

HEALTH CARE DELIVERY SYSTEMS:

OPPORTUNITIES FOR PUBLIC MANAGEMENT EDUCATION IN CENTRAL AND EASTERN EUROPE

EDITED BY
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NISPAcee

THE NETWORK OF INSTITUTES AND
SCHOOLS OF PUBLIC ADMINISTRATION
IN CENTRAL AND EASTERN EUROPE

NISPAcee
The Network of Institutes and Schools of Public Administration in
Central and Eastern Europe

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Editors:

Allan Rosenbaum, Juraj Nemec, Kenneth Tolo

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(The Network of Institutes and Schools of Public Administration in Central and Eastern Europe)

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Introduction

Allan Rosenbaum *

The last fifteen years have been ones of extraordinary transition for the countries of Central and Eastern Europe (CEE) and the Newly Independent States (NIS). Simultaneously, these countries have undergone many very significant changes. These changes have profoundly impacted their political and economic systems, often have produced the restructuring of their societies and, in some cases, have created massive social and political upheaval.

Not surprisingly, these dramatic changes have often resulted in profound changes in the type and extent of public services available to the citizens of these countries. In many, if not all, of these countries the delivery of public services has been profoundly altered. In many instances, one has seen not only a massive decentralization of service delivery, with increasingly impoverished national governments turning over major responsibility for the financing of public services to local or regional governments, but also the major introduction of private sector activity and financial responsibility.

Nowhere has this pattern been more pronounced than in the delivery of health care services. In virtually every country of the region a major restructuring has occurred. As the country studies that follow will clearly illustrate, there has been a massive shift of responsibility for the delivery of health care services. In most countries a large part of the responsibility for the delivery of such services has moved from national to local governments; from health ministries to newly created insurance corporations (both public and private); and from state monopolized to mixed public/private delivery systems.

These changes have not taken place without some significant dislocation and institutional re-structuring. In some cases, the consequences of these processes of change have been positive, but in many cases there have been some very severe negative consequences. Again, as the country studies that follow will suggest, a wide array of problems have plagued the restructuring of health care systems in many of the region's countries.

Among the most significant of these problems have been, in some cases, the shortage of drugs, materials and necessary equipment. Many countries are also finding themselves having to deal with the problem of worn out buildings and equipment. There are also major problems of staff morale – in part, a problem of low salaries and, in part, a consequence of working in a complex and sometimes highly dysfunctional environment. In too many instances, this has resulted in a declining commitment of health care personnel to the effective delivery of services in their countries (as reflected in the out-migration of health care personnel from many countries) and the growing problem of under-the-table (or “gratuity”) payments.

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Another area of major concern has been the significant over-supply of hospital facilities and the lack of adequate primary care facilities. These situations have been further complicated by the declining capacity of government at all levels to effectively guide, develop and regulate their health care systems. At the same time, in some situations, national health ministries still impose counter-productive regulations that impact the operation of individual health care facilities.

As this very brief initial review of the issues facing the CEE and NIS countries suggests, and as the chapters which follow will elaborate even more clearly, the fundamental problem facing these countries in the provision of health care services has less to do with medical techniques and processes and more to do with issues of finance and organization. Indeed, it is widely acknowledged that the most critical problem facing these countries in terms of virtually every area of public service delivery, including health, is inadequate funding.

It is, however, less frequently acknowledged that another major cause of the current difficulties, especially in the area of health care, are organizational and administrative ones. However, as the country studies that follow more than adequately suggest, many existing health care facilities are not effectively and economically managed. In many cases they are mismanaged with a resultant waste of resources which are already in short supply.

It was this reality that resulted in the initiative which produced the book that follows. Its specific origins go back to a meeting that took place in Krakow, Poland at the tenth annual conference of the Network of Institutes and Schools of Public Administration in Central and Eastern Europe (NISPAcee). This meeting, which had been suggested by the then incoming President of the US National Association of Schools of Public Affairs and Administration (NASPAA), Jo Ivey Boufford, involved Ludmila Gajdosova, the Executive Director of NISPAcee; Noah Simmons, program officer responsible for health policy studies at the Open Society Institute in New York City; Juraj Nemec, of Matej Bel University, also representing NISPAcee; Paulina Soto, representing NASPAA; Violetta Zentai, of the Open Society Institute – Soros Foundation in Budapest and Allan Rosenbaum of Florida International University, also representing NASPAA.

The idea behind this meeting was a simple one. It was to explore the question of whether improved management generally, and in particular the improvement of the education and training in administration of those responsible for the management of health care facilities and the shaping of health care policy in the CEE and NIS countries, could improve, either in the short or long run health care service delivery in those countries. Underlying this concern was the assumption (demonstrated to be correct in the studies that follow) that, in most cases, the heads of health care facilities in CEE and NIS countries were medical doctors with little or no training in administration and management.

The idea that improved education and training in administration could have a positive impact in terms of improving the quality of health care service delivery in CEE and NIS countries also was in part based upon familiarity with the system of education and training for health care managers and policy makers in the United States (US). This was

a particular concern of the Open Society Institute representative in the Krakow meeting. Located, as it is, in New York, the Foundation was familiar with the US experience in the education of health care managers. There, as the chapter on the US indicates, the majority of managers of health care facilities are not medical doctors but rather are trained in administration, with their graduate education occurring either in specialized health management programs or, in some cases, general public administration programs.

Out of the discussion in Krakow, and subsequent conversations between Gajdosova and Simmons emerged the idea to explore in greater depth the issue of whether improved education and training in administration and management would be of value in terms of improving the capacity of CEE and NIS countries to more effectively manage the scarce resources which they have available for health care service delivery. This in turn led to the creation by NISPAcee of a working group on health management and education in the CEE and NIS countries. Ultimately, that process of exploration led to creation of the book that follows.

It was decided to commission for the working group, through competitive processes, a series of studies in a number of CEE and NIS countries. Each study was to include a brief but comprehensive review of the current status of the health care delivery and public administration systems of the country being examined. It was also to look at the current systems of educating and training those who manage health care facilities and those who manage in the public sector more generally. Particular attention was to be paid to any instances in which there were collaborative efforts between public administration programs and health related programs, especially those based in medical schools.

The author of each country study was given the opportunity to propose recommendations regarding the potential utility of introducing in one manner or another general public administration education into the processes of educating and training those responsible for health service delivery system management and health policy formulation within the country. Obviously, where any such programs existed, the author of the country study was asked to describe and assess those as well.

Each of the country studies serves to provide a wealth of information about all of these topics. Hopefully, these studies will have an impact, both collectively and individually, in helping to shape education and training in the areas of health care service delivery and policy making in the region. In turn, this will, at least over the long run, help to provide the citizens of this region with the quality of health care that they both want and deserve.

Finally, it is necessary to note that, like any book of this sort, many people deserve recognition for helping it make the long and often difficult transition from good idea to actual reality. The first person deserving such acknowledgement is Noah Simmons of the Open Society Institute in New York - and of course the Foundation itself for providing the resources necessary to make this effort possible. Likewise, Ludmila Gajdosova and one of her managers, Juraj Sklenar, played important roles in initiating and overseeing this effort. Finally, this book could not have become a reality without the considerable dedicated efforts of the authors of each of the chapters.

PART I

Health Sector Reforms: Measures, Muddles, and Mires

*James Warner Björkman*¹

1. Introduction

For several decades, public sector reforms have been premised on the assumption that improving the ability of government to manage its business will lead to improved social and economic progress. The 1997 World Bank World Development Report describes a first generation of reforms in which steps were taken to cut government expenditures and to revive the private sector. Measures included budget cuts, tax reforms, limited privatization, liberalization of prices and, most conspicuously, efforts to downsize the public sector. The latter was almost invariably described as “bloated” and therefore in need of surgery, followed by a strictly enforced diet.

It soon became evident that the transformation of government would require a long period of time and that the savings from reduced bureaucratic costs would be insufficient to provide even basic levels of public services. A second generation of public sector reforms then sought to improve the efficiency and effectiveness of government. While the first generation reforms stressed downsizing, contracting out and improved control over budgeting and public expenditures, the second generation reforms advocated decentralization to sub-national levels, the creation of semi-autonomous agencies in the central government, and reforms of human resources management (including recruitment, selection, training and performance).

More recently, the agenda for reform has refocused yet again on improving social outcomes and improving service delivery. This third-generation strategy has emphasized sector-wide approaches, particularly in health and education, in order to produce a coherent program for delivery of services that involves both governmental and non-governmental organizations.

These generations of reforms, of course, are overlapping rather than strictly sequential. But all reforms have been driven by a combination of external and internal agencies. Multilateral aid and bilateral aid often entail conditionalities that require a (commitment to) change in governmental behavior before money can be transferred. In turn, national planning commissions and ministries of finance require line agencies to adopt reforms that may include a combination of these generations. The purposes of this chapter are to review the logic of New Public Management (NPM) in the health sector, to examine in more detail the reforms applied to the delivery of health services, and to suggest strategies for reforming the health sector that take capacity into account. The chapter concludes with

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reflections on the emergent importance of the European Court of Justice for enforcing competitive approaches in the health sector throughout member states of the European Union.

2. New Public Management In The Health Sector

Despite the rhetoric of increasing the role of the private sector and of “downsizing” government, the private sector for the delivery of health care in developing countries is already extensive. Indeed, the private sector is often bigger than the public sector – but, due to ideological blinkers or “group think,” the private sector has not been acknowledged and therefore not measured, at least in public data sets. The private sector in health is also largely unregulated. Consequently, instead of “downsizing” the number of staff as applied to the civil service, most of the NPM reforms found in the health sectors of developing countries emphasize internal reorganization of the public sector – particularly through decentralization.

There is a parallel with civil service reforms. In most cases, reforms in the health sector have been stimulated by economic recession and severe fiscal problems rather than by an ideologically driven taste for reform. Declining government budgets have adversely affected service delivery, even in those countries that previously had reasonably well-performing systems for the public delivery of health services. Pressures for the reform of health care often emanate from central ministries such as finance and planning. Ministries of health then struggle to reinterpret and to respond to policy directives outside of their control. Creative leadership is required to initiate and sustain such reforms, but the empirical track record has been erratic (Bossert *et al.* 1998; Nelson 2000).

Economic realities affect not only the types of policies that are implemented, but also the reaction to them by the users, beneficiaries and citizens. The stage of raising revenue through the introduction of user fees in order to supplement government budgetary resources was critical for many governments because of the endemic economic crisis. But the success of the policy, no matter how logical in theory, was constrained by the dwindling capacity of the poor to pay for health care. And the transaction costs of administering the fee system often exceed the revenue collected.

Public sector reforms range across streamlined budgets, staff reductions, raised tariffs, contracting out and other forms of privatization. Reform of the health sector has focused on four main options, none of which is mutually exclusive, and all of which may occur at the same time. These are:

- the establishment of autonomous organizations;
- the introduction of user fees;
- the contracting out of services; and
- the enablement and regulation of the private sector.

While such reforms have been widely espoused in international fora as well as by technical experts, their implementation has been much more limited. It is

difficult to assess the real potential for NPM reforms in the health sector because such reforms have been either partial or only recently introduced. More time is needed for proper assessment, particularly because social inertia and institutional lethargy require time-frames measured in decades rather than in months or years. Frequently, however, and rather ironically, countries with the most radical reform agenda appear to be those with the least capacity to implement them – or, as Caiden and Wildavsky (1980) commented caustically about budgeting: the smaller the capacity, the greater the ambition, and vice versa. Perniciously, the depth of the economic recession in such contexts requires a radical approach in terms of policy pronouncements, yet economic recession reduces the ability to implement such a radical agenda.

Different types of capacity constraints have been identified, none of which is unusual. Human resources constraints in terms of the number of skilled staff available, and the motivation of staff to carry out their assigned tasks, are widely prevalent problems. Organizational culture often militates against effective operation of the new modes of government. In organizations that favor hierarchy and command over initiatives and team development, the autonomy formally granted to government entities may not be fully acted upon.

While the New Public Management emphasizes the importance of linking performance to rewards, parallel informal systems often undermine the formal reward systems. For example, promotions are often made on the basis of patronage and favors in the traditional patrimonial system, rather than on objective assessments of performance. Key systems, such as management information systems, frequently fail to function effectively. Another significant barrier is the lack of incentives for individuals within the health care sector to plan or to monitor their work in terms of the information that is produced. In other words, there is almost no feedback system for self-correcting action.

A further sign of weak capacity is poor coordination among different actors. Governments experience great difficulty in translating their broad policy statements into concrete strategies for implementation. As a consequence, there are problems in specifying and then enacting the details of decentralization policies. It is not clear, for example, as to the level of government at which financial rights and responsibilities lie. Likewise, it is not clear which organization should report which data to whom. These are all simple, but disastrous, problems in coordination.

Of course, some of the constraints on capacity just noted are actually rooted in the broader public sector rather than only within the ministry of health or similar agencies. This is particularly true of human resources management, but it also applies to other systems. Traditional, centralized, financial control processes frequently undermine innovative reforms and/or generate a perverse process of resource allocation.

Especially in Central and Eastern Europe (CEE), old budgetary rules impede efforts to increase efficiency. An illustrative example is a district hospital

in Slovakia which, continuing to operate under old, traditional, budgetary rules, procured between 1997 and 2002 medical equipment for 68 million Slovak crowns (US\$2 million) without starting to use any of it before 2003. During the entire period, the hospital produced large debts which were covered by the government (*Národná obroda*, 6. 8. 2003). Similar or related problems exist in other parts of the world. Until recently, all the revenues generated from user fees in Zimbabwe had to be returned to the Ministry of Finance – thus providing little incentive for their collection (Dlodlo 1995). Such a disincentive more or less ensured that, contrary to the expectations of NPM, such fees had zero impact upon the quality of health care.

In contrast, in Jaipur (the capital of Rajasthan state in India), local hospitals are now allowed to keep the user fees that they collect rather than returning them to the state treasury (Björkman and Mathur 2002). Not only do those hospitals have a better record for collection of fees, but also they re-invest the surplus in such long-term benefits as higher quality equipment, more reliable stocks of pharmaceuticals and other medical supplies, and even lower (or exempted) fees for the truly destitute. The Rajasthan case demonstrates rapid returns on the three classic criteria for health care – that is, better **quality** of care, easier **access** to care, and lower **cost** of care.

Similar trends are now visible in CEE countries. Outcome-based financing creates new incentives – although such processes are much slower to emerge in health care compared to other public sector branches because of the monopolistic environment. New financial rules and the setting of strict budgetary limits after decentralization in Slovakia did significantly change the behavior of decentralized health care providers – for example, savings of about 900,000 Slovak crowns per month are now achieved in the hospital in Piestany by the decreasing of the number of employees by 53 persons. The hospital has been transformed into a non-profit body and shall operate with a balanced budget (*Pravda*, 30. 4. 2003).

Other factors influencing capacity that are outside the control of health ministries include the limited extent of private sector development. Limited development or inadequate depth of involvement of the private sector in health care hinders government efforts to contract out services. More important, it implies that government has few local examples of effective management practices in organizations from which to learn. Moreover, in the broad economy, there is a limited reservoir of management skills upon which to draw.

3. Types Of Reforms

When describing health sector reforms (HSRs), questions include the types of reforms being applied (or at least recommended) and whether they are working in local or even national contexts. When addressing these questions, one must be aware that generalizations – or their opposite, namely, limited particular examples – tend to caricature reality. The world, particularly the developing world, is vast and diverse. Furthermore, if one argues that HSRs are working, what tangible

evidence exists for this claim? Conversely, if one is skeptical, what questions need to be asked?

It does not require a critical stance to observe that some proposed HSR measures are simply structural adjustment measures in disguise. They are often complicated and mostly “top-down.” Other HSR measures call for major changes that are politically unsavory and would require strong determination to get underway. Yet weak and weakening states are no match for strong societies with well-entrenched interests (Migdal 1989; Myrdal 1968). Even getting started is often such a problem that elaborate plans for implementation tend to remain on the drawing board.

More important – and overshadowing the above constraints – is the fact that the proposed reforms have come to mean market-oriented interventions in the health sector. The concept has literally been hijacked or monopolized by a World Bank-led paradigm of health reforms that parallels and is embedded within the so-called Washington Consensus. It is important to address the underlying assumptions being made about market-oriented health sector reforms that are currently being aggressively promoted around the world.

Without much analysis, it is contended that a more decisive market orientation of the existing public health sector will bring about increased efficiency. Evidence that market-oriented health care systems are more efficient than public health care systems, however, is not even to be found in countries such as the United States, with its already highly market-oriented health care system (Marmor 1998). Almost twice as many financial resources (approximately 14% of the Gross National Product (GNP)) are required in the United States to provide the same type and quality of care available in Western European countries (which spend only 7-8% of their GNP) – a comparison that indicates that great inefficiencies remain in the most market-oriented health care system in the world.

One major reason for this pattern is that it remains profitable to provide unnecessary care. Another is that – in systems where private, for-profit health insurance companies play a major role – transaction costs (administrative and other) are very high, in the order of 20-40%. Consequently, even using pure traditional efficiency criteria, evidence from many countries indicates that public health care systems can be not only more equity-oriented but also more efficient than market-oriented health care systems.

Of course, this observation does not imply that all public health care systems are efficient. The point is that inefficient public health care systems can be made more efficient by improving relevant public policies. Embracing a market orientation is not necessarily the preferred way to improve health care for people. Unfortunately, however, reforms that propose to strengthen public health policies and to ensure public financing of health care via taxes are gratuitously dismissed as supposedly “non-viable” as a realistic option for the future.

This dismissal is reinforced by the theoretical contention of mainstream health economists that the role of government is “to adjust the market failures” found

in the health sector. The underlying assumption is that a “perfect market” – one with no failures – will provide the best health care system. But this model implies that demand, as expressed by purchasing power, should ultimately determine the supply and utilization of health care services. It is thus, by definition, impossible for a perfect market to provide health care services according to need, regardless of ability to pay. Only if the groups with the greatest need for care would be those with the most resources for buying the care they need would the “market forces” be a possible regulator of access to care.

In reality, as evident in all countries, the opposite is the truth. The economically least privileged groups are the ones experiencing the greatest disease burden, thus having the greatest need for care. If we acknowledge this reality – and if our objective remains the provision of health care according to need – we must look for ways to improve the public health care system, ways that can cater to the health needs of those with less ability to pay. This search does not exclude a role for a parallel private, for-profit health care sector that follows market forces primarily catering to the needs of the most privileged groups. But the main concern for health sector reforms must be to secure quality health care services for the great majority of the population, thus reducing social inequities in terms of economic, geographic and ethnic access to care.

Let it be understood that there is nothing inherently wrong with market-oriented reforms in health, provided that:

- they work in the direction of greater efficiency and equity;
- they receive no government subsidies; and
- they comply with well-monitored regulations promulgated up-front.

