During the last decade, the area around the railway station in the centre of Newham has been rebuilt with public funding. Since 1997, health has become an increasingly important factor in the regeneration of the area. Although regeneration schemes are common in the United Kingdom, “Fit for Work” (FFW), a 5-year project and the first of its kind, attempted to link health and regeneration. This meant that different sectors – with neither a common language nor common terms of reference or focus – had to learn to cooperate in order to create a coherent basis for the project.

The project counted on £3.7 million from the Single Regeneration Budget Challenge Fund (SRB), which was administered by the Department for Transport, Local Government and the Regions (DTLR). Five objectives formed the framework of FFW:

³¹ *Fit for work. Newham Health Partnership. Delivery plan year 5 – 2001/2002.* London, Stratford Development Partnership Limited, 2002.

Health systems confront poverty

1. access to jobs in the health care sector
2. development of business
3. improvement of health and access to health services
4. integration of care
5. management and publicity.

These five objectives were formulated with an eye on Government policy and the Government's SRB strategic objectives, in order to facilitate funding and necessary support. Twelve key FFW projects³² were organized and run under the objectives.

The rationale of the project was that the health sector is like any other industry and, consequently, it is a major economic force in the area. As such, it could be a powerful tool to bring about major changes for good in the area, not only in terms of economic development but also in terms of health.

With this in mind, FFW attempted to tackle two major local problems: large numbers of vacancies in the health sector and high unemployment. The project used various means, such as training for work in the health sector and encouraging the health sector in Newham to purchase locally and use local services. It used the economic power of the health sector to generate employment. Since the link between unemployment and pressure on the local health services is well documented, less unemployment can only benefit the health system.

Involving the unaware actors

The three main driving forces behind FFW were its key partners:

- Newham Primary Care Trust – a government-funded organization working in the health sector;
- Newham Council – the local government authority; and
- Stratford Development Partnership Ltd (SDP) – a social entrepreneur/non-profit project management and development agency.

Although FFW was funded primarily by public money, it linked together not only the public and the private sectors but also nongovernmental and

³² The projects are listed in the Appendix on pp. 156–159.

Linking city regeneration and health in Newham, London

other non-profit organizations. The single projects under the FFW attracted a wide range of matched funding from both the private and the public sectors, in addition to FFW funds. Another key partner was the King's Fund, a research-based think tank/independent charity organization whose goal is to improve health. The King's Fund has been pivotal in helping to evaluate the FFW scheme and disseminate its good practices.

Stephen Jacobs, Chief Executive of SDP, pointed out that the health sector can make a difference and was keen to see it move away from its role as just a health provider:

There is a high level of vacancies in an area with high unemployment, so why not wed the two? ... The health sector is not just about getting better, but [it must] recognize that it is a pivotal force in the economy, a force which can create jobs for people, who might otherwise be ill because of unemployment. ... We want to see the health sector as an industry. In that way, it's easier to get the necessary money and tackle the serious issues. ... In addition, health institutions are servicing the ethnic minorities poorly, which means that people from the ethnic minorities are less likely to get good service.

But the health sector cannot address the social issues single-handedly – it needs partners. “It tends to look inward,” said Jacobs, who pointed out that the ideal partners for the health services can be found among nongovernmental and non-profit organizations.

The benefits should be obvious. According to Jacobs, “By getting people into employment they stop drawing benefit, which means that the state gets tax revenues as well as saving on the benefit payments, and there will be less pressure on the health services. This can't be anything but a win-win game” (Box 3).

It takes more than just the health service to do something about unemployment. “In FFW, we are involving other actors, such as the local authorities and employment services, which may have been unaware of the fact that they are able to contribute to better health,” said Jacobs. “In bringing these actors together we are addressing the main social concerns, such as crime and safety, because these are in turn influenced by higher employment, health and education. All these vital concerns are influenced by FFW projects.”