But these prerequisites rarely exist anywhere at present – including in countries with a “socialist market-oriented economy” such as China and Vietnam, and countries in transition in Central and Eastern Europe (as described in country studies in this book).

In order to get reforms in the health sector on a more sustainable track, deep structural changes need to be enforced. Such a track has to assure minimum care for a growing number of poor people who have fallen through the safety net. Public hospital care has become increasingly unaffordable for the poor due to steep user fees. Additional hidden costs complicate this situation – “under-the-table payments” to doctors being just one type (Avetisyan 2002; Baru 1999). Subsidizing such a system, instead of reforming it, will only channel additional funds to the wrong (non-poor) recipients.

Health sector reforms have been used as crutches to pretend one is changing the system, but basically staying the course or even regressing. Historically, there is a non-accidental link between structural adjustment programs (SAPs) and HSRs. The link is a calculated internal logic to apply the principles of the market economy to the health sector. The bottom line is that HSRs alone (as conceptualized and promoted in much of the literature) cannot address the structural constraints faced

by the poor in obtaining equitable access to preventive, curative and rehabilitative health services.

Furthermore, as currently applied, HSRs use technical terminology with misleading imprecision. Examples that come to mind are:

- “efficiency” (which is measured only in economic terms);
- “willingness to pay” (which is used in lieu of the real determinant, namely, “ability to pay”); and
- “cost-sharing” (which is applied to regressive fee-for-service systems – forgetting that general taxes have the potential of being a more progressive cost-sharing system when those who have more are made to pay more).

The issue is thus not whether people should share the costs – because the people always end up paying. The real issue is who is to pay more and who is to pay less or nothing at all. The point is that the terminology used is linked to one specific ideological outlook (and thus one type of health sector reform).

4. Interim Recommendations

What interventions would be more effective and sustainable? The best response to a part of this question is in another question: why not ask the beneficiaries directly to respond to this question? This response has the wisdom – on top of so much that has already been said about it – of accepting the fact that:

- localized responses will (and should be) multiple and varied;
- no single response fits all (or even many) diverse situations;
- technical expertise can be put to a more effective use in a genuine dialog with community representatives than in a technical dialog among (self-proclaimed) experts;
- an all-encompassing wisdom is not necessarily a trademark of communities (as often is romantically implied) – communities do not always know best, so mistakes are made; and
- quickly learning from mistakes in an ongoing dialog between communities and professionals can lead to quicker sustainability than applying schemes imposed from outside, no matter how promising these schemes look.

Paraphrasing Nobel laureate Amartya Sen, in order to understand people’s choices one must know which alternatives are open to them in real life. Such a grassroots-centered approach calls for an unprecedented change in priorities and modus operandi. The locus of control has to shift to beneficiaries for decisions that affect them directly on an everyday basis.

At the same time, equity-oriented measures have to be implemented from the central level. In this era of almost automatic decentralization, the merits of centralization should not be overlooked. And that is the other part of the response to the question posed above. For the time being, and until the equity situation changes for the better, some of the key elements of such reforms in transitional

countries could be the following (percentages are only illustrative and will change in each concrete context):

- Public rural health care services need to be primarily financed by governments (central and local). Government should cover around 70-75% of total costs; only up to 10-15% can be realistically expected to be raised by community contributions or rural health insurance schemes; 5% can come from direct user fees; and perhaps an additional 10% from foreign aid.
- Financing public urban health care services probably requires 50-60% government financing; health insurance could cover around 30% of costs, and user charges 15%; the rest could come from foreign aid.
- Financing of health care will have to move progressively away from regressive fee-for-service schemes and toward prepayment schemes where the whole population – not only the sick – contributes.
- Direct and indirect progressive taxes must constitute the financial base in an efficient, equity-oriented health care system. Government funds thus collected can then be used directly to fund public health services or can subsidize social health insurance schemes that will gradually cover the whole population.
- Governments will have to reallocate resources gradually from rich regions and districts to poorer ones according to a set of needs-based indices, and then by amending recurrent and development budgets accordingly.
- General tax revenues that apply more to the rich (e. g., taxes on luxury items, spirits, and tobacco, or on assets, estates, and wealth) should be seriously considered as a means to obtain financial resources for the health sector.
- Existing resources (human, material, organizational and financial) should be rationalized to adapt them better to actual needs. This will entail reallocating (even shedding) personnel as well as mobilizing more resources for outreach work outside the health stations. All this should be linked to medium-term reforms that bring health staff income up to minimum standards of living, preferably based on a system of monetary and non-monetary incentives.

These are but a few of the central and local level options that merit careful examination. But most important, the process must open the doors to a more participatory and empowering dialog (especially engaging women) in order to generate more options and answers. For this to happen, the process has to be decisively steered to concrete departure and finishing lines – and health professionals can facilitate this task.

What is really needed is an “HSR of the public health care sector,” not one overwhelmingly biased in the direction of the private sector. The often touted non-service-mindedness of the public sector is not a given. The public system has many flaws but also many strong points. As its core is streamlined and strengthened, one can indeed contract out some ancillary services to the private sector – provided there is a fair system of competition in place. Health sector reforms will explore these possibilities for improving the public sector in health care and

keeping it at the core of a delivery system that can ensure equity at the highest levels of priority.

This brings us full-circle to the old “political will” issue that, everyone should understand, is not really an issue of “will” as such: it is an issue of “choice,” of political choice and subsequent commitment. And being an issue of choice, for the time being – short of an awakening of civil society initiatives and movements around the world – the responsibility to move toward appropriate HSRs is still squarely that of the respective governments.

5. Conclusions

In practice, many social policies have been designed and implemented as a “residual” to the priorities of economic policies and have often been explicitly labeled “compensatory” programs to “alleviate” the social cost of economic adjustment. In contrast, a social reform strategy as argued above would require the development of an integrated and coordinated strategy comprising, first, broad-gauge measures and, then, practical health policies:

- economic reform policies, including macroeconomic stabilization policies and structural adjustment policies that redistribute productive assets (e. g., agrarian reforms, removing constraints to access to credit);
- social sector reform policies, comprising measures to improve the efficiency and equity of service delivery (e. g., health, education, housing) in order to facilitate equal opportunities for human development and social integration;
- reform of social protection systems, including social safety nets (protection of vulnerable groups in the short run) and social security programs; and, to complement and facilitate the above,
- institutional and administrative reforms aimed at improving the governance of public action through improvements in the decision making process.

While the implications of these observations for capacity building approaches in the health sector have not been fully explored, a few lessons for the process of institutional reform in health have already emerged that are worth enumerating:

1. Health reforms need to be designed and implemented in phases in a way that reflects existing capacities. Rather than attempting to do too much all at once, it is helpful to identify easy entry points upon which reform programs can be built and through which incremental reforms can be achieved.
2. Some aspects of capacity – generally those internal to the implementing organization – are easier to address than others. Efforts to build capacity (or to remove constraints on capacity) should start with the objectives that are less difficult to achieve.
3. Some of the skills required to operate the new modes of government effectively cannot be easily taught in formal training courses because they are based on experience. Reform strategies should be designed to encourage experience-based learning, especially through apprenticeships and/or internships.

4. Elite units and autonomous organizations, so often used to bypass bottlenecks in government, should be deployed sparingly. While this strategy may be an effective mechanism for achieving a high-priority short-run goal, such as the expansion of an AIDS control program, its longer-term effect is unintentionally pernicious. That is to say, long-term reliance on special elite and autonomous organizations can prevent fundamental problems from being addressed. The resurgence of malaria, after decades of attempting to eradicate it, is a case in point. If one can deploy military imagery, battles may be won but the war is lost.
5. Communities can be an important source of support to the government in strengthening reforms. They also can help to police the effectiveness of government, particularly in countries where there is a rich civil society. But such approaches should be used selectively in order not to overburden the “third” sector. It is important to understand the capacities and constraints of the voluntary, non-governmental, community-based sector.
6. Finally, better communication of reforms to a variety of audiences – health workers, the general public, politicians and others – is critical. It is critical not only for the political viability of reforms in terms of generating support, but also so that these groups can fully participate in the reformed system.

None of these six recommended strategies is a fail-safe solution to the problem of reforming the health sector and its capacity to deliver good quality services to the appropriate population at reasonable cost. All of them have empirical merit. In some countries, however, particularly from the Newly Independent States (NIS) region, but also in accession countries in Central Europe, there has been a severe depletion of institutional capacity. Basic systems fail to function, and reform agendas have further stretched ministries of health that are already exhausted. In such situations, capacity development will inevitably be long term, and policies should be devised accordingly. Those policies should start by addressing the basic capacities of government that are common to reformed and unreformed systems.

Finally, recent evidence indicates another source for market-oriented reforms in the health sector, namely, judicial decisions about ensuring a competitive market. The obvious case in point is how provisions of the Single Common Market within the European Union have been interpreted and applied by the European Court of Justice (Koivusalo 2001; Hamilton 1996; Doorslaer *et al.* 1993). As new members are inducted into the charmed circle of blue stars, their health sectors may be compelled to open themselves to ever greater competition. In the short run, the old public health agencies will predictably be undermined and public services will deteriorate. The challenge is to provide reforms of the health sector that do not, in a hackneyed metaphor, “throw the baby out with the bath water.”

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Preparing Managers for the U. S. Health Care System

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1. Introduction

The health of the public and the role and responsibilities of governance and public systems in assuring a healthy population are key issues for all of society. Every country in the world faces the challenge of assuring the health of its population and of providing access to health services with limited resources and cost constraints.

While this challenge is universal, the health systems designed in response to this challenge vary greatly. The different economic, social and political realities of nations and states create unique systems, and, within each nation, transition and reform are essentially continuous. In the United States, it is hard to conceive of any set of organized human endeavors that has been more heavily impacted by the forces of change than the delivery of health care services. Similarly, the rapid social changes in Central and Eastern Europe (CEE) since 1989 have had an impact both on health and its determinants and on the organization of health care systems (Kickbusch 2002). For most of these countries, reforms in the health system remain a critical and unfinished agenda (Peterson 2002).

Regardless of their level of economic development or wealth, health systems in all countries face an ongoing struggle to manage multiple demands and pressures (Fried & Gaydos 2002). Included among these pressures are achieving an appropriate balance between access and costs, between public and private provision of services, and between the need for preventive and curative services. The point of balance for these forces is predicated largely on the policies of governments and the practice of public administration nation-by-nation.

Sound health policy provides the foundation for achieving the goal of public health and for the successful delivery of public health services (Curran 2002). Policy development and health system design, including financing and organization, emerge from the dynamic interplay of government, social and economic conditions. The interplay of these sectors is also influential, if not critical, in the health status of populations. Public administration, as a pivotal component in many of the forces that determine the effectiveness of health systems, can provide a bridge of collaboration between sectors, as well as between policy and management. By participating in health management and policy education and training together and in cooperation with medical schools, more effective health policymaking and management can be achieved.

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This chapter focuses on two issues – defining public health and its main aspects and dimensions, and describing the main channels of preparing managers and policy makers for the U. S. public health care system, including the most important aspects of curricula development, quality control (accreditation) and cooperation between public administration and medical schools.

2. Defining Public Health Systems

Public health is a broad term with no universal international definition and structure (Bobak *et al.* 2002). The broadest definitions include functions of the state other than health care and public health services such as education, housing and transportation. Other definitions include health service provision and management, while narrower definitions focus on the essential public health functions that include monitoring population health and its determinants, health promotion and prevention, and protection of the environment.

Definitions focused on public health functions create a distinction between organized societal efforts focused on populations (public health) and clinical medicine and curative services (health services delivery) focused on the individual. Distinguishing between public health and health services delivery is common in the United States as well as in other countries of the world, and a key differentiation is in the assignment of responsibility. Population-based public health services in the United States are provided by governmental agencies at the local, state and federal levels, while the delivery of services to individuals is largely outside governmental agencies and provided by a vast array of public, private, for-profit and non-profit organizations.

Both population-based and individually-focused health services delivery systems are integral to achieving the goals of public health. Researchers and practitioners alike are calling for more integration and more cooperation between the two systems. Analyses of health systems within countries must include both systems and recognize the distinct challenges for government roles and responsibilities within each system and in efforts to achieve more integration.

Public Health: Population-based Efforts

In the United States, governmental public health agencies at the local, state and federal levels provide a critical foundation for the public health system (Boufford 2002). These three tiers of governmental agencies must work together to make public health services available in every community. There are more than 3,000 local public health agencies, 3,000 local boards of health, and 60 state, territorial and tribal health departments in the United States (Institute of Medicine (IOM) 2002a).

Local public health professionals work with their communities to identify health problems and define resources and programs to address them. The National Association of Local Boards of Health (NALBOH), in partnership with other public health organizations, has identified the fundamental responsibility for local agen-

cies as ensuring: 1) that their communities have access to essential public health services; and 2) that these services improve community health.

The state health departments assure the safety of water and food supply, maintain information systems to detect health threats, and assist local officials in responding to health needs of their communities. State health departments serve as a link between localities and the federal government.

The federal public health agencies assist in the development of national policy, provide information, set standards for regulating the quality of services, and finance programs for special populations and specific national health problems. Federal public health agencies may be housed in either the United States Department of Health and Human Services (HHS) or the United States Public Health Service (PHS). The Centers for Disease Control and Prevention (CDC), housed in the HHS, in partnership with other health agencies have developed model national public health performance standards and are facilitating their use by state and local health systems and local public health governing bodies. These standards are not imposed by the federal government but serve as an instrument to assess and guide agencies.

Public Health: Organization, Financing and Delivery of Health Services

Compared with other industrialized countries, the United States has shown a distinct reluctance to move into a unified publicly owned and financed health services system. The U. S. health care delivery system has been described as less a system and more a fragmented array of care providers, payers and patients (McAlearney 2003). Organizations providing and financing health care services include public, private, for-profit and non-profit organizations. Government activity in health care can be considered along three dimensions: financing, delivery and regulation.

The U. S. federal government's role in the health care delivery system is largely financing, through programs such as Medicare and Medicaid. Medicare is a national health insurance program for citizens 65 years of age or older. Medicaid is a federal and state partnership health insurance program that provides basic health care for low-income individuals, mostly children or pregnant women. In 2000, public sources paid for 43% of personal health spending in the United States (Kaiser Family Foundation (KFF) 2002).

The federal government sets regulations for Medicare providers and provides general guidelines for state regulation of Medicaid. Other regulatory activities at the federal level prohibit discrimination by providers and establish criteria for approval of drugs and medical devices. The federal government currently provides health services directly to special populations – for example, through the Veterans Health Administration and the Indian Health Service.

States vary in their financing, delivery and regulatory roles. On a broad basis, however, states have a substantial financing role through participation in the Medicaid program (a federal/state partnership). States contribute to the education

of professionals through subsidies to medical and professional schools. In the regulatory arena, states establish standards for insurance, health care facilities and personnel (licensing) and establish health codes through the state health department. States are direct providers of mental health services.

Historically, local governments subsidize public hospitals and fund local health departments that establish local health codes. The role of local governments has been increasing in recent years, as they face pressures to address issues not traditionally assigned to localities (Clark 2000). Health care problems and solutions are being pushed down to the local level at the same time that funds and support from state and federal government levels are declining. Clark (2000) contends that local residents no longer tolerate the “passing the buck” answer that health care issues are the responsibilities of some other jurisdiction (state or federal). He suggests that local governments can turn the situation into an opportunity to increase local control and to foster civic responsibility and participation through multi-sectoral solutions.

An “uneasy equilibrium” between public and private control and financing of health care exists in the United States (Anderson 1985). This uneasiness is also seen in regard to the extent to which market mechanisms influence the system. The United States has moved significantly toward a market system following the failed attempt at comprehensive national health care reform in 1994 (Schroeder 1999). In the past, public policy initiatives and governmental activity, primarily centered on Medicare and Medicaid, had been the motivating forces for change. After years of describing the American health care systems as being policy driven, though, it would now have to be said that the system has rapidly become market driven (Williams and Torrens 1999). In recent years, pressure for change in the U. S. health care system has largely been driven by market forces in the private sector, primarily from employers and other larger purchasers of health insurance.

Private health insurance, provided and purchased by employers and individuals, is the most common funding source for health spending in the United States. Private insurance companies may operate as either non-profit or for-profit entities. Private sources, including private insurance and consumer out-of-pocket costs, account for 57% of personal health spending; of this amount, private insurance accounts for 35% of the dollars spent (KFF 2002). The majority of Americans (67%) have insurance coverage through employer-based insurance programs (KFF 2002); however, this number is expected to decrease given the current economy in the United States. Insurance products are increasingly limiting consumer choice of providers and the types of services covered through managed care arrangements.

Many observers see the wide array of private and public health services programs and insurance products as a strength of the U. S. system (Upshaw and Deal 2002). However, more than 41 million Americans (15%) are uninsured, making public responsibility for health services an important national issue. A press release by the American Public Health Association in January 2003 notes “The number of Americans with little or no health insurance contributes to the poor state of the

nation's health. ... Widespread lack of coverage affects not only the uninsured and their families, but also the communities in which they live." Renewed calls for a national health insurance system for all Americans are being heard (Davis 2003), and the United States, like other countries, must find a way to balance the "uneasy equilibrium" to assure access and improve the health of the public.

3. Managerial (administrative) policy professionals in public health care systems

Generally, three main groups of managerial, administrative and policy posts are found in public health care delivery in the United States. One is the group of public health/health policy professionals; the second group consists of managers/administrators of health establishments delivering health care services; and the third group (which this chapter will not examine further, because they represent the private sector more than the public sector) consists of managers/administrators from the field of health insurance business.

Public Health Professionals

The American Public Health Association (APHA) is the oldest and largest organization of public health professionals in the world. APHA brings researchers, health service providers, administrators, teachers and other health workers together in a multidisciplinary environment of professional exchange, study and action. Individuals who pursue a career in public health can take many routes into the field. While a degree in public health is considered optimal, achieving the goal of public health requires many disciplines and individuals with wide-ranging expertise, experience and education. The directors of government public health agencies are frequently physicians; however, many, if not most, of the physicians in these positions also have earned a master's degree in public health (MPH).

A recent report by the Institute of Medicine (2002b) states the importance of recognizing a new definition of public health professional and the inclusion of a number of types of schools, programs and institutions beyond traditional schools of public health. The working definition of a public health professional offered in this report is "a person educated in public health or a related discipline who is employed to improve health through a population focus." These professionals require a broad range of skills and information and may be educated not only in schools and programs of public health, but also in schools of medicine, nursing, law, and urban planning, to name a few. Though public administration is not mentioned directly in the report, the concepts of policy, law, regulation, urban planning, zoning, design, construction standards and others commonly taught in public administration programs are included as key components in addressing population health issues. An understanding of the multiple determinants of health and their interactions is critical to shaping new knowledge, programs and policies relevant to individual health and health care, as well as to population health (IOM 2002a).