Health systems confront poverty

Box 3. FFW: its impact in the local community

FFW started in 1997 and finished in 2002. During this period, the main achievements reported were:

- almost 350 jobs were created and a further 350 safeguarded as a result of government investment;
- 400 people who participated in FFW training programmes obtained a formal qualification;
- 450 local residents obtained employment as a result of FFW projects;
- 500 local residents obtained jobs after completing FFW training courses;
- thousands of Newham schoolchildren benefited from awareness-raising initiatives in relation to young people's health;
- 100 new businesses were started with the assistance and support of FFW investment;
- 700 businesses sought advice and assistance from FFW projects; and
- 25 000 residents were able to access new health facilities and over 300 voluntary organizations were assisted.

Source: Stratford Development Partnership, London, 2002.

“We are interested in showing that health is not just for the health sector,” said Teresa Edmans, Programme Manager for Health and Regeneration at the King's Fund. “There are other players in the field, and our role is to help them realize what they can do and how they can work with others.”

Money was not enough – new thinking needed

Jacobs was adamant about recognizing the health sector as the large industry that it is – a key economic driver in most areas, often the biggest employer and biggest constructor and an important purchaser of goods and services, as in the case in Newham: “By thinking of the health service as an industry that needs to modernize, it is both easier to get funding and to tackle the serious issues such as inadequate services – for example, for minority groups.” But it is not only the big structures that should be seen as businesses. Smaller units like general practitioners and dentists should also recognize that they are also small businesses.

The special situation in Newham was that, although vacancies in various parts of the health services can range from 15% to 30%, there was a high level of unemployment. “That means that the largest employer in the area is not getting enough workers,” said Jacobs. That was tackled by attracting different actors onto the scene, as well as searching for a new way of thinking: “It is easy for the government to give more money and tell the

Linking city regeneration and health in Newham, London

health services to spend it differently. But under Fit for Work, we set up a structure, involving local government, health organizations, general practitioners, companies and voluntary organizations to find out how they can help each other.”

That was where the different projects came in. Each was based on a new way of thinking and/or involving partners that otherwise would not have worked together. Jacobs mentioned the exercise on prescription programme (one of the projects under FFW) whereby, if appropriate, general practitioners could prescribe exercise in the local fitness centre instead of painkillers or other standard measures: “This project is doing radically different things and is more about conjuring up a lasting improvement, which is less expensive than painkillers.”

Teresa Edmans used to work in housing estates in deprived areas, where regeneration was not the business of the health services but of local government. In her opinion, regeneration needed to be considered from the health point of view. She found it insufficient to look only at individual projects and, deciding she wanted to influence policy-making, moved to the King’s Fund. Her interest was to see that the thinking behind FFW moved away from being an area-based initiative to become mainstream government policy.

Lessons learned

Lesson one: tackling the forces of inertia

The move from single projects to a mainstream policy is a difficult route to follow, however, with a lot of scepticism and many barriers. But those who bore the brunt of the changes inherent in FFW, like Gillian Seabright, Assistant Director of Service Development at the Newham Primary Care Trust, felt that there was some impact: “Before, we almost had to go under cover in breaking the rules we wanted to change. Now we can be more open about it.”

It is a misunderstanding to think that, if projects turned out well, they would be happily embraced by health workers eager to try something new. “The health system is very hierarchical and insular with zones of power, which those involved try to defend,” said Jacobs. “There is a profound scepticism in the health system towards new ideas.”

Health systems confront poverty

Edmans pointed to the middle management level in the organizations: “It is a big stumbling block. It’s about unwillingness to take risks, give up power and change professional zones. How can nurses, for example, pass something on to unskilled workers? This is about changing behaviour and professional relationships.” Alina Lubinska, Programme Manager at SDP felt that mainstream funders were not picking up the good projects or learning lessons quickly enough:

The FFW programme provided an opportunity to test out innovative projects and practices. There is a danger that without further funding, projects will fold and lessons and good practice will fail to get absorbed. There is the perennial issue of having to reinvent the wheel at a greater cost in the future, purely through an inability to recognize and process change more efficiently through the health service system.