Health care establishment managers/administrators

Leaders and managers in the organization and delivery of health care services are the product of multiple educational backgrounds and multiple career paths in both the public and private sector. As in the public health arena, multiple disciplines and individuals with wide-ranging expertise, experience and education may pursue professional paths. Common degrees, however, include health services administration, business administration and public administration.

Physicians in Executive Roles

In the United States, unlike in many other countries, physicians do not dominate leadership in the administration of the health care field. While physicians do seek leadership roles in the areas of public health, health policy and health administration, their numbers are considerably less than one might see in other countries. Even when serving in executive positions, physicians generally report to a non-physician executive. The American College of Physician Executives (Grebenschikoff 1997) found that 90% of physician executives reported to a chief executive officer and another 5% reported to a chief operating officer. Leland Kaiser, founder and president of Kaiser Consulting, remarks in an article on U. S. health care trends that “one of the strengths in our country is that we have non-physician CEOs [In the future] I don’t see them as a majority” (Weber 2003).

While in the minority, physician executives are found in every sector of health care. Only a third of physician executives either have or are working on a management degree (Weber 2003), although numerous accredited and non-accredited master’s level programs exist that are tailored for physicians. Many physicians working in public health or public policy possess a degree in public health. Moreover, physicians in either management or public health have the option of taking numerous non-degree educational and training programs to gain the knowledge, skills and values required for management positions.

4. Public Health, Health Administration, and Public Administration Education

The educational background and training of individuals employed in health systems and in public policy and governmental positions in the United States vary greatly. There are numerous starting points and multiple routes to a successful career. There is no single set of preparation or credential requirements. The multiple disciplines that intersect and may provide the initial foundation for a career in the health care field include public health, management, business, medicine, health administration and public administration. The knowledge, skills and competencies found in these disciplines provide a rich foundation for shared leadership and collaboration. The multiplicity of backgrounds and career paths recognize, if not promote, multiple contributions and perspectives.

Opportunities to make significant contributions to the public’s health and to the effective and efficient delivery of health care services abound for individuals

trained in public administration. With regard to the health status of individuals, there is a general consensus that changes in health are related to changes in social and economic conditions. Public administrators and policy analysts should be at the forefront of developing and advocating sound social and health policies. In the delivery of public health and health care services, public administration can provide expertise in organization and management, decision making and problem solving, budgeting and financial processes, information management, and program formulation, implementation and evaluation.

Public administration can play a major role in the development of partnerships within and across the public and private sectors and can demonstrate, through practice and training, a broad approach to the challenges of a healthy society and the management of health care systems. In this process, individuals trained in public administration and public policy can contribute to and play a vital role in the development of policy as well as in the development of new systems and collaborative partnerships.

The National Association of Schools of Public Affairs and Administration (NASPAA) is the membership association of graduate schools and programs in public administration, public policy and public affairs in the United States. NASPAA's mission is twofold: to ensure excellence in education and training for public service and to promote the ideal of public service. The core focus of NASPAA institutional members is administration and policy; however, programs often provide one or more specializations or concentration tracks. Health sector management education concentrations comprise one of the most rapidly growing tracks within NASPAA. NASPAA estimates that approximately one-fourth of its 250 institutional members currently offer specializations in health services administration (McFarland 2003).

5. Assuring Quality of Health Management/Policy Education

The United States has no federal ministry of education or other centralized authority exercising unitary national control over postsecondary education institutions. The states assume varying degrees of control over public education, but, in general, institutions of higher education are permitted to operate with considerable independence and autonomy.

In order to ensure a basic level of quality, the practice of accreditation arose in the United States as a means of conducting non-governmental peer evaluation of educational institutions and programs. The standards of accrediting agencies are established in collaboration with educational institutions and programs in the area of expertise. Peer review is a hallmark of both the setting of standards and the accreditation process. While many schools offer non-accredited programs in the areas of public administration and health services administration, accreditation is viewed as a commitment to quality and recognition of the established standards.

NASPAA Accreditation

The Commission on Peer Review and Accreditation (COPRA), the accrediting body of NASPAA, provides voluntary peer review evaluations of master's degree programs in public affairs, public policy, and public administration. COPRA has identified the question of how to treat the growing trend toward specialty degrees and specializations in non-profit management and health care management as an issue to be addressed. Currently, COPRA-accredited programs that have these specializations often seek an additional accreditation from a specialized accrediting body. For specializations in health services administration, for example, accreditation may be sought from the Accrediting Commission on Education for Health Services Administration (ACEHSA).

In 2000, NASPAA established a formal section on health sector management education; this section had an extensive agenda and two major priorities (Hewitt 2003). The first priority was the development of a better informed perspective on health sector management programs, and the second priority focused on establishing a relationship between NASPAA and the Association of University Programs in Health Administration (AUPHA) and ACEHSA to ensure comparability in health care management education.

The following year, the results of a web-based survey of NASPAA schools were presented by Marshall, Hewitt and Badger (Hewitt 2003). This survey indicated wide variation in requirements, electives and credit hours, suggesting a need for further assessment. The Robert Wood Johnson Foundation subsequently funded a proposal submitted by NASPAA's Health Sector Management Education Section to conduct an assessment of the variations between programs. This project's final report will examine program curricula, syllabi, students, faculty and alumni variables.

NASPAA's Health Sector Management Education Section institutional members have strongly supported the development of guidelines for all master's degree programs in public administration, public affairs, and public policy that offer health care management concentrations. Section members are also exploring the following alternatives: (1) seek dual accreditation with ACEHSA, (2) pursue a separate NASPAA health concentration accreditation, (3) promote NASPAA accreditation recognition by external stakeholders, and (4) engage in joint marketing efforts with AUPHA without pursuing accreditation development (Hewitt 2003).

Appendix A shows the broad categories of NASPAA/COPRA standards for accreditation. See <http://www.naspa.org/accreditation/accreditation.asp> for the full accreditation standards and guidelines.

Health Services Administration Accreditation

The Accrediting Commission on Education for Health Services Administration (ACEHSA) is recognized to grant accreditation to individual academic programs offering a professional master's degree in health services administration in the

United States and Canada. The programs accredited by ACEHSA are housed in a variety of disciplines and may be found in schools of public administration, public affairs and public policy, as well as in schools of public health, schools of health-related professions, schools of medicine, and schools of business.

ACEHSA is organized to establish criteria for graduate education in health services administration, planning and policy; to conduct surveys that will encourage universities to maintain and improve their programs; to determine compliance with the Commission's criteria; and to provide ongoing consultation to health services administration programs. Through the peer review process, the Commission seeks to assess and promote quality education in health services administration.

Appendix B shows the broad categories of ACEHSA criteria for accreditation. The full standards and guidelines are available at <http://www.acehsa.org/criteria.htm>.

Schools Of Public Health Accreditation

The Council on Education for Public Health (CEPH) accredits schools and programs in public health. The CEPH believes that accreditation attests to the quality of an education program and also represents peer recognition. Schools of public health are required to have a specialization in health services administration. As with NASPAA program specializations, many of these health services programs also receive accreditation by ACEHSA. Fifteen of the 32 accredited schools of public health in the United States offer ACEHSA-accredited health administration degree tracks and are AUPHA members. Currently, there is a proposal for CEPH to recognize ACEHSA accreditation to avoid an overlap in the process of dual accreditation.

Appendix C shows the broad categories of CEPH standards for accreditation. The full standards and guidelines are available at <http://www.ceph.org/benefit.htm>.

The Association of Schools of Public Health in the European Region (ASPHER) provides peer reviews in public health training in Europe and plans to eventually establish accreditation. ASPHER is primarily concerned with strengthening public health and has played a central role in seeking a higher level of expertise in the health sector (<http://www.ensp.fr/aspher>).

Shared Standards And Curriculum Content

A review of the broad categories in Appendices A through C demonstrates that, while these categories differ among the organizations, the primary concerns of program mission, curriculum and faculty are shared. Appendix D provides a comparison of the broad categories of standards for accreditation by the three accrediting bodies, and Appendix E displays the commonalities in the basic body of knowledge, understanding, skills and values suggested in the curriculum criteria. Note that, for NASPAA, the content knowledge reflects general administration and policy and is not specific to health services. The CEPH does not provide specific

requirements for the five areas of knowledge basic to public health (see Appendix C). Instead, its criteria state that the school of public health must provide depth of training sufficient for a student to pursue a professional degree. The content displayed in Appendix E reflects the general definition for health services administration by CEPH as a core area of knowledge.

Boufford (1999) has presented an agenda for managerial education in health services administration. She observes that the process of educational design at the professional school level must be a combination of the core knowledge and skills needed in the field, influenced by the challenges that graduates will face. Boufford distinguishes between a numerator-oriented model and a denominator-oriented model of the health care delivery system. The numerator-oriented model responds to the needs and demands of individuals seeking care, while the denominator-oriented model responds to the community's health, a population focus.

The population focus on health that is critical today (IOM 2002a) should be considered in the development of health programs in all countries. A population focus takes us beyond medical/curative service delivery and emphasizes the multi-sectoral determinants that influence health and acknowledges the collaborative efforts across sectors and stakeholders necessary to assure the population's health. Future leaders in health care must provide a broad focus and develop collaborative models across multiple sectors. Public administration can be one of many routes for leadership in health care and may provide expertise across multiple sectors.

In discussing international models, Boufford (1999) suggests that "... there is an important convergence of opportunities to learn from each other at both the policy and the operational levels" (p. 285). As public administration programs in both the United States and other countries review the appropriate curriculum content for public health, health administration and public administration, they should consider the opportunities and challenges facing their graduates and the health systems of their countries on both the individual and community level. The design of education for health care systems should address the leadership challenges as well as the curriculum content and competencies required to address those challenges.

Some of the basic questions should be:

- What is the organization of the country's health care system?
- What leadership challenges do the system and its structure pose?
- What are the challenges in training public health leaders in the country/region?
- What skills are needed to lead in the country/region and in the system?
- How can country/region programs provide the appropriate education and training for health care leaders?

6. Conclusions

In July 2002, the United States Agency for International Development (USAID) sponsored a conference on “Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia” in Washington, D. C., with the objective of providing an experience that could be the foundation for future health transition efforts of country leaders and donors (see <http://www.eurasiahealthtransitionconference.org>). A central theme of the conference focused on shared learning. Learning from others can provide models for adaptation to local realities as well as prevent health systems from repeating the mistakes of others. On a regional level, “expensive and time-consuming mistakes have been avoided by developing partnerships and collaborative programs with other countries” (Deac 2002).

Within countries, public administrators and policy makers may help avoid expensive and time-consuming mistakes by spearheading collaboration between public health, governments, and health services delivery organizations within their systems as well as across country boundaries. Sharing programs and courses across educational schools and institutions may also lead the way for future collaboration and understanding.

The role of public administration in the health system of each country will vary. The contribution of public administration, however, can be significant. Public administration practitioners and educators are at the threshold of the future preparing a workforce for leadership to improve population health.

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Appendix A.

Categories of Standards for NASPAA/COPRA Accreditation

Eligibility for Peer Review and Accreditation

Eligibility

Institutional Accreditation

Professional Education

Program Length

Program Mission

Mission Statement

Assessment

Guiding Performance

Program Jurisdiction

Administrative Organization

Identifiable Faculty

Program Administration

Scope of Influence

Curriculum

Purpose of Curriculum

Curriculum Components

 Common Curriculum Components

 Management of Public Service Organizations

 Application of Quantitative and Qualitative Techniques of Analysis

 Understanding of the Public Policy and Organizational Environment

 Additional Curriculum Components

General Competencies

Minimum Degree Requirements

Internships

Faculty

Faculty Nucleus

Professional Qualifications

Practitioner Involvement

Faculty Quality

Instruction

Research

Experience and Service

Faculty Diversity

Admission of Students

Admission Goals and Standards

Baccalaureate Requirement

Admission Factors

Student Services

Advisement and Appraisal

Placement Service

Supportive Services and Facilities

Budget

Library Services

Supportive Personnel

Instructional Equipment

Faculty Offices

Classrooms

Meeting Area

Off-campus and Distance Education

Definition and Scope

Program Mission, Assessment, and Guidance

Program Jurisdiction

Curriculum

Faculty

Admission of Students

Student Services

Support Services and Facilities

Appendix B.

Broad Categories of Criteria for Acehsa Accreditation

Program Mission, Goals, Objectives and Performance

Mission, Goals and Objectives

Students and Graduates

Research and Scholarship

Service

Institutional Support

Teaching and Curriculum

Curriculum Design

Curriculum Content

Faculty

Qualifications and Availability

Responsibilities

Recruitment, Development and Evaluation

Appendix C.

Broad Categories of Criteria for Ceph Accreditation

Mission, Goals and Objective

Organizational Setting

External

Internal

Governance

Resources

Instructional Programs

The areas of knowledge basic to public health include:

1. Biostatistics – collection, storage, retrieval, analysis and interpretation of health data; design and analysis of health-related surveys and experiments; and concepts and practice of statistical data analysis;
2. Epidemiology – distributions and determinants of disease, disabilities and death in human populations; the characteristics and dynamics of human populations; and the natural history of disease and the biologic basis of health;
3. Environmental health sciences – environmental factors, including biological, physical and chemical factors, that affect the health of a community;
4. Health services administration – planning, organization, administration, management, evaluation and policy analysis of health programs; and
5. Social and behavioral sciences – concepts and methods of social and behavioral sciences relevant to the identification and the solution of public health problems.

Research

Service

Faculty

Students

Evaluation And Planning

Appendix D.

Comparison of Broad Categories of Standards for Accreditation

NASPAA/ COPRA ¹	Eligibility	Program Mission	Program Jurisdiction	Curriculum	Faculty	Admission Students	Student Services	Support Services	Off-Campus Distance Education
ACEHSA ²		Mission, Goals, Objectives & Performance*		Teaching & Curriculum	Faculty				
CEPH ³		Mission, Goals & Objectives	Governance	Instructional Programs	Faculty	Students		Resources	

Appendix E.

Curriculum Content

The required curriculum must include a basic body of knowledge, understanding, skills and values relevant to health services management.

ACEHSA	NASPAA/COPRA	CEPH (HSA)
Structuring, marketing and positioning health organizations		
Financial management	Budgeting and financial processes	
Leadership, interpersonal and communications skills; managing human resources	Human resources	
Managing information resources	Information management, technology applications and policy	
Statistical, quantitative and economic analysis	Economic and social institutions and processes	
Legal and ethical analysis – business and clinical decisions	Political and legal institutions and processes Decision making and problem solving	
Health policy	Policy and program formulation, implementation and evaluation	Evaluation and policy analysis of health programs
Health status and determinants; managing risks		
Development, organization, financing performance and change of systems	Organization and management concepts and behavior	Planning, organization, management
Outcomes measurement; methods for process improvement		

¹ National Association of Schools of Public Affairs and Administration/Commission on Peer Review and Accreditation

² Accrediting Commission on Education for Health Services Administration [³ Includes Students and Graduates, Research and Scholarship, Service and Institutional Support]

³ Council on Education for Public Health

PART II

Public Health Management and Policy Education and Training: Albania

*Albana Abmeti*¹

1. Introduction

The ultimate goal of the health sector is to maximize the population's health. However, the health status of the population depends on many factors – quality of health care being just one of them. Thus, reforming health services must be part of an initiative that recognizes the impacts of the wider social, physical and economic environment on health status, and vice versa. Public policy in the area of health is successful if it influences the main health determinants, including income distribution, employment, education, transportation and agriculture. It also requires an ability to assess health care needs and to identify, develop and implement appropriate services in response to them.²

The characteristics of a health system are the results of a mix of economic, social, political and historical factors outside the system itself. One important factor that has a great impact on health care reform is the involvement in, and structure of, the state in policy development and implementation - including the level of decentralization, the extent of national or local government intervention, the degree of development of a public health infrastructure, and the presence of public health input at decision making levels.³

The reform of the health sector will succeed only if there are enough professionals available and equipped with appropriate skills. Thus, there is a need to invest in the education and training of public health professionals with relevant skills. World trends show substantial improvement in educating health managers and public health professionals, the establishing of new programs and schools, and increasing the quality of education and training in the field; however, the scope and scale of progress varies considerably between countries.

Central and Eastern European countries (CEE) and the Newly Independent States (NIS) began to adopt the market economy model after 1989. This model has drastically impacted the health care systems of most of these countries. Albania, as part of the CEE, started its economic transformation from central planning to a market economy 12 years ago. The main changes in the economy were followed by changes in administration in general, and by changes in the public health sector in particular. Health reforms were initiated more recently; they typically

¹ Institute of Public Health, Tirana, Albania.

² World Health Organization (WHO) (1995). Health Promotion and Health Care System Reforms: A Consensus Statement. First meeting of the European Committee for Health Promotion Development, Dublin. Copenhagen: WHO Regional Office for Europe.

³ WHO (1997). European Health Care Reform: Analysis of Current Strategies. WHO Regional Publications, European Series, No. 72. Copenhagen: WHO Regional Office for Europe.

have been more fragmented, with pilot programs and local initiatives, rather than consistently implemented within national policies. The main changes in the health sector focus on:

- the reduction of direct state involvement through decentralization; and
- privatization reform orienting various actors to market forces and competition to improve allocation decisions.

There is a particularly urgent need to increase the availability of skilled and knowledgeable public health managers and policy makers in Albania. In addition, not enough has yet been done to prepare, introduce and implement market-based health sector reforms. The system of education and training of health managers is in an early phase of development, and health policy education and training is more or less missing.

2. Basic Geographic and Sociopolitical Facts

Albania is situated in the southwestern part of the Balkan peninsula. It covers 28,748 square km., of which 34.8% is comprised of forest, 15% of pasture, 24.3% of agricultural land and 4% of lakes. The landscape is mainly mountainous, with an average altitude of 714 km., nearly twice as high as the average altitude for Europe as a whole. The border of Albania is 1094 km. long; 529 km. borders the former Yugoslavia (north and northeast) and 271 km. borders Greece (south and southeast). The coastline is 476 km. long. See Table 1 for basic Albanian demographic indicators.

Since 1990, Albania has undergone important social and political changes as it experiences a delicate transition toward a market economy and a democratic government. This progress was twice severely disrupted, by social unrest from 1991 to 1992 and in 1997, and then by the war in Kosovo in 1999. Current Gross Domestic Product (GDP) per capita in Albania is US\$810, making it the country with the lowest per capita income in Europe.⁴

In the context of a severe economic crisis, migration from the rural areas has resulted in weakened village social structures and chaotic city life, while also placing pressure on social and physical infrastructure in both locations. Health and social services are experiencing increasing demands but there is little additional capacity, so the quality and delivery of those services throughout Albania is deteriorating (most obviously in rural areas). Other forms of infrastructure, such as roads and transport, also are in urgent need of attention.

Population migration and emigration will create a need to strengthen services to accommodate the shifting population. A net out-migration of the younger population will shape future developments, and the impacts of new social problems (e. g., increased drug trafficking, violence and prostitution) will also lead to increasing demand for health services. A strategy designed to improve the health of the

⁴ World Bank (2001). World Development Indicator Database. July. Available at <http://www.worldbank.org/albania>.

Table 1. Demographic Indicators in Albania: 1994-1998

Indicators	1994	1995	1996	1997	1998
Population (millions)	3,354,300	3,202,031	3,248,836	3,283,000	3,324,317
% population under 18 years	40.3%	40.1%	39.6%	40%	40.5%
Ratio of births to deaths	6.9	6.5	5.7	4.8	3.49
Live births per 1,000 population	23.1	22.2	20.8	18.6	17.6
Deaths per 1,000 population	5.5	5.6	5.7	5.5	5.1

Source: INSTAT; Statistics Sector in Ministry of Health, Albania.

population will have to focus initially on involving the younger population as a means of investing in the long-term health and development of the country.

Public Administration System

Since the restoration of democracy in 1992, public administration reform has been one of the weakest aspects of the Albanian reform program. It has been characterized by *ad hoc* responses to crisis situations, with little building of long-term institutional capacity and efficient administrative procedures. Generally, public administration is characterized qualitatively by inadequacy. The absence of a professional and competent civil service in public administration has resulted in the following problems:

- low motivation, a lack of monetary incentives, and, given the salaries, endemic corruption (major and petty);
- brain emigration; and
- a growing movement of public officials to the private sector.

The allocation of human resources is inefficient, with overstaffing in many areas and critical shortages of key professional staff in others. Budgeting and resource management in all public sectors remain weak. The understanding of the rule of law in civil society and in public administration is low, and control institutions (e. g., auditors, administrative courts) are weakly developed and of uncertain status. This situation also has had its own impact on health management and administration.

Legislation passed in 1992 introduced an element of political and administrative decentralization to Albania with the creation of 37 districts, 45 municipalities and 313 communes. However, this was not followed by any clear division of functions between central and local governments for the provision of public services, and there was subsequently little attempt to clarify areas of responsibility. The territorial structure of government was further confused by the creation of 12 prefectures, each covering a number of districts and having responsibility for coordinating the activities of central ministries at the local level.

In practice, the weak points are still the local governments, especially when delivery of public services depends on good cooperation among the decentralized services of the central administration and the local authorities. Local administration

and agencies suffer from inadequately defined and probably very limited responsibilities and powers. They also have very limited capacities and resources, as well as lower performance in the management of investments.

Public services have suffered from a lack of facilities and equipment as well as inadequate operational budgets. The 1997, civil war resulted in considerable damage to infrastructure, as well as a looting of facilities.

Finally, various problems exist on the macro level as well:

- The quality of policy and law is poor, largely because of inadequate procedures and an absence of cross-ministerial checking, a low level of political capacities in the ministries, and a lack of experience in techniques such as legal drafting and problem analysis. At least formally, there has been progress in the latter area, but the system is not firmly embedded and is exposed to risk.
- The weak definition of the roles of organizations and the poor quality of the substance of the law mean that public administration is generally unable to implement policy effectively and fairly under the rule of law.
- Corruption is endemic; there is no judicial oversight except from the Constitutional Court, and there is no administrative procedures act.⁵

Despite these problems, important initiatives have been implemented:

- a) A new budgeting system was introduced and a treasury function established in 1992-1993.
- b) The Department of Public Administration was set up in early 1995.
- c) A Civil Service Law was adopted in 1996.
- d) An external audit function was established, and the State Control Service is being transformed into an independent audit unit; however, the law to establish a recognized Supreme Audit Institution has not passed.
- e) More effective policy management and infrastructure exist.
- f) Leadership within public services has been developed through:
 - training in civil services management and public administration;
 - opportunities for periodic foreign study; and
 - higher salaries.
- g) Reforms of local government have focused on:
 - clarifying the respective roles of central and local governments; and
 - ensuring more adequate budgetary provisions for local government service.⁶

⁵ Durata, T. (n. d.). "An Overview of Public Administration in Albania."

⁶ Ibid; and Albanian Ministry of Economic Cooperation and Trade (1998). "Public Investment Program (PIP): 1998-2002."

3. Health Care System

This section describes the most important features of the health care system in Albania, including the main health status indicators.

Health Status of Inhabitants

Despite the massive economic and social changes, health indicators appear to have remained favorable when compared with health indicators in countries of similar per capita income levels, as described by the following data:⁷

- Total population (2001) 3.4 million
- Average life expectancy 72 years
- Infant mortality 15 per 1,000 lives
- Maternal mortality 25.8 per 100,000 live births
- GNP per capita US\$870
- GDP US\$3.1 billion
- Total health expenditure (2000) 3.1% of GDP

Morbidity

The morbidity rate is one of the main indicators for evaluating a country's health status. Statistical data show that respiratory diseases have the highest rate in Albania; the average density of respiratory diseases is 12.5 admissions per 1,000 population. The gastrointestinal diseases remain a relevant problem, with about 10.09 admissions per 1,000 population. Infectious diseases are in third place, with 9.32 admissions per 1,000 population.

Mortality

This death indicator is going down, decreasing from 5.4 deaths per 1,000 population in 1992 to 4.97 in 2000. The most common cause of death is circulatory disease, followed by respiratory disease and neoplasm; the last two diseases occur much more frequently in rural areas than in urban areas. There has been an increase in deaths from injuries resulting from accidents.⁸

Health Care System

Historically, Albania's health care system has been based on the principles of free access, wide coverage of the population, and financing via general taxation. During the Communist system, the government was responsible for both the financing and the delivery of health care. The Albanian health system, like systems of other countries with a formally socialist economy, has the following typical characteristics:

⁷ World Bank (2001); and European Observatory on Health Care Systems (1999). Health Care Systems in Transition: Albania. Copenhagen: World Health Organization (WHO) Regional Office for Europe.

⁸ Bureau of Statistics, Albanian Ministry of Health; and Institute of Public Health, Albania.

- apparent equity;
- inefficiency because the health system is highly centralized, very bureaucratic and unresponsive to citizens; and
- a public sector that has suffered from serious shortages of drugs and equipment and a lack of skills to manage changing health institutions.

These problems have resulted in declining quality of care and declining staff morale. A 1993 World Bank report advanced the debate concerning the role of government in health by focusing on a combination of three key issues:

- investments in the health of the poor to reduce poverty and its consequences in health status;
- improvements in government spending in health (e. g., financial packages of benefits, prevention of communicable diseases) can enhance health status; and
- the promotion of diversity and competition in the provision of health services; increasing the participation of the private sector by improving the mechanisms of health insurance and helping them understand how the markets function.⁹

The World Health Organization (WHO) regional office for Europe offers a pragmatic approach to link health improvement to the development of economic and social infrastructure. Its documents have influenced health reforms in Albania. Recent health reforms have also been influenced by the main goals of the government's strategy for economic development during 2001–2004, based on the Growth and Poverty Reduction Strategy (GPRS) and the Stabilization and Association Agreement (SAA) process. The health of the nation has been identified as a priority sector under this GPRS strategy.¹⁰

Health Reforms

After the breakdown of state socialism, changes occurred in the legal framework for health care, as well as in the governmental policy regarding ownership, production, financing and reimbursement of health care. The aim of the second public administration reform in 1993 was a decentralization process based on strengthening the role of local government, which is now responsible for primary health care in rural areas, except for the Tirana region. Local government also is responsible for managing the allocation of financial resources supporting the operational costs of the health sector.¹¹ This reform was seen as an effective means to stimulate improvements in health services delivery through better resource allocation. Despite these efforts, this reform has not yet had a significant impact on the health care system - due both to the lack of local professional capacity and inadequate resource allocation.

⁹ World Bank (1993). *Investing on Health*. Washington, DC: World Bank.

¹⁰ Albanian Ministry of Economic Cooperation and Trade (1998).

¹¹ European Observatory on Health Care Systems (1999).

A specific decentralization initiative was the establishment of the Tirana Regional Authority in order to undertake the decentralization of health sector planning and management at the regional level in Tirana. This pilot project was developed by the World Bank as one of the most important components of its Health System Recovery and Development Project.¹²

The Institute of Health Insurance was established in 1996. It has developed a useful approach for health financing reforms, contracting with private sector providers of pharmaceutical services and general practitioners (GPs) at the primary health care level. Starting in early 2003, the Institute of Health Insurance has been preparing the packages of insurance benefits in collaboration with the Ministry of Health and the Regional Health Authority.

Ministry of Health's Role in the Health Care System

The Ministry of Health (MoH), with its district level branches, is the body for policy formulation, decision making and management. During the first public administration reforms in 1990, administrative authority was taken away from the central authority and given to the regional authorities (prefectorates). The MoH continues still retains the important role of controlling the health budget, and it still remains the major funding source and provider of health care services. The Ministry of Health devotes much of its efforts to health care administration; for example, many health care institutions (e. g., tertiary care institutions) are under the direct administrative control of the MoH. Through its directorate of human resources and district health teams, the MoH is also responsible for controlling human resource development and some training. However, it has not been able to set up a national strategic planning process, a regulation system involving the development of health care standards, quality accreditation, or consumer protection.

The Ministry of Health needs to improve the efficiency of financial resource allocation to different levels of the health care system. Fund allocation must be based not only on historical budgets, but also on population needs relating to health indicators and geographical areas.

Because of the lack of access to health care, and poor conditions in hospital and health centers, the health care system has the problem of “under-the-table” payments to doctors. More than three-fourths of the population (80%) have admitted paying an illegal fee to doctors. The situation is made worse by the fact that people in the rural areas, and those who are less educated and poor, cannot afford these payments.¹³ The government, through the Ministry of Health and its health care strategy, needs to improve the accessibility of health care services.

Albania has nearly the lowest human development index in Europe; moreover, it has dropped since 1999. High levels of poverty and unemployment, as well as

¹² World Bank (1998). “Health System Recovery and Development Project.” May 12.

¹³ Albanian Ministry of Health (n. d.). “Towards a Healthy Country with Healthy People: Public Health and Health Promotion Strategy.”

regional differences in infrastructure, have contributed to this inequity. To combat this problem, the government, through the Ministry of Health and the Tirana Regional Authority, in collaboration with the Institute of Health Insurance, wants to ensure a basic package of health services for everybody in order to improve equity in health care. However, this is very difficult, given limited existing financial resources, especially since current activities are not well coordinated and managed.

Health Services Delivery

Health services are typically delivered as follows:

Primary health care and public health services. In rural areas, most services are delivered by the local health center or ambulatory center, which is staffed with up to three primary care doctors, and by nurses. A health post, staffed by a nurse or midwife, provides maternity care, child health services and immunization. In urban areas, large polyclinics provide outpatient specialized care and also are the first point of contact with medical care.

General hospitals. General hospitals at the district level remain publicly owned, principally under the jurisdiction of the Ministry of Health.

Specialized hospitals. Tertiary care remains very limited and is located mainly in Tirana; this includes the following services:

- Tirana University Hospital “Mother Tereza,” the biggest hospital in the country (around 1,600 beds), offers secondary and tertiary care;
- Tirana Obstetric and Gynecology Hospital offers secondary and tertiary care;
- Lung Disease Hospital offers secondary and tertiary care and long-term treatment for tuberculosis patients; and
- Military Hospital (under the authority of the Ministry of Defense) specializes in trauma cases and contains the university orthopedic department.¹⁴

The general decline in health services delivery capacity is obviously reflected in the physical deterioration in health facilities, medical equipment, furniture and medical vehicles.

Albania’s inadequate system of referrals lacks appropriate gate-keeping and/or required documentation to promote effective case management. One undesirable consequence is a high rate of referrals directly to tertiary services, bypassing district and regional hospitals. Thus, the tertiary level provides relatively simple services that should be managed at the district or regional levels at less cost. It also means a large part of the budget for the district and regional hospitals goes to maintaining greatly underused facilities.

¹⁴ European Observatory on Health Care Systems (1999).

Health Care Financing

In the context of a rather non-transparent Communist administration, little reliable information exists as to past financing mechanisms of the system, particularly in quantitative terms. Some consequences of this funding system were common to all former socialist countries (e. g., health services suffering from a chronic shortage of funds, lack of quality and motivation among the personnel, social dissatisfaction, low levels of medical technology in either primary or secondary care).

Albanian health care finances remain at a very low level. Budgetary spending on health was 3.1% in 2001, one of the lowest in the region. Funding for health services is a mix of taxation and statutory insurance. The three main sources of financing are:

- general taxation (public state budget);
- Health Insurance Fund; and
- out-of-pocket payments.

The bulk of funding for health care still comes from the state budget, but the tax base is problematic given the low incomes of the population, the largely unregulated economy and problems with tax collection. Because of a lack of funds to obtain services, the health care sector also uses “under-the-table” payments.

The government’s reform strategy has sought to diversify the sources of financing in the health sector and to introduce new provider payment mechanisms, in order to shift the emphasis from input to output financing. One of the outcomes of these efforts was the establishment of the Health Insurance Institute (HII) in 1996. The health insurance system finances general practitioners on a per capita basis and covers some costs for pharmaceutical drugs (280 essential drug reimbursements).

Local authorities also play a role in health care financing. They now receive special earmarked grants from the Ministry of Finance for paying staff costs (excluding GPs, who are paid by the HII) and operational costs (including medical supplies) of health posts and health centers, as well as maintenance costs.

In the present situation, the financing of the Albanian health sector is as follows:

- Hospital funding still directly depends upon decisions of the Ministry of Health (MoH). It allocates funds directly to the hospitals, with the budget earmarked for staff salaries and other recurrent expenditures.
- Health centers and other primary health care institutions are funded through a more complex scheme: the Health Insurance Fund pays doctors’ incomes through capitation and recovers part of the costs for pharmaceuticals included in the “explicit list of essential drugs”; and the MoH pays nurses and other staff members’ salaries through local authorities, which also pay most of the operating costs and other expenses with earmarked funds received from the Ministries of Finance.

- For the Tirana region, the financing scheme is different because of the Tirana Regional Authority (TRA). Through the state budget, the TRA is responsible for managing the funds for public health investment at the first and second levels in the region of Tirana. The other funding source is the Health Insurance Institute, which buys only the services of GPs on a capitation basis.
- The Institute of Public Health, the National Center for Blood Transfusion, and other special health units remain directly funded from the state budget; they are the most important “functional branches” of the Ministry of Health.
- Pharmaceuticals are not included in the “Essential drugs list”; most dental care and some other services are directly paid for with out-of-pocket money.¹⁵

Human Resources

The Albanian health workforce numbers 28,624 people. Of these, 25,670 work in the public sector. Private sector health care activity is primarily that of dentistry and pharmacy; only a relatively small number of clinical specialists work full-time.

Albania has fewer physicians and nurses than other countries in the region. The data in Tables 2 through 4 show the number of physicians, nurses, and general practitioners per 1,000 population in Albania, compared with other CEE countries.

Table 2. Number of Physicians Per 1,000 Inhabitants

	1995	1996	1997	1998	1999
Albania	1.40	1.41	1.30	1.29	1.33
Croatia	2.03	2.25	2.25	2.28	2.29
CEE average	2.44	2.47	2.48	2.48	2.50

Sources: Health for All, WHO.

Table 3. Number of General Practitioners Per 1,000 Population

	1995	1996	1997	1998	1999
Albania	0.60	0.48		0.46	0.46
Croatia	0.72	0.68	0.68	0.68	0.68
CEE average	0.69	0.68	0.70	0.71	0.72

Sources: Health for All, WHO.

Table 4. Number of Nurses Per 1,000 Population

	1995	1996	1997	1998	1999
Albania	3.89		3.71	3.79	3.67
Croatia	4.03	4.42	4.55	4.74	4.77
CEE	6.04	6.14	5.90	5.94	5.89

Sources: Health for All, WHO.

¹⁵ Albanian Ministry of Health; and WHO Regional Office for Europe (2000). “Health Care Reform in Albania.” Unpublished document.

On the other hand, the total number of staff employed in Albanian health services as a whole is comparable with that of wealthier Western European countries. [The ratio for the population as a whole is 1: 119.] The distribution of professionals is adequate, with the exception of the visible imbalance of specialized doctors compared to GPs. Pay differentials of medical professionals are low (e. g., the ratio between the salaries of the lowest and highest paid persons is 1: 1.7). The distribution pattern of staff among regions creates a significant inequity in the current provision of services, with staff-to-population ratios varying by plus or minus 50% between districts.

Job and role specifications are rather outdated, inflexible, poorly defined and evaluated, and not linked to organizational purpose or scale of activities. In most institutions, human resources performance objectives are not established; staff development and career management also are very limited and uncontrolled. Inadequate supervision and management control tools make management procedures and employment practices out-of-date. There is a severe shortage of trained supervisory and management professionals, which has resulted in the managerial infrastructure being developed less quickly than the health services. Moreover, the managerial infrastructure is not being developed to create a health services system in which attention is concentrated on effectiveness and quality.

The most common problems faced in the human resources processes are:

- No mechanisms are in place to manage the movement of staff into and through the health services and between the public and private sectors.
- There are variable approaches to the recruitment and appointment of staff, but recruitment, in the absence of planned objectives, does not match needs and leads to massive over-supply in certain areas.
- The training for many types of staff is not keeping pace with the need for increased skills in the health services as a whole, particularly when new objectives are considered.
- Staffing decisions are based on institutional staffing norms that are not related to the actual workload; this is leading to low levels of efficiency and underutilization of many current staff.

4. Public Administration Education System

The Department of Public Administration (DOPA) in the Prime Minister's Office is in charge of developing personnel policy. It has drafted some decrees concerning the personnel management system; these decrees were approved by the Council of Ministers. The implementation of personnel policy is not centralized. Except for the heads of directorates and general directorates, who are appointed by the Prime Minister, ministers decide independently on appointments. There is no central body to deal with recruitment and promotion, and decisions are made by the individual ministerial and non-ministerial institutions. The bodies that will deal with these issues will be the Department of Public Administration for the central administration, and the personnel departments in the independent administrations

(in municipalities and districts). The personnel management of public administration is to be supervised by the Civil Service Commission, which will be a unique, independent body accountable to the Parliament.¹⁶

An important event was the approval of the Civil Service Law (8549) by the Parliament on 11 November 1999. Subsequently, on 23 June 2000, the Council of Ministers approved decree No. 315 on the “Establishment and Functioning of the Training Institute of Public Administration (ITAP).” This Institute is financially supported by the UNDP, the Soros Foundation, and the State budget. The establishment of this Institute shall assist in the consolidation and development of a professional civil service system in Albania by offering initial training, periodic training, promotional training and special training. Training shall be based on the needs and demands that the Department of Public Administration identifies in collaboration with the line ministries.