Jane Woolley, Assistant Programme Manager at SDP, pointed out that, in order to ensure change, the FFW partnership brought together health workers and others from senior levels of the institutions involved: “The list of partners has changed over time, because we have learned who we need on board to make things happen.”

“The beauty of the FFW partnership is that we have widespread links in order to get the good practice out as widely as possible,” said Edmans.

Lesson two: bridging the culture barrier – learning each other’s language

Funding FFW with DTLR money meant that the source of the money was within an institution where health was an alien subject. “They have understandably no idea about health,” said Edmans, “so there was a steep learning curve. Their reports are written in a language different from that of the health sector, so there was quite a language gap – but they do understand jobs.”

Since so many institutions and individuals with neither knowledge nor understanding of health were involved in FFW, those with a background in health had to adjust their own thinking to make themselves understood. For example, it is hard to translate the meaning of building a school into health terms, or to translate regeneration in general into improved public health. In this sense, Edmans pointed out that the FFW partnership

Linking city regeneration and health in Newham, London

involved a cultural shift – attacking cultural barriers. Seabright noted that it was very helpful for her to have a development agency, SDP, to “translate” for her. The agency was at home both in the health field and in the other fields involved.

Lesson three: disseminating and sharing information

Those involved seemed surprised that the matter of publicity should have been an important issue from fairly early on. The publicity was not only about letting people know about the projects but, equally important, about sharing the lessons learned with others. The information sharing had been locally focused for too long. “FFW was seen as a new local focus, which was right to start with, but this focus was continued for too long. We were not shouting enough, underlining that there were general things to be learned from FFW, not just local,” said Seabright. “The main lesson for me is: publicize, share what you have learned – and get recognition!”

Woolley “underlined” the work that members of the FFW partnership are now undertaking: they are going out, talking about the projects and reinforcing the message that they were effective. That has brought unexpected benefits to others: somebody who heard about FFW took up one of the projects in his own area and recently won an award for it. “In general, the health service is not good at publicizing its work,” said Seabright. “All the focus has been on Newham and on reporting locally, but I spend about 20% of my time looking at other people’s ideas and projects. This is seldom mentioned, but it should be – we give a lot of tips to others.”

In order to influence the Government’s policy and get funding, Woolley pointed out that it is essential to know what the Government is aiming at, get into the process early and look for those who can link to the project: “We found out what the Government’s objectives were and linked the projects to them. There were about 30–40 projects put forward, and the FFW partnership worked through them and found those that are fitted best.”

Woolley said that her gut feeling was that FFW has had a lot of influence but, since disseminating good practice was not built in and monitored from the beginning, this is difficult to show. “It should be ingrained into the project,” she said. The question is also how the publicity should be focused: should it focus on the local general public or the national public, and should it target the health sector or other relevant sectors? FFW does not

Health systems confront poverty

have an answer to this, since publicity was only incidental. The cross-boundary character of the project makes it even more difficult to decide who should be the target for publicity. Woolley points out that, since this was a regeneration project, they tried to awaken the interest of the media in the field: “But in the field of regeneration the big cost items, such as construction, are of more interest than health.”

Appendix: single projects within FFW

The idea behind FFW was not just to create jobs and keep people in them but also to create jobs that give people the opportunity (*a*) to work and (*b*) to continue training and move on to better jobs. The projects were publicly funded and widely available to organizations, institutions and companies in the borough, which means they were widely connected to the community. They ran for different lengths of time and were all assessed at some point. The following 12 projects were run within the FFW framework.

1. Training

The greatest success was probably the nine-week course that was set up to train people for work in the health sector. The idea was to help people find a job there and to point out that the first job did not need to be a final step, but could lead on to other jobs within the health sector. The target group was anyone who was currently unemployed, and there was no age barrier. Ethnic groups were not targeted, but about 60% of those enrolled were from an ethnic background.