The new reforms in public administration, including the establishment of ITAP, have done little to train people in health care administration and management, however. The courses conducted by ITAP are focused more on improving teamwork, quality management and communication with target audiences. ITAP was formally created for all levels of civil servants, but, in reality, only employees at the ministries’ level attend ITAP courses.¹⁷

In Albania, there is no university education in public administration. The only similar studies are offered by the University of Economics, through business administration.

5. Health Policy and Management Education and Training

The first initiatives in this field were driven mainly by external forces, for example, the World Bank, UNDP, UNFPA, USAID, and other donors. The first step was the development and implementation of workshops and seminars for general practitioners, nurses and midwives. A Memorandum of Understanding was signed on 5 April 1996 between New York University, the University of Tirana (Faculty of Economics and Faculty of Medicine), and the Ministry of Health to establish the course in Health Management Education (HME) supported by the American International Health Alliance (AIHA), with the following objectives:

- develop a course in health management for undergraduates studying medicine, nursing, and business administration at the University of Tirana;
- design a curriculum for a graduate-level program in health management at the University of Tirana;

¹⁶ See the Public Administration Department website at <http://www.pad.gov.al/index.asp?lang=eng>.

¹⁷ See the Training Institute of Public Administration website at <http://www.itap.gov.al/english.html>.

- develop an in-service training capacity for managers of the Ministry of Health and Environmental Protection (MOHEP) by identifying and preparing MoH staff to serve as trainers and help develop curricula;
- establish a health management resource center at one of the partner institutions to support development of the university-based curriculum, the in-service training, and the analytic work of the policy analysis unit within the MOHEP; the center will be available to students, faculty and staff from the three partner institutions; and
- establish a learning resources center (LRC) at each Albanian partnership institution; the LRCs will provide staff with access to Internet and computer-based information resources to foster effective communications between partners to complement partnership activities.

The civil war in 1997, followed by the Kosovo war, interrupted this initiative for establishing the master course in Health Management Education. To build on it, however, the Ministry of Health is preparing the draft for establishing a learning resources center for training general practitioners and other health care workers in the area of health care management and administration.

Today, health education and training in Albania are developed by two main institutions: the Faculty of Medicine in Tirana University, and the Institute of Public Health.

The mission of the Department of Public Health (DPH) within the Faculty of Medicine is based on the Albanian law “On Higher Education in the Republic of Albania,” No. 8461, dated 25 February 1999 (article 2), which states that the mission/goal of high/postsecondary schools is:

- “... to establish, develop, protect and transmit knowledge through teaching and scientific research...”;
- “to train high cadres”;
- “to prepare new scientists.”

DPH has improved its work by:

- increasing the number of subjects taught by the DPH staff (Health Education & Health Promotion; Health Economics; Health Management and Health Organization; Biostatistics & Demography; Non-Infectious Diseases; Epidemiology; Sociology; and Psychology) and also the number of staff;
- changing and completing the staff composition with non-medical professional members (full-time and also part-time staff); and
- improving the quality of the staff and their teaching methodologies and skills (through short-term and long-term training, including master’s and Ph. D. degrees).

The Department of Public Health is organized in three sections:

- Section on Environmental Health;

- Section on Health Information and Biostatistics & Demography; and
- Section on Health Economics and Health Management.

DPH has focused its learning activities on

- pre-graduate students from the Faculty of Medicine, providing them with basic knowledge about health economics and management and other topics;
- short-term and long-term training courses for graduate students; and
- specialization courses for medical doctors in different public health areas (e. g., Hygiene, Epidemiology, Health Education); the certificate awarded is “Specialist in Public Health,” and the law acknowledges it as essentially a master’s degree in public health.

Table 5 presents the number of graduate students earning certificates as “Specialist in Public Health” at the Department of Public Health, Faculty of Medicine. This certificate is almost equivalent to a master’s degree in public health.

Table 5. Number of Graduates: Specialist in Public Health

Years	Men	Women	Total
1994 - 1997	5	7	12
1996 - 1998	6	5	11
1998 - 2000	3	2	5
1999 - 2001	3	6	9
2001 - 2003	5	4	9
Total	22	24	46

Until 1995, the program for graduate students was three years long, and the content was based more on the traditional school of hygiene. After 1995, changes were made in the content of the curricula for pre-graduate and graduate programs, including new public health disciplines.¹⁸ (See Appendix 1 for a list of Department of Public Health academic programs.)

The Ministry of Health has recognized the Institute of Public Health (IPH) as the institution for supporting the public health education of health care workers. The IPH has organized short courses for public health management, epidemiology, HIV/AIDS/SST, reproductive health, drug demand reduction, etc. The most important six-month course, organized by IPH in collaboration with the University of Montreal (Canada), is a “Training Program in District Health Planning and Management.”¹⁹ This program was financed by the World Bank for the first two years and by the Swiss in its third year. A comprehensive list of training programs in public health management and administration organized by IPH and the University of Montreal is presented in Appendix 2.

¹⁸ Roshi, E. and G. Burazeri (2002). “Public Health Training: Long Way Toward a School of Public Health,” *Croatia Medical Journal* 43 (3): 503-508.

¹⁹ Bino, S. (2002). “Establishment of the school of public health.” Draft report (unpublished document). Tirana: Institute of Public Health.

The general goal of the “Training Program in District Health Planning and Management” is to increase planning and management capacities at the district level, in support of more decentralized

decision making processes and resources management within the public health system. During the period 1999-2002, the total number of people trained was 75. Those people currently work in the area of public health at the district level all over the country.²⁰

Certain training and education programs are organized outside Albania. An example is the short-term training course in health management for family doctors, organized with the family doctor department at the Faculty of Medicine, IPH and the Institute of Health Services in Romania. This course was supported by AIHA and offered in Tirana.

Also, the MoH, supported by external resources from such organizations as the World Bank, the PHARE program, and the Soros Foundation, has provided funding to train people abroad in the areas of health policy, financing of health, and public health. Most of these individuals work at the ministry level, the Institute of Public Health, and the Department of Public Health in the Faculty of Medicine.

6. Conclusions

Albania faces problems in its health sector similar to those faced by other countries in the region. Albania has a shortage of personnel with knowledge and technical skills in research, policy and planning, and health administration. There are no professionals in the areas of health economics, health management and health policy.

Reform of the system for health planning and management is in its early stage. The government has recognized the need for decentralized mechanisms in health care reform. One result has been the Regional Authority of Tirana, which was implemented as a pilot project supported by the World Bank in 2000. Developing and implementing this health care reform strategy, as well as strategies for privatization, for ensuring financial sustainability, for more efficient management of financial resources, and for implementing new payment mechanisms within the scheme of the Institute of Health Insurance, will require a strengthening of management capacities.

To improve the situation, in recent years limited changes have occurred in educating and training people in public health administration, e. g., establishing the six-month course organized by the Institute of Public Health and funded by the World Bank in collaboration with the University of Montreal and the Swiss.

Regarding education programs, the development of curricula for health economics and health management for pre-graduate and graduate students is the

²⁰ University of Montreal and Swiss Agency for Development and Cooperation (2001). “Training program in district health planning and management.”

responsibility of the Department of Public Health (DPH) at Tirana University. The teaching materials provided by DPH currently cover only the basic concepts in health administration, economics, or management, and the teachers that instruct those subjects within DPH do not have substantive training in health administration or management.

There is a need to be more open-minded and to adapt new training forms or approaches in the field of health management and administration in Albania in order to consolidate the capacities in key institutions like the Ministry of Health, Institute of Public Health, and Institute of Health Insurance, as well as the capacities of the teachers in the Department of Public Health at the Faculty of Medicine.

Foreign technical assistance was and still is present – and important – in helping Albania manage its reform, but such foreign assistance will be effective only if it is reinforced by Albanian support. So, it is essential to build long-term capacities in the area of health administration and management, and especially in leadership.

Giving more power to the regional and district levels through the decentralization of policy to the health directorates will require continuous strengthening of human management capacities.

At the present time, there is no school of public health administration and management in Albania, nor is there any institution in which to educate and train people in health policy making and implementation. New initiatives, like a new project supported by the Soros Foundation, with technical support from the Open Society Institute – the ASPHER project, which is planning the strategy for the establishment of a local School of Public Health to help provide the capacities in health administration and management - are needed. Such activities can be well supported by the Faculty of Economics (and its business administration program).

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Appendix 1.**Academic Programs in Public Health in the Department of Public Health (DPH)****Subjects taught at the pre-graduate level:**

Ethics and Deontology	15 hours theory	7 hours seminar/practice
Sociology	15	7
Informatics	15	30
Psychology	15	30
Biostatistics	15	30
Environmental Hygiene	26	54
Health Organization	13	14
Epidemiology (Non-Infect.)	26	12
Health Economics	13	
Health Management	13	13
H. Education & H. Promotion	7	--

Subjects taught at the postgraduate level during the two-year course:**a) First year**

Theory of Public Health	8 hours lect.	16 supervised
Biostatistics seminars	12 of 60 min.	50 practices/
General Epidemiology	24	110
Medical Sociology	6	20
Health Education & Health Promotion	6	20
Survey and Methods for Research in PH	12	50
Environmental Epidemiology	8	30
Demography and Reproductive Health	4	20
Human Ecology	8	20
Environmental Engineering	7	20
Informatics	10	10

b) Second year

Clinics and Epidem. of Infect. Diseases	10	40
ST Diseases	4	50
Cardiovascular Diseases Epidemiology	12	50
Chronic Diseases Epidemiology	12	50
Occupational Health	12	50
Health Management	8	20
Health Economics	5	20
Health Policy	5	20
Health Organization	8	40
Nutrition	13	20
Adolescence	6	12
Child and Mother's Health	7	30
Geriatric	3	15

Appendix 2.

Long-term Training Course in Public Health Management and Administration Organized by Albanian Institute of Public Health and University of Montreal (Canada)

Block 1. Public Health

Module 1

Introduction to Health, Basic Concepts of Health, and
Essential Facts from the History of Public Health.....Duration 3 days

Module 2

Health System Analysis.....Duration 5 days

Module 3

Demographic and Health Indicators.....Duration 2 days

Module 4

Basic Elements of Health PromotionDuration 2 days

Module 5

Environmental HealthDuration 2 days

Module 6

Basic Concepts and Tools in Health.....Duration 3 days

Module7

Reproductive Health, including Mother and Child Health,
Nutrition, Family Planning and Sexual Health.....Duration 4 days

Module 8

Surveillance and Prevention of Communicable Diseases.....Duration 3 days

Module 9

Chronic Diseases with Special Importance for Public Health....Duration 2 days

Module 10

Quantitative and Qualitative Methods Used in Public Health...Duration 8 days

Module 11

Health Legislation.....Duration 2 days

Block 2. Health Planning

Module 1

Introduction to Health Planning..... Duration 1 day

Module 2

Situation Analysis.....Duration 5 days

Module 3

Priorities and ObjectivesDuration 4 days

Module 4

Strategy Development and Programming.....Duration 4 days

Module 5

Monitoring and EvaluationDuration 5 days

Block 3. Health Management

Module 1

Financial Planning and Management.....Duration 10 days

Module 2

Information System ManagementDuration 2 days

Module 3

Human Resources ManagementDuration 10 days

Module 4

LogisticsDuration 5 days

Block 4. Field Exercises and Final Paper Duration 1 month

Public Health Management and Policy Education and Training: Armenia

Gayane Selimyan and Lucig H. Danielian¹

1. Introduction

Independence and the transition to a free market economy have forced many changes in the health care sector in Armenia. Most important among these changes are the following: all state medical institutions have been privatized, the decentralization of medical institutions is near completion, and all such institutions are responsible for their own funding and are no longer financed from the state budget.

These changes have raised important issues regarding health care administration and management in Armenia. During the Soviet era, medical doctors received superficial training in these areas. However, the reforms in the health care sector have created a real need for the knowledge and practical skills required to manage health organizations successfully. Currently, Armenian medical institutions are managed by medical doctors who have minimal formal training in management but who must implement major government health reforms and, at the same time, deliver health care. Education in health care management and administration has been identified as one of the main requirements for the successful implementation of health reform in Armenia.

Public administration and management in the health sector is currently taught in three educational institutions in Armenia: the Yerevan State Medical University; the National Institute of Health; and the College of Health Sciences of the American University of Armenia. The College of Health Sciences has two programs in which health care administration, management and policy are taught: the Master of Public Health program and the School for Health Care Management and Administration. This report presents information on the missions, curricula and achievements, as well as shortcomings, of these four institutions and their educational programs for health care administration and management.

Legislation and decisions that are analyzed for this report include the Law on Civil Service in Armenia, the Law on Civil Servants Payment, the Regulations of the Civil Service Council, the Statute of the Ministry of Health, the Law on Health Care, and the Ministry of Health's Program on Development and Reforms of the Health Care System of the Republic of Armenia, 1996-2000. In addition, all projects and activities of major international organizations that are assisting health care development in Armenia were analyzed through interviews and reviews of reports. A questionnaire was developed and semi-structured interviews were conducted with the Vice-Minister of Health of Armenia, heads of all departments of health care management and administration in Armenian medical institutions,

¹ Center for Policy Analysis, American University of Armenia, Yerevan, Armenia.

representatives of international organizations, members of the Civil Service Reform Commission, and the new Director of the Armenian Government's Academy of Public Administration.²

Two institutions are principally responsible for the organization of health care in Armenia: the Ministry of Health (MOH) and the State Health Agency (SHA). The legal bases for both MOH and SHA are their charters. The main direction of health care reforms was defined and adopted by the Government of the Republic of Armenia in 1997.

Delivery of health care in Armenia is regulated through a variety of legal acts. According to an analysis performed by PADCO, Inc., the main legal acts in the health sector are the Constitution of the Republic of Armenia, the Law on Health Care, and the Law on the State Budget.³ In addition, several newly adopted laws and draft legal acts are directly or indirectly related to the health care system. These include the Law on Government Procurement and the Amendments to the Law on Health Care. Important draft legal acts include a law on licensing and a law on state health care programs. It is expected that the newly adopted legislation and the draft laws will positively impact health care administration and will change significantly the structure of health care delivery in Armenia.

2. Country Profile

Armenia is a mountainous and land-locked country located in the southern part of the Caucasus region. The smallest republic of the former U. S. S. R., Armenia covers an area of 29,800 square kilometers, of which only 55.7% represent living settlements. Armenia has a population of about 3.8 million, of which 2.8-3.1 million permanently reside in the country. Sixty-six percent of the population is classified as urban and 34% as rural. Yerevan, the capital of the Republic of Armenia, has a population of about 1.2 million, or 32% of the country's population. Administratively, the country is divided into 10 provinces, called Marz. The capital city, Yerevan, enjoys the status of the 11th Marz. Appointed Governors rule provinces. Elected local councils and mayors exercise decentralized local governance in the communities. The country has 831 municipalities.

Analyses of the efforts that Armenia has been making to reform its public administration system lead to the conclusion that positive changes have occurred since 1999. The Armenian government received assistance from the United Kingdom's Department for International Development (DFID) through the Public Sector Reform Project during the years 1996-2003. The project provided extensive support in the areas of public sector reform, civil service legislation, and human

² See Appendix A for a full list of interviewees.

³ PADCO Armenia Social Transition Program (2000). "Report No. 5: Legal Analysis: Issues Related to Organization and Delivery of Health Care in Armenia." Available at <http://www.padco.am>. [PADCO, Inc. is a U. S. consulting firm that is implementing USAID's \$26 million Armenia Social Transition Reform Program in Armenia that focuses on health policy and social services reforms.]

resources management policy and practice. Structural reviews across ministries and project management were implemented by DFID. DFID's larger involvement in Armenian public sector administration is through the Public Sector Reform Program (PSRP). Under the Public Sector Reform Program, a Public Sector Reform Commission Secretariat was established. An overall goal, as defined by DFID, has been to "introduce a modern, professional civil service that is highly skilled and effective, and reform the functions of the State to ensure that they are aligned with a changing role of the public sector in a free market economy."⁴

The Law on Civil Service was adopted at the end of 2001. It focuses on the regulation of government so that it meets the main civil service principles, creates job classifications and grades, creates a system of appointments to civil service posts, provides guidelines for attestation and the training of civil servants (both new and in-service), creates personnel reserves through databases of applicants, and provides for the legal status, organization and administration of the Civil Service of the Republic of Armenia.⁵ The concept of civil service and explanations about the rights and duties of civil servants are presented in the law. The law distinguishes between civil service positions and political positions and stresses the fact that incumbents in civil service positions should not be replaced for political reasons.

In 2002, the Civil Service Council enacted regulations covering the charter of the Council, made various decisions on implementing the main aspects of the Law on Civil Service, and completed the first competitive recruitment for the chiefs of staffs of ministries of the central government. Any person working as of December 31, 2002, automatically became a civil servant under the new classification scheme.

The reforms enacted in the 2001 Civil Service Law will assist in the creation of an Armenian civil service that is more compatible with standards applied in democratic countries. The law provides the legal safeguards needed for the effective functioning of the civil service system in Armenia and ensures new job security for civil servants that is based on merit and that is not connected with politics. In addition, the law provides guidelines that ban nepotism, corruption, and non-professional attitudes toward work.⁶

⁴ Department for International Development (DFID), United Kingdom (2002). DFID Departmental Report. Available at <http://www.britemb.am/dfid/>.

⁵ Chapter 1, Article 2, Law on Civil Service, Republic of Armenia.

⁶ Egyan, Rafael (2002). Civil Service in the Republic of Armenia. Yerevan: Yerevan State University Press [in Armenian].

3. Health Care System Profile

Health Care in Armenia

According to *Health Care Systems in Transition*,⁷ Armenia inherited a highly centralized and bureaucratic health care system from the Soviet Union that was managed and financed solely by the state. The structure was vertical, strictly hierarchical, and political party-influenced, and it provided little freedom of health care choice to the population. The centrally organized budget system prevented flexibility and adjustments to different local needs. The lack of reliable health care data on all major matters made it impossible to assess correctly the situation and to develop appropriate strategies to identify and solve problems in health care delivery. Moreover, much of the data that did exist were made to fit standards and expectations prescribed by the state. Despite the proclaimed guarantee of free medical assistance regardless of social status, the practice of unofficial extra payments to receive good medical treatment was common.⁸

The sociopolitical and economic upheavals that followed the devastating 1988 earthquake, combined with the political collapse of the Soviet Union, created a catastrophic public health situation in Armenia. After gaining independence, Armenia did not have the finances required to sustain the existing health care system, which was expensive, unmanageable, and inefficient. The government of Armenia identified the urgent need for a radical reform program in the health sector, and the National Health Policy Program was developed in 1996-1998.⁹

The Armenian government has introduced radical health care system reforms that are based on the assumption that health care can not be provided free of charge. However the government understood the need for a health care package for the most vulnerable populations,¹⁰ and the central feature of health care reform was the introduction of the Basic Benefits Package (BBP) in 1996. The BBP is “a tool that has been widely used throughout the NIS as state health systems transform themselves from one in which all expenses are covered by the state toward a mixed system in which state budget transfers are augmented by formal patient co-payments and, in the case of Armenia, subsidies to pay some of the transition costs from the World Bank.”¹¹

⁷ Hovhannisyan, Samvel G. et al. (2001). *Health Care Systems in Transition: Report on Armenia*. European Observatory on Health Care Systems.

⁸ PADCO Armenia Social Transition Program (2002). “Report No. 86: Recommendations on How to Reduce Informal Payments for Medical Services in Armenia.” Available at <http://www.padco.am>.

⁹ Mkrtchyan, Ararat (2001). *New Tendencies in the Healthcare of Armenia*. Yerevan: Hakob Meghapart Press [in Armenian].

¹⁰ Hovhannisyan et al. (2001).

¹¹ PADCO Armenia Social Transition Program (2002). “Report No. 87: Recommendations for Improving the Definition and Administration of the Basic Benefits Package (BBP).” Available at <http://www.padco.am>.

The basic reform principles of the health system in Armenia include the following:

- health services should be equitable and fair;
- the health care system should be efficient;
- health services should have realistic aims and objectives; and
- each citizen should have freedom of choice to select a health care provider and the individual responsibility for his/her health.¹²

The Ministry of Health has placed considerable importance on the optimization of the health care system, privatization, and the introduction of medical insurance.¹³

There have been four major changes in the legal status of health care facilities during recent years as they were transformed from organizations funded from the state budget to state non-commercial companies. As outlined in PADCO Report No. 86 (2002), before 1995 all health care facilities were financed by the state budget and were exempt from taxes. In January 1995, all health care facilities were transformed into state enterprises. In 1997, another change was introduced as part of the decentralization of the health care system: all health care facilities were reconstituted as non-commercial state joint stock companies following the passage of the 1996 Law on Joint Stock Companies. After enactment of the Law on State Non-Commercial Organizations in November 2001, health care facilities were required to be reconstituted as state non-commercial organizations (SNCOs). By law, only the Republic of Armenia is allowed to create a SNCO.¹⁴

Health care reform in Armenia has been extensively supported by international organizations. For example, the World Bank is implementing a US\$12 million project that supports health sector financing and primary health care reform. The project, which started in 1997, is aimed at strengthening the Primary Health Care Development System, the Health Financing System, and project management. The project financed the establishment of the State Health Agency.¹⁵

An even larger program is a component of USAID's Social Transition Program for Armenia. PADCO is assisting USAID in managing a team of five U. S. and five Armenian subcontractors, plus 50 full-time Armenian, U. S., and regional staff, to implement USAID's Armenia Social Transition Project (ASTP), a US\$26 million program for 2000 through 2005. The initiative's two components focus on policy and systemic reforms of the health and social sectors. An earlier three-year ASTP began in 1997 with the goal to assist Armenia with the development of an integrated legal, regulatory, and information framework to support sustainable social insurance programs, provide needy people with adequate social assistance,

¹² Hovhannisyan et al. (2001).

¹³ PADCO (2002). "Report No. 87."

¹⁴ PADCO (2002). "Report No. 86."

¹⁵ The World Bank (2001). "News Release No. 98/1429 ECA."

and help improve primary health care for all Armenians. One of the main objectives of the health care reforms was decentralization.

Health Care Management and Administration

With such extensive support from international organizations, institutional changes in the governance of the health care sector have been made. The Ministry of Health, previously overstaffed, was greatly reduced in size. In order to separate the provision of health care from the financing of health care, the State Health Agency was established. Although the Ministry of Health remained accountable for health care policy and provision, the responsibility for financing was transferred to the State Health Agency.¹⁶ The Agency acts as a third-party player that distributes the state allocations to health care facilities and takes full responsibility for the management of state financial resources. The Ministry of Health is responsible for policy formulation, formulating reforms, and overseeing their implementation. The responsibilities of the Ministry of Health also include monitoring the population's health status, determining the terms of medical education, licensing, and regulation and setting standards.¹⁷

In 1997, the Ministry of Health established a Department of Reforms, Program Implementation and Monitoring, which focuses specifically on changes in the health care system, and formed the Department of Health Policy and Development Program. However, this department was dissolved in 2002, and currently each department of the Ministry of Health is responsible for the development and implementation of policies.

Despite the reform programs, the creation of legislative frameworks, and the substantial assistance received from international organizations, Armenia's health care system is far from perfect. One of the many problems still facing the health care sector is the absence of a serious program to train health facility managers. Many senior managers and administrators have received little or no training in the new techniques that can replace their old method of reporting financial revenues and expenditures.¹⁸

The need for good managers and good accountants for successful health care facility management has been identified, and the Ministry of Health is currently developing training and retraining requirements for the positions of accountants and managers of large health care facilities. People appointed to these positions will be required to successfully complete appropriate training and to demonstrate competencies in skills that will be defined by the Ministry.¹⁹

Over the last three years, the Center for International Management Studies (CIMS) has developed customized programs adapted to the needs of health care

¹⁶ Hovhannisyanyan et al. (2001).

¹⁷ PADCO (2000). "Report No. 5."

¹⁸ PADCO (2002). "Report No. 87."

¹⁹ Ibid.

managers.²⁰ The Canadian International Development Agency (CIDA) and other organizations provide funding for these types of programs in Armenia. Program components include curriculum development, faculty training, and development of learning materials adapted to the Armenian environment, as well as the acquisition of institutional educational tools and evaluation criteria. The feasibility of developing regional training campuses in Armenia is being examined. CIDA's contribution will include funding for two fact-finding missions to Georgia and Azerbaijan to facilitate development of similar programs, as well as to develop a Caucasus regional health management training center.

The Armenia Social Transition Program (ASTP) has recommended that the Ministry of Health develop training requirements using the required competencies in health management training programs that are offered in education institutions such as the American University of Armenia. ASTP also recommends that the Ministry of Health establish a date by which the competency requirements for managers and financial directors will be the only basis for appointments. Managers and financial directors should demonstrate the necessary competencies through the completion of the Ministry of Health's licensed training programs.²¹

4. Overview of Public Administration Educational Practices

The process of transforming a former command economy into a free market economy creates extraordinary requirements for creative leadership from both the current generation of top-level government officials and future generations of government leaders in Armenia. These requirements create even greater needs for effective education and training in public administration. Both the current government leadership and the next generation of public servants must develop new interactive skills, which their predecessors neither required nor exhibited. These skills include “mediating, negotiating and interpersonal skills, the ability to include and integrate a much wider diversity of actors in the decision-making process, and language skills and technology literacy.”²² Most important, given the scarce resources for training purposes, priority training areas must be established by the Armenian government. These areas might include policy development capacities, resource management capacities, and the capacity for improved public service delivery.

Currently, public administration is taught at the American University of Armenia, the Armenian Academy of Public Administration, Yerevan State University, and the Yerevan State Institute for the National Economy.

²⁰ The CIMS homepage is available at <http://www.intranet.management.mcgill.ca>.

²¹ PADCO (2002). “Report No 87.”

²² United Nations/International Association of Schools and Institutes of Administration (UN/IASIA) (2002). “Initiative on Public Administration Education and Training for the Current and Next Generation of Government Leadership.” Available at <http://www.unpan.org/corethemes-civilservice.asp>.

The American University of Armenia (AUA) was established in 1991, at the same time Armenia gained independence, and is an affiliate of the University of California System. AUA is the joint undertaking of the Republic of Armenia (RoA) Ministry of Education and Science and the American University of Armenia Corporation (AUAC). AUA is the first university located outside the United States and its territories to be granted candidacy for accreditation by the Western Association of Schools and Colleges, one of the U. S. Department of Education's six regional accrediting associations for higher education institutions.

The American University of Armenia teaches public administration in its Graduate School of Political Science and International Affairs. Courses include an introduction to public administration, public administration in Central Europe, public financing and budgets, public personnel administration, and several courses on policy making and analyses. Students also are taught democratic theory, economic theory, Armenian legislative processes, and Armenian government structures and processes. Research methods in political science and the major quantitative and qualitative data collection methodologies and policy evaluation are covered. All courses seek to prepare a new generation of policy makers, policy analysts, and public administrators. (See the educational plan of the Graduate School of Political Science and International Affairs in Appendix B.) Its graduates are working successfully in the government of Armenia, international organizations, and non-governmental organizations.

The government's Armenian School of Public Administration was renamed the Academy of Public Administration in 2002. The Academy operates under the aegis of the Civil Service Council and has an extensive mandate for civil service training and the organization of this training through a variety of educational entities. The Academy's public administration program includes political science, law, economics, and organizational aspects of public administration. (See the educational plan of the Academy of Public Administration in Appendix C.)

The Academy implements postgraduate specialized education, and its curriculum was developed and implemented with the assistance of the European Union TACIS program. The mission of the Academy is "to provide [the] Republic of Armenia with administration officers prepared in accordance with modern requirements, who are able to work in conditions of political democracy and [the] transition of economies to market relations." The full-time education program prepares new specialists in public administration and local government. The admissions process is carried out on a competitive basis; the graduates receive a diploma authorized by the government of Armenia. The Academy's Department for Improvement of Professional Skills and Retraining of Specialists provides in-service training for members of the government. The Academy prepares tests for the attestation of civil servants; more than 2,000 civil servants at central and local levels have been trained.

Elements of public administration are taught at Yerevan State University in the economics department, but the University does not offer a specialized de-

gree. Courses address administrative law, comparative administrative law of foreign countries, the political system of the Republic of Armenia, government economic regulations, and principles of management and budgeting.²³ Elements of public administration also are taught at the Yerevan State Institute for the National Economy. Courses taught by the Faculty of Management include administrative theory, organizational theory, public and municipal administration, financial management, organization of administrative decision making processes, personnel management and strategic management.²⁴

The government of Armenia recognizes the importance of education for public administrators and, with the 2001 Law on Civil Service, introduced requirements for in-service education of civil servants that will lead to new education programs. For example, beginning in 2004, the Civil Service Council will administer a competition among institutions of higher education for the development of new in-service curricula.

5. Overview of Other Current Education Practices in Health Care Administration, Management and Policy

Social and economic changes have had a deep impact on health care management and organization during the first decade of independence in Armenia. Instruction in health care administration, management, and policy is taught at the Yerevan State Medical University, the National Institute of Health and the American University of Armenia. The administration, management, and policy courses and lectures in these programs are listed in Appendices D through G.

Yerevan State Medical University

The Yerevan State Medical University, named after Mkhitar Heratsi, is an institution that trains highly professional medical staff. During its 70 years of existence, it has experienced a rich history and continues to play a major role in the training of medical personnel. The faculties (or departments) organize the academic process. These faculties are: General Medicine, Stomatology, Pharmacy and Military Medicine. After graduating from the University, the students enter an Internship or a Residency. The 661 representatives of the teaching staff include 8 academicians, 122 doctors of medical science, and 375 candidates to become doctors of medical science working in different programs.²⁵

Although health care management was previously taught at the Yerevan State Medical University (YSMU), new realities have forced curricular changes. The knowledge necessary to enable students to adapt to the free market economy

²³ Tumanyan, David (2000). "Report on Armenia," in Evaluation of Academic Programmes in the Field of Public Administration and their Degree of Europeanization. Bratislava: Network of Institutes and Schools of Public Administration in Central and Eastern Europe (NISPAce). Available at <http://www.nispa.sk/reports>.

²⁴ Ibid.

²⁵ See the Yerevan State Medical University webpage at <http://www.ysmu.am>.

were identified. Taking these needs into consideration, the Department of Social Medicine and Health Organization developed a new educational program, with three main topics:

- statistical methods and their implementation in public health;
- public health and the study of its various components; and
- basics and principles of health care organization in Armenia.²⁶

The goals of the program are to provide future physicians with required knowledge and skills in public health, health care administration and the statistical methods most frequently used in health care management. Other objectives of the program include instruction in the general principles of administration, how to organize and optimize health care facilities, how various institutions function in the new economic reality, and the methodologies, analyses and evaluations used to assess medical facilities. Students are provided with an overview of laws, Government decisions, Presidential decrees, and other changes in the legal and regulatory fields of Armenia, as well as international legislation. [See the YSMU educational plan in Appendix D.] The Department of Social Medicine and Health Organization is currently developing curricula for postgraduate training in health care management; only the National Institute of Health offers postgraduate training in this field now.

Physicians are licensed after five to six years of study and one year of residency, followed by licensing exams. Internships are compulsory and consist of specialized one-year post-diploma training, after which interns receive qualification as a general practitioner in a specific area: Physician, Doctor of Preventive Medicine, General Pediatrician, Stomatologist, and Pharmacist. Under the supervision of tutors appointed by YSMU authorities and the Armenian Health Ministry, interns improve their practical skills and knowledge in various Yerevan clinics during their medical studies. Twice a year all interns take tests, and, at the end of their training, if they pass a license exam, it gives them the right to work in their area of qualification.

Post-diploma specialization is highly specialized training that lasts two to four years, after which residents receive qualification as a specialized doctor. Every resident is supervised by a tutor who is a leading specialist at the University. Every resident gets his/her own curriculum, which he/she has to complete within the training term. The individual plan includes theoretical and practical skills as well as research. Twice a year, each resident takes a test in his/her specialized examination board, which evaluates the resident's study. At the end of the training term all residents take a final license exam, which, if they pass it, gives them the right to work in their specialty.²⁷

²⁶ Ibid.

²⁷ Ibid.

National Institute of Health

The National Institute of Health (NIH) is an independent organization supported and financed by the Ministry of Health. Its mission is to improve the health of the population by providing a high level of postgraduate professional and academic training, stimulating health and clinical research, and integrating different activities to promote and facilitate the performance of health care institutions. The objective of the NIH is to prepare health care professionals and clinicians to draw on knowledge and skills from a variety of disciplines to define, assess and resolve public health problems.

The National Institute of Health has six departments. One is the Educational and Training Department, with the following faculties: Therapy, General Surgery, Dentistry, Pharmacology, and Training and Retraining Teaching Staff. Another is the Scientific Department, in which research on the scientific and legislative bases of public health development are conducted. The Department for Foreign and Public Relations is responsible for the coordination of regional educational and training center activities. The fourth department is the State Licensing Center of Specialists; all medical specialists are required to pass a computerized examination, after which they are issued a license. The fifth department is the Health Care Department. The sixth department is the School of Health Care Management and Administration, which has the following chairs: Health Care Management, Health Care Financing and Economy, Health Care Policy and Legislation, Public Health, Medical Sociology, and Behavioral Sciences.

The NIH School of Health Care Management and Administration (SHCMA) was launched in 1999, with the support of the Ministry of Health, for retraining health care administrators and other professionals. [See the educational plan for the National Institute of Health's SHCMA in Appendix E.] SHCMA offers 10 programs that provide graduate and postgraduate level education. A two-year graduate program for medical specialists who already have a university education leads to a Specialization Certificate in Health Care Administration. The other nine programs provide continuing education to meet the special needs and demands of different groups of health care managers, directors, head and supervisor nurses, head accountants, economists and statisticians in medical facilities. Continuing education programs last from three weeks to two months.

The Department of Health Services Administration, in collaboration with the graduate level Program in Health Services Administration of Creighton University (Omaha, Nebraska), has begun a three-year health management education partnership with the School of Health Care Management and Administration of the National Institute of Health. This partnership is sponsored by the U. S. Agency for International Development (USAID) and the American International Health Alliance (AIHA); it will support the development of a sustainable program in health services management in Yerevan. The project seeks to increase the capability and

capacity of SHCMA and its faculty to provide education and training to health care administrators.²⁸ The project also seeks to establish a health care management training model that can be replicated in other South Caucasus countries.

Public Health Department of the American University of Armenia

The American University of Armenia (AUA) was established in 1991 in Yerevan. AUA grants eight master's degrees in six academic departments. Its Public Health Department was established in 1992 and is a member of the Association of Schools of Public Health in the European Region (ASPHER). Currently, there are three programs within the College of Health Sciences: Master of Public Health (MPH); Center for Health Services Research and Development (CHSR); and School for Health Care Management and Administration.²⁹

The Master of Public Health (MPH) program provides experienced health professionals a thorough grounding in population-based approaches to health sector problem identification, investigation, analysis, and managed response. The overall objective of the MPH program is to prepare health professionals to draw on knowledge and skills from a variety of disciplines to define, critically assess, and resolve problems affecting the public's health. The intensive, modular curriculum emphasizes basic public health sciences and essential managerial and analytic skills, including project planning and evaluation, epidemiologic investigation, understanding complex determinants of health, effective communication to professional and lay audiences, and leadership. [See the educational plan for the MPH program in Appendix F.]

Each of AUA's academic departments has a research center. The College of Health Sciences' Center for Health Services Research and Development (CHSR) is an applied research center established in 1995 to respond to research and development needs in public health in Armenia. CHSR is a resource to support and facilitate the existing public health infrastructure; it collaborates on projects with many local organizations and employs an outstanding professional research staff. Its objectives are to:

- provide supervised field training for students enrolled in the MPH program;
- serve as a venue for linkages among the Ministry of Health, donor agencies, and MPH program faculty;
- respond to requests for technical assistance from local Armenian ministries and research institutes;
- support the programmatic development of health services in conjunction with the Ministries of Health within the regions; and
- respond to requests for technical assistance from international organizations working on health projects in Armenia.

²⁸ See the National Institute of Health webpage at <http://www.medlib.am/nih/>.

²⁹ See the American University of Armenia webpage at <http://www.aua.am>.

In 2002, CHSR introduced an e-learning program called Basics of Health Planning. This course provided a comprehensive introduction to fundamental concepts, principles and methods of health planning and was addressed to health managers. By providing basic knowledge in planning design, the program also sought to prepare participants to design and conduct qualitative and quantitative research. The distance learning course was free of charge and was available in Armenian, Russian and English. It gave people a unique opportunity to study irrespective of place or location, financial possibilities, and language. This course fostered and enhanced skills and enlarged experience related to the use of technology for accessing and using information, and for communicating with colleagues. The four-week course consisted of eight classes, with basic materials provided.³⁰

The Public Health Department of AUA offers a postgraduate Master of Public Health degree. However, there are no public administration or health care management courses in the syllabus. Rather, public administration is taught at AUA's Graduate School of Political Science and International Affairs. Currently, there is no link between the two programs.