Adetimola taking the nine-week training course to work in the health sector



One of those doing the course was Adetimola, a teacher by profession. He had had many different jobs and took the course because his wife was a nurse and he was thus familiar with the health sector. His aim was to work in

the social services in order to contribute to community activities, and he felt that the course prepared him well for seeking a job in the social sector.

Linking city regeneration and health in Newham, London

Priscilla took the same course. She was already familiar with care work, but was very happy with the course since she felt it was good preparation for getting work. Her aim afterwards was to find a job in the field of care for the elderly.



Priscilla, assisted by teacher Diane English

Before taking the course, Marie-Jeanne had been on a training course to go back to work. She was satisfied with the course, felt that she learned a lot from it and was confident that she would find work at the end.



Marie-Jeanne with teacher Bobby Spall

2. Exercise on prescription

Can exercise replace medicine? Not without the consent of the general practitioner. But through cooperation with four fitness centres in Newham, patients who might profit from physical activity were referred to these centres, where they received the time and care to help them improve their fitness. This scheme has now been established as a Primary Care Trust activity, which ensures the sustainability of the project. The scheme has proved very popular, and general practitioners are sometimes considered too diligent in referring patients to the centres.

3. Integrated care centre

The most ambitious project in the FFW framework was constructing a health care centre in Newham. The building, opened in the spring of 2002, is owned by Newham Primary Care Trust. It houses all the Trust's activities as well as linking to other relevant activities.

Health systems confront poverty

4. Dental nursing

Before this project began, dental nurses in Newham were trained in hospitals, as is common practice. But most dental practice is provided by community dentists, so that hospital training is inappropriate. The team believed that it was more suitable to train nurses for the small business environment of local dental practice. Training is now geared towards this reality with the result that the high drop-out rate was reduced, both by this new way of training and also by a more careful selection of trainees than the local job centre would provide. In less than 3 years, 118 jobs were created, mostly for ethnic communities. The idea is to franchise the training/recruitment scheme.

5. Bilingual co-workers

Communicating with patients and relatives who speak a foreign language can often be a problem. This project offered training in communication to health workers of all sorts, from cleaners to nurses and doctors, who spoke languages other than English. The idea was that, instead of enquiring among health workers if they have the necessary language skills, all existing multilingual staff could be trained to be intermediaries between health workers and patients and/or their families. This ensured better communication, added value to the workers' jobs and, consequently, added to their salaries.

6. Interview coaching

Employed people are likely to be healthier than unemployed people, and most will probably do better in job interviews. This programme targeted long-term unemployed people and helped them to improve their curriculum vitae and their interview skills, thus increasing their possibility of finding a job.

7. Health and safety at work

This project aimed to provide education on health and safety at work to 14–15- and 18–25-year-olds, either before work experience or before they started working life. It was also aimed at educating home care workers, to make them aware of health and safety issues related to their work. This initiative was supported by the Trade Union Council.

8. Supplier development

One way to increase employment within an area is to encourage local trade. This project aimed at brokerage within the region so that small- and

Linking city regeneration and health in Newham, London

medium-sized business could successfully bid for purchase contracts. Often the problem is that a new business does not have a “track record”, but within the project this problem was alleviated by introductions to relevant businesses and possible purchasers. This was done in cooperation with business organizations and support groups in the area.

9. Advocacy

This project was run jointly by the social and health services to encourage the use of public services by those who traditionally failed to do so. The three groups targeted were people with learning difficulties, young people and those with mental problems. The project aimed at training workers to be better at advocating the services to these groups, and to others who need the services but do not ask for help or assistance.

10. Teenage health promotion

This project aimed at getting health information across to teenagers. A special health plan for teenagers will eventually be developed in Newham.