School of Health Care Management and Administration of the College of Health Sciences, American University of Armenia

The School of Health Care Management and Administration (SHCMA) at AUA was developed in 1999, with the support of the Ministry of Health, as an executive center for retraining and continuing professional education for health and hospital administrators, as well as for offering a long-term health management residency program for persons seeking a specialization in the field of health care management and administration. The mission of the SHCMA is to contribute to the health of the population by providing competency-level professional and academic training in the field of health care management and administration.

AUA's SHCMA is jointly supported by the Ministry of Health, the Republic of Armenia, and the American University of Armenia. During 1999-2001, the School was also supported by the USAID/AIHA partnership in Health Management Education. In 2002, the School joined the AUA as an integral organizational part of the Center for Health Services Research and Development (CHSR) and the College of Health Sciences. The SHCMA training programs are targeted on postgraduate continuing education and refresher courses specifically designed for acting health care administrators or oriented toward more general long-term academic professional training (residency) in health management education. [See the educational plan of SCHMA (AUA) in Appendix G.]

For many years, senior health officials and facilities felt the need for training and developing the professional status of hospital and outpatient clinic administrators, so called "chief doctors." The creation of the SCHMA graduate degree

³⁰ See the Center for Health Services Research webpage at http://chsr.aua.am/e-learning/eng/comm_center.php.

program in public health at AUA has had an important impact on Armenian health care systems and national policy in health, which in turn has stimulated the Government and academics to change their visions and attitudes toward health care development in the country. When the College of Health Sciences and CHSR were founded, Armenia did not have a residency program in health management education and the situation severely limited access to training for professional health care managers.³¹

SCHMA offers a certificate of completion for its students, who receive a U. S. –style education. However, the program is too new to assess the roles of its graduates with respect to health services delivery and their impact on health policy.

6. Conclusions

Public health administration and management is an important part of health care reform in Armenia. The importance of this issue is widely recognized; there are three educational institutions that address this subject. However, there is no cooperation between these institutions.

The National Institute of Health is the leader in postgraduate training of health care administrators. In 1999, the School of Health Care Management and Administration moved from the National Institute of Health to the American University of Armenia. However, the name also was retained by the National Institute of Health. Thus, both the NIH and AUA currently administer the academic unit known as the School of Health Care Management and Administration, yet the two organizations implement their respective programs separately.

The State Medical University provides basic knowledge and graduate training in health care management. Despite the changes made in its curriculum, though, it can not award a diploma in health care administration. Only the National Institute of Health can issue such a certificate, after completion of a two-year postgraduate course. The AUA School of Health Care Management and Administration provides short-term courses on health care management and administration. In addition, the Medical State University is working toward starting a postgraduate program in health care administration and developing curricula for postgraduate training programs with the Ministry of Health.

The lack of cooperation and the lack of information exchanges between Armenian educational institutions are negative factors preventing the development of a sound system of public health management and administration in Armenia. Only greater cooperation and exchange of ideas, teaching methods and materials will facilitate the creation of an effective working system of health care administration and management.

³¹ See the American University of Armenia webpage at <http://www.aua.am>.

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Appendix A.

List of Interviewees

Dr. Tatul Hakobyan, Deputy Minister of Health, Republic of Armenia

Dr. Ruzanna Juzbashjan, Head, Department of Primary Care, Ministry of Health, Republic of Armenia

Dr. Samvel Hovhannesyan, Ph. D., Expert of the National Assembly of Armenia, Committee on Social Affairs, Health Care and Environment

Dr. Mihran Nazaretyan, Ph. D., Dean, School of Health Care Management and Administration (SCHMA), American University of Armenia

Dr. Theresa Khachatryan, Ph. D., Dean, School of Health Care Management and Administration (SCHMA), National Institute of Health

Dr. Marina Mardiyan, Ph. D., Senior Lecturer, Department of Social Medicine and Health Organization, Yerevan State Medical University

Dr. Vache Gabrielyan, Ph. D., Member of the Public Sector Reform Commission; Board Member, Central Bank of Armenia; Professor, Yerevan State University

Mr. David Tumanyan, Communities Finance Officers Association

Mr. Armen Harutunyan, Ph. D., Director, Academy of Public Administration

Mr. Hrair Aslanyan, World Health Organization (WHO) Liaison Officer

Appendix B.

Educational Plan for Graduate School of Political Science and International Affairs, American University of Armenia

Western Political Thought

A historical survey of Western schools of political and socioeconomic thought from the early times to the present, based on the writings of Plato, Aristotle, Augustine, Aquinas, Machiavelli, Hobbes, Locke, Rousseau, Montesquieu, Smith, Burke, Hegel, Mill, Marx and contemporary theorists of nationalism, liberalism, socialism, conservatism, pragmatism, puritanism, constitutionalism, authoritarianism and welfare statism.

Political Science Methodology

Introduction to research methods in political science covering the overall logic and theory of empirical research and the major quantitative and qualitative data collection methodologies and policy evaluation.

Comparative Political Systems

Comparative analysis of political elites, governmental institutions, and political processes in selected industrial, developing and socialist countries. A representative sampling of countries would include the United States, Britain, France, Germany, India, Saudi Arabia, China, Egypt, Iran, Mexico, Russia, Syria and Israel.

International Political Relations

Theories and issues in contemporary world politics and diplomacy, foreign policy formulation, strategic problems, techniques of conflict management and conflict resolution.

Theories of Democracy

Central concepts in contemporary democratic theory, including the core problems of macro democracies and the normative functions and basic requirements of the theories for contemporary practice in modern nation-states.

Ethnicity, Geopolitics, and International Law in Transcaucasia

Analysis of the complex relationships among current regional conflicts and ethnicity, geopolitics, and international law and factors and participants in the development and potential for conflict resolution.

International Economic Systems

A comparative analysis of economic theories and practices in different modern states focusing on the United States, Japan, Canada, and West European countries; examination of the processes of privatization and marketization in both ex-communist and Western economic systems.

Introduction to Public Administration

The role and scope of bureaucracy in the modern state; examination of issues in the formulation and implementation of public policy; planning, programming, and decision making in the bureaucratic policy making process.

Comparative Public Policy

The analysis of diverse administrative cultures and processes in different political systems with emphasis on bureaucratic roles and functions, bureaucratic ethics, problem-solving, and social responsibility.

Conflict Resolution Strategies

The role of international organizations in the management and resolution of ethnic conflicts and theories of ethnic identity and conflict.

Public Finance and Budgeting

A survey of public finance and budgeting systems in selected Western states, with an emphasis on the processes of planning, programming, appropriation, taxation and modeling.

Comparative Policy Making and Public Opinion

Bringing the public into successful policy formation and implementation processes and the functions of public opinion in democratic states, focusing on political participation in public policy formation in selected countries.

Public Personnel Administration

An examination of the basic concepts and techniques of management of government employees, with a special emphasis on problems of recruitment, selection, position classification, promotion, training, motivation, performance evaluation, career development, leadership, and patronage.

Politics and Public Administration of Eastern Europe

Survey of management in the former U. S. S. R., Eastern and Central Europe and institutional transitions to market economies and pluralistic political systems.

Organizational Behavior

Consideration of general theories and concepts of organization and bureaucratic behavior, strategies for control, stability and change in modern state systems.

World Political Economy

The interaction of political, social and economic forces in the global arena and their impact on international trade, foreign aid, and economic dependency, focusing on decision making in multinational corporations and key transitional institutions.

Politics of Russia and the CIS

An analytical and historical survey of politics in the post-Soviet period, with an emphasis on the interplay of ideological, national and geopolitical factors in problems of political change and development, independent state-building, political organization, and interstate conflict resolution.

Leadership and Decision Making

An examination of management skills by government functionaries with emphasis on understanding and using power and influence effectively, utilizing appropriate leadership and decision styles and techniques, and managing ethical dilemmas, cultural differences and political pressures on decision making.

Politics of the Islamic World
An interdisciplinary survey of politics in the Arab East, Turkey, and Iran, with an emphasis on Middle Eastern factors, institutions, and processes since World War II; examination of problems of sociopolitical change, role of Islam, international influences and inter-state relations in the region.

Comparative Legal Systems and Human Rights

Analysis of major legal systems and their impact on public policy and human rights, administration of justice and socio-economic well-being; emphasis on the social roots and historical development of modern democratic legal cultures.

International Law and Organizations

A survey of the origins and principles of international law, its historical development and utilization in inter-state relations; examination of major regional and international organizations and their role in the settlement of disputes; the changing role of the United Nations in peacemaking and economic development.

Armenian National Assembly

Introduction to legislative processes in the Armenian government and the roles and responsibilities of the Armenian National Assembly in relationship to other branches of government.

Appendix C.**Educational Plan for Academy of Public Administration**

Teaching Course	Hours
Political Sociology	12
Theory of Political Science	16
Constitutional Law	18
Ethno-politics	6
Geopolitics	6
Local Government System	6
International Law	8
Analysis of Economical Performance	8
Statistics	10
International Economic Relations	6
Social Security System of Population	6
Tax and Customs System	6
Psychology of Public Administration	8
Conflictology	6
Public Relations	6
Crisis Management	6
Marketing	6
Labor Law	8
Political Futurology	6
Foreign Language	32
Macroeconomics	12
Information Systems	58
Administrative Law of Republic of Armenia (RoA)	12
Civil Law	16
State Management of Economy	12
Macroeconomics	6
Regional Economics	16
State Budget	16
Local Budget	16
Accounting	16
Personnel Management	12
Principles of Public Administration	16
Organization of Administrative Performance	12
Legislation of Administrative Decisions	8
Sociology	6

Appendix D.**Academic Programs in Public Health Management and Policy at Yerevan State Medical University**

	Lectures taught in the Department of General Practice	Hours provided
1.	Public health and health care organization as science and subject of teaching; main methods of its study	2 hours
2.	General understanding about statistics; basics of sanitary statistics	2 hours
3.	Medical-social aspects of demographics; statistics of the population; population of the Republic of Armenia (RoA)	2 hours
4.	Dynamics of the population; birth rate, mortality, child mortality; reproduction problems of the population in the RoA	2 hours
5.	Study of population sickness; international classification of diseases and its importance	2 hours
6.	Epidemiology of non-infectious diseases and prevention; primary and secondary prevention	2 hours
7.	Medical-social aspects of important non-epidemic diseases (SAH, oncologic diseases, traumatism)	2 hours
8.	Neuro-psychiatric diseases, alcohol mania and drug mania as social-hygienic problem; problems of tuberculosis and AIDS in the RoA	2 hours
9.	Reforms and optimization of the public health system in the RoA; leading bodies of public health; basics of public health administration	2 hours
10.	Principles of the public health financing; state mandatory insurance	2 hours
11.	The law of the RoA "On medical assistance to and service of the population"; state target programs of public health	2 hours
12.	Organization of ambulatory-polyclinic care in the RoA (city polyclinics, child polyclinics, women's consultation centers)	2 hours
13.	Organization of public health for rural population; medical rural center, marz (regional) and republican hospitals	2 hours
14.	Organization of hygienic, anti-epidemic assistance in the RoA	2 hours
15.	Basics of social insurance and of social security; organization of medical expertise of work-efficiency	2 hours
16.	Systems of public health in foreign countries	2 hours
17.	World Health Organization, its structure and functions	2 hours
18.	Basics of medical ethics and gerontology	2 hours

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	Course content for practical courses in the Department of General Practice	Hours taken
1.	Organization of population health study; sanitary statistics and its importance in the assessment of activities of medical institutions and management bodies as well as of the population health; organization of the statistical investigation, composition of the program and plan of the investigation; relative constants, their implementation in the system of medical investigations and practical health care; graphic expression of the results of statistical investigation	5 hours
2.	Average constants; methodology of composing the variation series; methods of calculating the average arithmetic and their comparative score; average square deviation, average error of the average arithmetic, coefficient of variation, their importance and calculation; implementation of average constants in the assessment of the population health; study of the physical development	5 hours
3.	Assessment of reliability of the results of statistical investigation; systematic and situational analysis; assessment of reliability of relative and average constants; assessment of reliability of the difference	5 hours
4.	Correlation analysis; R x/y regression; correspondence coefficient	5 hours
5.	Dynamic series; analysis of the dynamic series; control work/examination	5 hours
6.	Diseases as index characterizing the population health; main methods and sources of diseases study; main documents of diseases registration and report; the role of doctor in provision of completeness and quality of information about diseases; analysis and assessment of the main indices of diseases as the main index of the planning of the public health institutions' activities and medical assistance; registration and report documents necessary for the study of population diseases	5 hours
7.	Main indices characterizing the population health; main calculation and assessment methods; standardization of the indices	5 hours
8.	Medical-social aspects of the demographic statistics; their importance as the main index characterizing population health, of analysis and planning of public health institutions' activities; methods of calculation and analysis of demographic indices; main tendencies of the medical-demographic processes in the RoA and perspective levels	5 hours
9.	Dynamics of population; impact of migration on the indices of the population health; birth and mortality as indices of natural movement; average life expectancy and main factors influencing the index	5 hours
10.	Role of the public health primary care in the system of organizing medical-prophylactic assistance to the population; main factors influencing the quality of organizing the analysis of polyclinic activities and medical-prophylactic assistance as well as main assessment indices; role of the public health primary care during the organization of expertise of the temporary work-inefficiency, order of giving the work-inefficiency leaflet; resolution of the situational problems	

Appendix E.

Academic Programs in Public Health Management and Policy at the National Institute of Health

	Courses	Duration	Number of credits	Dates
1.	Urgent problems of social hygiene and health care management and administration (for heads and their deputies of health care bodies and institutions (MoH and hospitals))	7 weeks	125	11.02-29.03 09.09-25.10
2.	Management and administration of the maternity homes and women consultation centers work (for heads and their deputies of the maternity homes and womens consultation centers)	7 weeks	175	13.05-28.06
3.	Urgent problems of health care economic s (for heads and their deputies for economic questions of MoH and hospitals)	5 weeks		24.06-26.07
4.	Sanitary statistics (for heads and their deputies of MoH and hospitals)	7 weeks	175	16.09-01.11
5.	Urgent problems of social hygiene and health care management and administration (for heads and their deputies of hospitals)	7 weeks	175	21.10-06.12
Short-term courses				
6.	Health care management and administration (for heads and their deputies of MoH and hospitals)	3 weeks	75	01.04-19.04
7.	Sanitary statistics (for heads and their deputies of MoH and hospitals)	3 weeks	75	13.05-31.05
8.	Urgent problems of health care economics (for heads and their deputies for economic questions of MoH and hospitals)	3 weeks	75	09.09-27.09
Course on the improvement of the mid-level medical staff				
9.	Basics of the administration of the work of chief and senior medical nurses	5 weeks	125	20.05-21.06

Appendix F.

Academic Programs in the Public Health Department at the American University of Armenia

Health Economics & Finance (6 units)

This course consists of two components. The first component addresses the basics of health sector financial management, including simple budgeting, variance analysis, and benefit/cost analysis as tools for assessing the financial health of an organization. The second component of the course explores the application of basic micro and macro economic principles to the health sector. Evaluation is based upon homework assignments, quizzes, and a project.

Comparative Health Systems (3 units)

This course provides a critical comparison of the organization, philosophy, financing, and benefits packages of the predominant health care system models. The strengths and weaknesses of these programs will be used as bases for discussing their relevance to Armenia. Evaluation is based upon examination and a project.

Health Services Management (5 units)

This course provides the practical and theoretical underpinnings of the organization and management of health organizations. Specific emphasis is placed on individual leadership and management skill development. Evaluation is based upon examinations and student projects.

General Principles of Public Health Problem Solving (5 units)

An introduction to the diverse profession of public health and a guiding paradigm for public health problems solving, this course emphasizes the development of essential skills in critical thinking and group process. Student groups will complete an analysis of a current public health problem, including recommended courses of action. Evaluation components consist of individual and group participation, an individual written critique and other written assignments, a group paper, and a group presentation.

Data Management Systems (1 unit)

Students will apply their knowledge of database, spreadsheet and statistical packages to the development of appropriate database and management information systems to process and analyze raw data. Issues of database design, coding schemes, data cleaning, and handling missing data will be addressed. Evaluation will be based upon graded problem sets.

Training of Trainers (4 units)

This course prepares MPH graduates to effectively respond to the enhanced job responsibility of providing formal and informal in-service training to professional

colleagues and co-workers. The course will prepare students to develop objective-based learning modules and to develop and refine effective presentation and teaching skills. Evaluation will be based upon the development and delivery of a brief instructional module relevant to the student's professional objectives.

Qualitative Research Methods (4 units)

This course provides hands-on experience in qualitative research methods useful in formative and community-based research. Topics include formal and informal ethnographic methods including key informant interviews, focus groups, direct observations, and free lists. Evaluation is based upon participation in practical exercises and a written report and presentation.

Survey Research Methods (4 units)

This course demonstrates the application of health survey research methods in the field. Topics include the design, implementation, and evaluation of a health survey instrument, including probability sampling, questionnaire design, interview techniques, coding procedures, and planning for the analysis and presentation of the findings. Evaluation will be based upon participation in field projects and a written report and presentation.

Biostatistics: Modeling and Sampling (4 units)

This course advances the concepts of linear regression to a unified perspective of generalized linear models, including multivariate regression, logistics regression, and log-linear models. A recently collected data set will be analyzed using these methods. The course will also address issues of sampling, sample size, and power calculations with respect to a number of study designs. Evaluation will be based on problem sets, quizzes, and examinations.

Program Planning (5 units)

This course addresses the analytic and practical considerations in designing and implementing a field program. Topics addressed include manpower and facilities planning, design, and implementation considerations, and planning for evaluation. Evaluation is based upon a student project.

Project Development and Evaluation (6 units)

This course provides a thorough grounding in the basic methods of health services evaluation, focusing on research designs, threats to reliability and validity, and instrumentation. Emphasis is on critical analysis and assessment of study designs. Evaluation is based upon student-prepared evaluation protocols and critiques of published papers.

MPH Project Planning (2 units)

This course allows students continuing into the MPH program to formulate a preliminary project proposal for their MPH thesis. Students will apply the knowledge

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and skills acquired during the first-year curriculum to shape and focus a tentative project proposal and implementation plan. Evaluation is based upon successful completion of a draft proposal. (Pass/Fail only)

Appendix G.