11. Healthy living centres pilot

The aim of this project was to set up a pilot “healthy living” centre, focusing on the needs of children and young people.

12. Monitoring and evaluation

Apart from choosing the projects carefully, great attention was paid to monitoring and assessing them. All those running the projects were trained at the University of East London, which also oversaw the monitoring and evaluation of FFW projects.

Conclusions

The collection of case studies has been a valuable exercise in its own right. It has provided the Regional Office with an overview of current perceptions about poverty in a number of Member States and an opportunity to map out issues that are being addressed, together with potential “gaps” in addressing issues within the Region.

Furthermore, the meeting in Düsseldorf included a review of the whole process and methodology chosen for the exercise, as well as the criteria for the selection of case studies. A number of “missing” areas in the initial set of 12 case studies were identified – in particular, the lack of case studies reporting actions to tackle poverty and health in rural settings. In accordance with these findings, a number of courses of action were considered appropriate and relevant in order to bridge the gap in information and to develop the necessary know-how in this area of increasing concern for all Member States of the European Region. These include the continuation of the process of developing, analysing and disseminating knowledge on the relationship between poverty and health and, in particular, the development of methodologies and tools for the systematic collection, validation and dissemination of case studies on the concrete role of the health system in addressing poverty and health issues.

It was also recognized during the meeting that many measures aimed at alleviating or reducing the underlying conditions that cause poverty lay beyond the scope of the health system. Consequently, although health ministries and health personnel are key partners in fighting poverty, it is fair to say that the health sector needs to liaise, coordinate and create alliances with other sectors in order to tackle poverty and health.

What emerges from this limited but diverse sample of case studies is that efforts in Member States to tackle poverty, including health system interventions and partnerships with the social care sector, have a common thread throughout the countries of our Region, poor and rich alike.

Health systems confront poverty

Finally, it is acknowledged that many other valuable comments and conclusions were made during the Düsseldorf meeting but could not be detailed in this publication. Instead, focus is placed on summarizing below the key conclusions with broad implications for future work.

Health systems can take effective action

The case studies show that health systems can take action at different levels, from local interventions in small communities, as illustrated by the case study in Croatia, all the way up to broad national policy development, as reported in the French study.

But which actions can have the biggest impact on poverty? On what administrative level should the experiences be institutionalized? Which initiatives can be easily scaled up and what are the pitfalls to be avoided while making them mainstream? What types of evaluation need to be in place in order to ensure sustainability?

This study could provide only partial answers to such complex questions. In fact, it recognized that in order to take effective action, policy-makers will require an information base with up-to-date and reliable information on what has been shown to work in tackling poverty and health. It is acknowledged, therefore, that further collection, analysis, evaluation and dissemination of a broad range of initiatives addressing the health of the poor and vulnerable groups are needed.

Health systems should not cause an extra burden on the poor

Being ill should not make people poor or drastically drain their resources. In practice, however, health systems can create barriers and unintentionally cause or increase poverty. For example, this study shows that in some cases traditional practices may force patients to stay out of work for unnecessarily long periods. Furthermore, other studies have shown that certain forms of revenue collection can make the poor pay unfair out-of-pocket contributions.³³ The Kyrgyz case study presented here, however, has shown that difficulties in securing enough tax revenue for health and the widespread existence of informal “under-the-table” payments may lead to

³³ *The world health report 2000 – Health systems: improving performance*. Geneva, World Health Organization, 2000.

Conclusions

pragmatic solutions that include co-payments within broader health care reform packages.³⁴ Indeed, besides increasing transparency, preliminary surveys in Kyrgyzstan indicate that the share of total patient spending on drugs and medical supplies was dramatically reduced after the co-payment policy was introduced, and that the hospitals' "reserve fund" allowed the provision of free drugs for poor patients.

These examples, which could only be briefly reviewed in this publication, suggest that it is important to have criteria, mechanisms and indicators that monitor how well different practices and policies affect the poor. Health care systems can, for example, work with other sectors to carry out regular reviews on legislation that has an impact on poverty and health. Similarly, the organization, provision, access and delivery of care in a given country can be periodically reviewed to appraise their impact on the health of the poor.

Skills, competencies and mobilization of resources

Despite the fact that the issue of poverty and its impact on health is becoming an area of greater concern in Europe, in many countries health systems have not developed adequate human and financial resources to address this complex area. Similarly, knowledge about poverty and health on a wide range of issues related to hospital and medical treatment of poverty-related diseases, prevention of disease and health promotion opportunities are not included in the curricula or training of health care personnel. In contrast, examples such as the Italian case study presented here show that the employment of personnel trained to deal with the needs of the poor can make a difference. Thus, in addition to mobilization of financial resources for tackling poverty, there is also a strong need for strengthening the skills and developing the competencies of health care professionals who are in the front line of this struggle.

Accordingly, there is perhaps one closing remark that captures the essence of the testimonies and the analysis carried out in this study: that it is worth

³⁴ The reasons for policy-makers to resort to co-payments, and the potential pitfalls involved, are well argued in the literature too. See, for example, MOSSIALOS, E. ET AL. *Funding health care: options for Europe*. Buckingham and Philadelphia, Open University Press, 2002.

Health systems confront poverty

investing in people, encouraging them to develop their own solutions, helping them to disseminate the lessons they have learned, and joining forces with them in showing that the competences and skills necessary to bring about change are within reach.

Annex 1

Template for writers

The writers commissioned for this publication brought a wide variety of experience and knowledge to the project, and were given the opportunity to write their reports in a creative style. None the less, to achieve a cohesive publication, the template below and a set of guidelines were prepared and distributed to all writers. The writers were requested to use the template as a guide and checklist to ensure that the various aspects of the cases were fully investigated.

General background information

Country

Name of project/initiative (explaining any acronyms)

Main partner organizations/institutions

Current status of the initiative/project

Life cycle of the initiative/project

Date when the initiative started

Date when the initiative will finish/finished

Reasons for termination

The general context of poverty and health within which the case study is examined

Organization of health care

Are there any major organizational or planning mechanisms that either tackle or induce inequities?

Are there key national targets to address poverty in general or vulnerable groups?

Health care finance and expenditure

What is(are) the main system(s) of financing health care – are poor people excluded from/included in such systems?

Health systems confront poverty

Do organizations/sectors outside government provide any significant support to alleviate the burden of ill health in poor populations/areas?

Other influences

Are there other policies that may be relevant to the case study?

The specific context: objectives and main activities

What are the main objectives of the initiative?

What are the main activities undertaken?

How does this initiative interface with the overall health system?

What are the main successes of the initiative?

Scope of the initiative

Was it experimental or part of an established policy?

What was the primary target group?

- a. Whole population
- b. Vulnerable groups
- c. Individuals

How was the initiative administered?

- a. Locally
- b. Nationally
- c. Regionally
- d. Other (what)

What was the primary setting?

- a. Rural
- b. Urban
- c. Both

Estimated number of people who benefited from the initiative:

Process/Methodology

What methods were used to recruit/reach members of the primary target group? How effective were they?

What were the main barriers to the initiative and how were they tackled?

Annex 1

Was the initiative evaluated? If so, how?

Were there any unanticipated negative impacts?

The main lessons learned

What did the initiative require (financial, physical and intellectual resources)?

What did it achieve (goods, services and capabilities)?

What were the results (access to, use of or satisfaction with services)?

What was the impact (effects on health and wellbeing)?

Other information

Who were the main actors in the initiative?

What was the profile of the primary target of the initiative?

a. Age:

- all age groups
- infants (0–2 years)
- children (3–12 years)
- teenagers (13–17 years)
- adults (18–65 years)
- adults (65+ years)
- other
- not applicable

b. Gender:

c. Measure of poverty:

- below national absolute poverty line
- above national absolute poverty line but poor
- non-poor but vulnerable

d. Groups with special characteristics:

- families
- pregnant women
- school-aged children
- low education
- health professionals
- unemployed
- ethnic groups
- workers/employees
- others

Health systems confront poverty

e. Geographical location:

Were there intermediary groups supporting the initiative?

- a. Health professionals
- b. Community residents
- c. Social workers
- d. Teachers
- e. Parents
- f. Others

What channels of communication were used to reach the target population/
groups?

Has this case been reported before? If so, when and by whom?

Annex 2

List of invited experts

The following experts were invited to take part in providing input to this publication and to participate in the technical meeting held in Düsseldorf, Germany on 18–19 April 2002.

Farman Abdullayev¹

WHO Liaison Officer, Baku, Azerbaijan

Martijntje Bakker

Policy Worker, Public Health Fund, The Hague, Netherlands

Rogério Barbosa

Technical Officer, Socioeconomic Determinants of Health, WHO Regional Office for Europe

Sara Burke

Public Health Development Officer, Institute of Public Health in Ireland, Dublin, Ireland

Sarbani Chakraborty

Health Specialist for Europe and Central Asia Region, World Bank, Washington DC, USA

Yves Charpak

Senior Policy Adviser, Office of the Regional Director, WHO Regional Office for Europe

Sigrún Davídsdóttir

Journalist and writer, London, United Kingdom

¹ Did not attend the meeting in Düsseldorf.

Health systems confront poverty

Finn Diderichsen¹

Department of Social Medicine, Institute of Public Health, University of Copenhagen, Denmark

Rebecca Dodd

Technical Officer, Strategy, Director-General's Office, World Health Organization

David Dror¹

Senior Health Insurance Specialist, Social Protection Sector, International Labour Office, Geneva, Switzerland

Philippe Duprat

Senior Project Adviser, Health Evidence Network, Office of the Regional Director, WHO Regional Office for Europe

Armin Fidler¹

Health Sector Manager, Europe and Central Asia Region, World Bank, Washington DC, USA

Joachim Gardemann

Professor, Humanitarian Actions Study Programme, University of Applied Sciences in Münster, Germany

Marina Gudushauri¹

First Deputy Minister of Labour, Health and Social Affairs, Ministry of Labour, Health and Social Affairs, Tbilisi, Georgia

Monika Hommes-Ruediger

Deputy Head of Division, Federal Ministry of Health, Bonn, Germany

Ainura Ibraimova¹

Deputy Minister of Health, Ministry of Health of Kyrgyzstan, Bishkek, Kyrgyzstan

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Annex 2

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Alexander Kvitashvili¹

President, Curatio International Foundation and member, Sub-Commission on Social Policy, Ministry of Labour, Health and Social Affairs, Tbilisi, Georgia

Jacques Lebas¹

Médecins du Monde, Paris, France

Suszy Lessof

Project Manager, Monitoring Country Health Care Systems, European Observatory on Health Care Systems, Brussels, Belgium

Christian Luetkens

Representative, German *Länder*, Wiesbaden, Germany

Johan Mackenbach¹

Director, WHO Collaborating Centre for Research on Inequalities in Health, Department of Public Health, Erasmus University Rotterdam, Netherlands

Peter Makara¹

Chief Executive, Council on Health Research for Development (COHRED), Geneva, Switzerland

Dario Manfellotto

Physician and scientific journalist, Rome, Italy

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¹ Did not attend the meeting in Düsseldorf.

Health systems confront poverty

Andreas Mielck

Senior Scientist, Institute of Health Economics and Health Care Management, National Research Centre for Environment and Health, Neuherberg, Germany

Piotr Mierzewski

Administrative Officer, Health Department, Directorate-General III – Social Cohesion, Council of Europe, Strasbourg, France

Aldo Morrone

Director, Department of Preventive Medicine for Migration, Tourism and Tropical Dermatology, San Gallicano Institute for Hospitalization and Cure with a Scientific Approach, Rome, Italy

Wolfgang Müller

Director, Academy of Public Health, Düsseldorf, Germany

Birgit Neuhaus

Evidence on Health Needs and Interventions, WHO Regional Office for Europe

Antonina Ostrowska

Professor of Sociology, Chief, Research Unit on Living Conditions and Social Determinants of Health and Deputy Director, Institute of Philosophy and Sociology, Polish Academy of Sciences, Warsaw, Poland

Lilia Ovcharova¹

Director of Scientific Programmes, Independent Institute of Social Policy, Ford Foundation, Moscow, Russian Federation

Fred Paccaud

Director and Chairman, Institute of Social and Preventive Medicine, University Hospital and Faculty of Medicine, University of Lausanne, Switzerland

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Annex 2

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Margaret Whitehead

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Erio Ziglio

Head, WHO European Office for Investment for Health and Development, WHO Regional Office for Europe

¹ Did not attend the meeting in Düsseldorf.

Annex 3

Template for group discussions

The template below was developed as a basis for conducting the group discussions that took place in Düsseldorf, Germany on 18–19 April 2002, and was used by the facilitator. Although not all elements presented here could be tackled in this first publication, the template and the answers provided by the technical experts remain important stepping-stones for future work.

Relevance

Do the initiatives address issues that are relevant to public health in general?
Do the initiatives contribute, directly or indirectly, to poverty reduction or poverty alleviation? If so, how?

Replicability

Is the initiative replicable in other contexts? If so, how easily?
Are there any key preconditions that should be spelled out?

Usability/Adequacy

Are the case studies presented in a way that is useful to the main target audiences?
Do some aspects need to be better documented or explained to increase understanding and/or usefulness?
Is the language/presentation adequate for the intended audience? Should it be supported by other efforts?

Sustainability

Are these initiatives sustainable in the short/medium/long term?
Are they/Can they be well integrated into other existing systems in the country/region?

Implementation

What are the key lessons learned from the initiative?
What was the impact of the initiative?

The “unreported”

Are there other key aspects of poverty and health that are related to the case studies but were not covered in the current draft (aspects that need further research)?

Quality of the evidence

Is there a clear and transparent account of how the information was collated (for example, sources consulted, potential conflicts of interest, etc.)?

Are there inconsistencies in the information made available?

Is the methodology compatible with the WHO Regional Office for Europe’s current work on evidence?

What are the next steps to improve the quality of the existing material?

Corporate view

Are the case studies consistent with corporate messages disseminated by WHO or do they challenge established paradigms?

The magnitude of the problem of poverty in the WHO European Region today is beyond dispute. Gross inequities in health and wellbeing persist and the gap between rich and poor continues to widen in many countries. Health systems have done and are doing much to tackle this complex and daunting problem, but such work has been sporadic and gained little visibility. This book is part of WHO's work to help spark more and better action on poverty and health by systematically gathering, analysing and disseminating information on direct action by health systems across the Region.

It describes 12 initiatives already undertaken in 10 WHO Member States: Croatia, France, Germany, Hungary, Italy, Kyrgyzstan, Poland, the Republic of Moldova, the Russian Federation and the United Kingdom. These initiatives range in scope from profound countrywide changes in legislation and care provision through programmes and projects in regions, cities and specific health institutions to action on the borders of the health system spearheaded by dedicated individuals.

This book documents WHO's preliminary findings on how health systems can help to alleviate poverty, and reaches three main conclusions: that these systems can take effective action to improve the health of the poor, that they can sometimes represent an additional barrier for the poor and that more knowledge, training and capacity building in this area are urgently needed. It is hoped that the information presented here will contribute to WHO's efforts to help countries across the length and breadth of Europe improve health and increase equity by tackling poverty and its effects on health.

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