Academic Programs at the School of Health Care Management and Administration at the College of Health Sciences,

American University of Armenia

	Course 1: Basics of health care management and administration (25 hours)
1	Basics and Principles of Health Care Management
2	Strategic Planning
3	Presentation Skills
4	Communication Skills: Basics, Methodology and Principles. Practical Use of Communication Skills.
5	Leadership: Basics and Principles. Leadership in Practice: Situational Leadership. Determine your own Leadership Style
6	Motivation: Basics and theories, methods and specific approaches
7	Decision Making and Problem Solving: Principles and Theory, Methodology, Stimulation Exercise
8	Time Management
9	Basics of Conflict Management. Methods of Conflict Resolution. Negotiation Skills for a Manager
10	Nominal Group Technique (NGT) – a tool for better and effective decision making (principles, practice and implementation).
	Course 2: Basics of health economics, finance and marketing, and health insurance and managed care (25 hours)
	What Economics is all about (terms, definitions and main questions). Basic Macroeconomic Concepts and Linkages with Health Sector.
1	Basic Concepts of Demand and Supply Law. Analysis of Demand for Health Care. Need vs. Demand in Health Care. Social Control on Proper Utilization of Health Care Resources
2	Health Care Economics and Health Care Market – specific characteristics, concepts and models. Methods of Economic Evaluation. Not-for-profit Types of Organizations in Health Care Sector.
3	Financing of Health Care System. Financial Management of Outpatient and In-patient Health Care Organizations.
4	Health Insurance and Managed Care – applications, schemes and models
5	Private Medical Office Management and Administration (how to start a private medical practice). Better Office Management.
6	Marketing in Global Economy and in Health Care System.
	Course 3: Health care human resources and quality management (25 hours)
1	Introduction to Human Resources Management
2	Planning Human Resources for Health
3	Staff Recruitment, Selection, Deployment, Orientation. Job Design
4	Staff Retention
5	Human Resources (staff) Development and Training
6	Appraising Performance of the Staff
7	Groups, Teams, and Teamwork.
8	Quality Management in Health Care: Introduction and Epidemiology of Quality; Methods of Performance Improvement; Assessment of Outcomes
	Course 4: Health care policy and reforms in Armenia and legal aspects and ethics of health care (25 hours)
1	Health Care Reforms in Armenia: What do we reform and why?
2	Health Care System in Transition: Matching Strategy to the Situation.
3	Health Status and its Main Indicators in Armenia
4	Health Care and Health Care Policy: Mission, goals and objectives; health care policy making and priority setting; policy making case study.
5	Legal Aspects of Health Care Administration: Introduction and main sources of law; liability and consent issues; medical records and legal reporting obligations; patients' rights and responsibilities

Public Health Management and Policy Education and Training: Bulgaria

Martin Gramatikov¹ and Nikolay Gavrailov²

1. Introduction

The introduction of health care management and policy, as well as public health education, in Bulgaria has coincided with profound changes in the country's political, social, legal and economic systems during the last decade. As an integral part of the overall societal system, reform of the health care system cannot be analyzed without linking it to the developments in other interacting social systems, such as the public administration system, the higher education system, the social security system, and the like. All components of the country's social network have witnessed rapid and often contradictory changes, and only by examining the total picture can one fully comprehend the overall status of health management education in Bulgaria.

The environment in which health care reform in Bulgaria is taking place is marked by two distinctive factors: the transition from a planned to a market economy, and the integration of the country into international structures, most notably the European Union (EU). Additionally, the transition effort has been accompanied by phenomena previously not experienced: poverty, unemployment, and a general reduction in the quality of life. Consequently, with the transition to a market economy, there has been a dramatic divestiture of the state from its functions as sole provider of health care services and the appearance of new forms of relationships in the delivery of health care services (WHO 1999).

This new economic environment has necessitated a major transformation in the financing system for the health care sector. Prior to 1989, health care was proclaimed to be free of charge and accessible for all citizens. With the profound changes, that paradigm could no longer be sustained. Under the pressure of the financial crisis, and international donor organizations, the country took steps toward an insurance-based health care system in which the accessibility of health care is based on contributions from employees and employers.

The process of accession into the European Union affects Bulgarian institutional and legislative domains. Under the European Agreement and the Accession Agreement, Bulgaria assumed certain obligations that were reflected in externally induced changes at organizational and policy levels (WHO/Duran 1999). Some of the main health care policies were formulated in laws enacted over the last five years: the National Health Insurance Act (1998), the Health Establishment Act (1999), and the National Framework Agreement between the National Health Insurance Fund

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and the Bulgarian Medical Association (2000). Aiming to bridge the gap between the EU countries and Bulgaria, the Government program addressed the problems of the health sector and formulated five targets that must be met:

- mitigating the negative trends in the nation's health;
- enhancing the health system's effectiveness through institutional and structural changes in health services design and delivery;
- promoting the quality of medical care;
- increasing the health system's effectiveness through change in the financing system; and
- adapting the human resources in health care to the new economic circumstances and the institutional and structural changes.

The reform of the health care system in Bulgaria sought to resolve numerous outstanding problems; these include, but are not limited to:

- centralization and inflexible mechanisms of control;
- corruption and unclear financial mechanisms for funding health care;
- unbalanced distribution of access to health care, highly skewed toward the big cities;
- lack of a service delivery culture and managerial skills; and
- severely restricted budget foundations of the health care system.

Other aspects of the transition from a planned economy to a market economy are reflected in public policies and programs to change the scope, structure and perceptions of the system of public administration organizations. These efforts span the entire decade, but only after 1997 did official public policies enter into an integrated phase in which the legal framework followed the declared public policies. These policies are still not thoroughly implemented, and many milestones have not yet been reached; nevertheless, the transition is in progress and has implications for health care reform and the related field of public health education.

Together, administrative reform, and the privatization policy that was accelerated after 1997, have had a visible impact on the health care sector. Prior to the Christian-Democratic government, privatization was largely debated at political levels but insignificantly implemented in practice. After 1997, the process was strengthened, and most state-owned enterprises were transferred to private investors through various schemes. Privatization gradually but consistently has changed attitudes toward the public sector in the country. As Bulgaria moves away from an all-encompassing public sector, the different social groups are becoming accustomed to a leaner public sector, with a very different role in society. Now the perception is that the public sector will provide a more limited range of public services, although there is no consensus on the scope and dimensions of the public services (Kettl 1988; Savas 2000).

The demand for profound changes in health care policies was accompanied by a shortage of professionals with adequate skills and abilities in policy analysis and implementation, strategic planning of public health policies, and evaluation and

appraisal of policy outputs and outcomes (UNDP 1999). This human capacity gap is attributable to various factors that have impeded the creation of a strong group of health managers. On the one hand, the social status of public health officials does not contribute to the establishment of the discipline as a full-fledged partner in the health care system. Usually, public health specialists face the problem of an unclear and ambiguous identity. Although the vast majority of them are medical doctors with a specialty of community medicine, occupational medicine, or the like, the general perception is that the public health field is peripheral to the core medical fields. Also, the low remuneration of public health professionals lessens the entry of talented professionals into the sector (Apostolov and Ivanova 1998).

One of the stated priorities of the National Health Strategy is to “improve the quality of education and convertibility of the medical education and post-graduate training with regard to the new priorities in the health care and the EU free movement of people policy.” This priority should bridge the gap between “traditional” medical education and the emerging field of health management. As suggested below, the general perception is that public health professionals and health managers in Bulgaria are only peripherally important to the health care system. Although not explicitly stated in official public policy, it is assumed that medical education and training should be the driving force in bridging that gap. Public health degrees and training programs must find their identity in order to attract talented and capable people with the potential to lead the public health initiatives.

Another misconception in higher medical education in Bulgaria is the blurring of the distinction between health care and health establishment management and public health. The joining of these two different domains contributes to the perception of the remoteness of the two specialties from pure medical education. In many current Bulgarian education and training programs in public health, there is a dysfunctional mix between health management and public health. One plausible explanation is the lack of theory and practice in the field; during the past decade there was rapid, but somewhat unsystematic, progress. Another possible explanation is the inconsistency of public policies in the health care sector, specifically public health policies. The fact that the draft Public Health Act is still in the Parliament is an eloquent statement about the political will of policy makers.

With the advancement of health care reform, the role of public health will not necessarily be explicit and evident. It is the public policies that must promote and advocate the principles and objectives of public health. In order to have these policies in place, there must first be a critical mass of public health professionals with specific skills, attitudes and mindsets. The crucial role of public health/health policy education is to provide that capacity of public health leaders who will have the capability, courage and drive to formulate, implement and evaluate public health policies as an integral part of health care reform (Doelemen 1997). However, this type of education does not now exist in the Bulgarian system.

2. Country Profile

Bulgaria, located on the Balkan Peninsula, has a population of eight million people and a territory of 111,000 square kilometers. According to the Constitution of the Republic of Bulgaria (1991), the country is a parliamentary republic with strict separation of legislative, executive and judicial powers. Legislation is the exclusive prerogative of the Parliament, which consists of 240 Members of Parliament (MPs) with four-year terms of office. The Parliament has the sole authority to enact, change and repeal laws and to make changes to the Constitution. In addition to its legislative power, the Parliament has the authority to ratify certain categories of international treaties and conventions. Although proclaimed and deemed independent, the executive branch is directly subordinated to the Parliament through the appointment of the Prime Minister and the government by the Parliament. Moreover, the government is responsible to the Parliament for its policies.

The government has the responsibility for executing the state's public policies. In order to do so, it has the authority to enact bylaws to implement the existing laws and to direct the administrative system through decrees and executive orders. The government administration itself is structured into ministries – currently, 16 line and functional ministries. Furthermore, the administration is divided into central and local units, with the central administration directly subordinated through the chain of command to the government. The central administration is organized into different types of organizations – ministries, state commissions, state agencies, executive agencies and other organizations. Based on the Law on Administration and legal provisions, it is not clear how these organizations are structurally and functionally different.

At the local level, 28 regional governors, who are appointed by the Prime Minister and report directly to him, administer the central public policies. Local self-governance is organized into 262 municipalities, which enjoy a certain level of decentralized authority but still depend on budget allocations made by the central government. Most health care services that fall outside primary health care are the responsibility of local governments, which causes constant tension because these services are cost burdens for the municipalities.

Essential for understanding the context in which health care reform takes place is an understanding of functional reform in the Bulgarian public sector. The most important legal acts that reshaped the public administration system and continued through the change of the government in 2001 are:

- the Law on Administration (1998); and
- the Law on Civil Service (1999).

The former law stipulates a uniform and streamlined system of public organizations based on a hierarchical, rather than a network structure. According to the law, administrative organizations differ from what is known in the Bulgarian system as administrative authorities; the main goal of the former is to support the administrative authorities in carrying out their functions. The concept of the

executive agency, with its goals and objectives to implement certain public policies, has been introduced, together with the Law on Administration, in the Bulgarian public sector. Many existing administrative authorities were accordingly transformed from mixed policy making and policy implementation organizations into strictly policy implementation units. Although legally based, this distinction is still not consistently made at the different levels of public administration. For instance, many ministries assume responsibilities in policy formulation, implementation and evaluation at the same time, which leads to the dilution of responsibilities, subjectivity in the evaluation phase, and a general blurring between policy making and policy implementation.

The Law on Civil Service provided for the establishment and development of a corps of professional civil servants to protect against the abuses of the spoils system. The law made a clear distinction between political and administrative positions in public administration organizations. The separation between the two domains was deemed as necessary to reduce the negative impact of the political life cycle and partisan appointments on the stability, consistency and knowledge management potential in the public sector. Another aspect of the Law on Civil Service is its orientation toward a career civil servant system based on relatively objective criteria for promotion. The law also provides for a merit-based system for the selection of public servants. However, the civil service is strictly limited to the so-called core civil servants and does not span the domains of health care, education, public order and defense. Thus, the Law on Civil Service governs only a small number of persons in the public health system, predominantly in the policy making organizations, while most medical professionals are not civil servants.

The structural reforms outlined in the preceding paragraphs play an important role. In order to understand the environment in which health care reform takes place, however, one must also analyze the policies that guide the public administration system itself. Changes in the principles of the public sector and the processes of public organizations are often referred to as “administrative reform”, although most of the time the reform involves changes of structure by legal means.

Most administrative reform ideology can be traced back to the New Public Management literature. In the public policies that govern the “re-engineering” of the public sector, one can find the whole set of cliché phrases, including customer-centric governance, “more for less,” output-oriented public service, and steering rather than rowing. Drawing the line between these “guru theories” and the real transformation processes in Bulgarian public administration suggests that the current situation is characterized by a very legalistic, rather than a managerial, approach to governance. The stringent legal environment (as enacted in the Law on Administrative Acts and the Law on Administrative Misdemeanors and Sanctions) makes it hard to implement proactive and outcomes-based governance in the Bulgarian public sector. Moreover, the shortage of human skills and abilities in public management contributes to that trend.

3. Health Care System

A description of the health care system in Bulgaria starts with certain basic facts. For the past 12 years, the country has experienced negative demographic growth, with a peak of -5.1 for the year 2000. In that year, there were 299 hospitals with 60,552 beds in Bulgaria (NCHI 2000), of which 127 hospitals (with 37,474 beds) were multi-purpose hospitals, 73 were specialized hospitals (with 12,186 beds), 11 were psychiatric hospitals (with 3,075 beds), 50 were dispensaries (with 4,348 beds), and the rest were hospitals attached to public authorities. Only 18 of the 299 hospitals were private in the sense that their capital was completely in the hands of non-public actors. At the same time, there were 5,619 general practitioners (GPs) and 173 group practices for primary health care services. The number of individually practicing dentists was 6,765, and 39 group dental practices existed. There were 5,422 medical doctors registered as individual specialists, and 42 group specialist practices.

Health care in post-socialist Bulgaria was plagued by the legacy of the country's ideology and its former health care system, which was characterized by a planned supply of health care, bureaucracy, and redundancies in the system. In a real sense, the ideology was realized by the total dominance of the public sector in health care. As a result, the whole process of planning, coordinating, financing, delivering, assessing and evaluating health care services and public health promotion was input-based, without any appraisal of the ratio between the resources allocated and the results achieved.

Moreover, health services were labeled as accessible to everyone and free of charge, which broke the connections between the supply and demand sides of the sector (Roberts 1995). In the eyes of the beholders, the system provided accessible and free health care. On the other hand, this abundance and accessibility were provided at the cost of excessive and ill-planned investments in the education of extremely large numbers of medical professionals and an excessive number of medical establishments and other important components of the health care sector. As evidenced by the statistical data, between 1980 and 1995 the usage ratio of the regional hospital beds decreased from 324 to 238 days per year, and of the municipal hospital beds from 304 to 222 days per year (National Institute of Statistics 2001; Lerer *et al.* 1998). Logically, the increased priority of hospital health care was at the expense of primary health care activities. Another distortion was the ratio between diagnostics and healing, on the one hand, and health promotion and prophylactic treatment, on the other hand. The former was considered a priority, and hence developed rigorously, while the latter remained an ideological cliché.

With the profound political, economic, social, and legal changes of 1989, the old health care system had to drastically change in order to conform with the new realities. First, the public monopoly in the health care sector was abolished, and private initiatives gradually started to develop. This process, however, took place not as part of a systematic effort but as a contingency accompanying other processes. For instance, the private ownership of municipal hospitals was allowed

by an act that regulated the administrative structure and mandates of self-governance, not by a dedicated health policy document. The private ownership of medical establishments was accompanied by the abolition of the ban on private medical, dental and pharmacist practices. Because of the lack of political leadership and commitment, reforms in the health care sector were stalled for more than seven years at levels of quasi-market transformations, which caused many negative effects, including unequal access to health care, low quality of services, "under-the-table" payments, and low salaries in the sector. In fact, although most of the health care services were *de jure* free of charge, *de facto* the users in one form or another had to pay for them.

Radical changes in the Bulgarian health care system were introduced in 1997 by the then-ruling right-wing government. Three fundamental acts were endorsed that allowed acceleration of health sector reform:

- Health Insurance Act (1998);
- Law on Professional Organizations of Physicians and Dentists (1998); and
- Health Establishments Act (1999).

The primary principles of health care public policies were insurance-based funding of the services, efficiency and effectiveness, and the sharing of responsibilities between decision makers, administrators, service providers and clients of health services (Rys and Rys 1995; Walt 1994). These principles were implemented at varying speeds and with varying success. In fact, policy makers chose the gradual transition from budget-funded to insurance-funded health care: on 1 July 2000, primary care and dental health care were reformed, and hospital health care was addressed as of 1 July 2001.

The main pillar of the reform is the funding of the transition to contractual relations between health care providers and the National Health Insurance Fund (NHIF) and commercial companies for voluntary health insurance. The Health Insurance Act stipulates that every Bulgarian citizen shall be insured for a minimum package of services, which is funded by the NHIF. Providers of health care can enter into a contractual agreement with the NHIF, according to which the services delivered shall be reimbursed on the basis of predefined prices fixed in the National Framework Agreement between the NHIF and the professional association of physicians and dentists. Along with the insurance coverage from the NHIF, every patient has to make small cash payments each time he/she uses health care services, e. g., for visiting a general practitioner or for spending a day in a hospital. Citizens can increase the coverage of the minimum health care package through voluntary insurance with health insurance companies. These companies are allowed to enter into contractual relations with health care providers for the reimbursement of services delivered to citizens who have voluntary insurance.

The Health Insurance Act regulates the institutional framework of the insurance-based funding of health services. The Act stipulates a process for conversion to compulsory and voluntary insurance schemes covering health care expenditures.

A minimum package of services is guaranteed to every insured person under the compulsory Health Insurance Scheme - Article 26: Citizens are entitled to accessible health care services in medical institutions that have signed agreements under the compulsory health insurance, and to the free health care services listed in Article 3a. The National Health Insurance Fund and its regional offices have the responsibility to manage the newly adopted system established by this Act. On the other hand, the voluntary insurance packages are administered by private companies, which are regulated in a manner similar to that of regular insurance companies.

On 1 July 2001, the new system of financing the hospital care sector was launched. Based on the Health Insurance Act, a National Health Insurance Fund was established to develop and manage the system of compulsory health insurance that replaced the old budget-funded system of health care. The NHIF enters into contractual relationships with health care providers and thus mediates the relationship between the insured population and the providers of health care. A National Framework Contract between NHIF and the associations of medical professionals provides the general context for the particular contracts with the providers and sets the scope of the services covered by the compulsory insurance.

National Health Strategy

Health care reform is based upon new principles that are in conformity with the nation's health needs, and therefore the economic relationships with respect to this reform must meet two major requirements:

- be in compliance with the market conditions created in the economic and non-governmental sectors of Bulgarian society; and
- maintain an adequate correlation between costs and benefits.

The main impact of these requirements falls upon the “de-monopolization” of health care services through legislative provisions ensuring that conditions for stimulating private investments in pre-hospital and hospital care are met, as well as through privatization of health care establishments.

The maintenance of adequate cost-benefit levels requires the establishment of an overall investment system in health care that covers activities related to public health. Public health funding should be a function of the benefits obtained through the respective expenditures. Therefore, it would be reasonable to introduce a program financing system in which funds are granted based upon the appropriateness of a given promotional, prophylactic, medical, social or other program.

The implementation of the National Health Strategy and its Action Plan are expected to

- limit the negative trends in the population's health status;
- increase the effectiveness of the health care system and bring it closer to the standards adopted by developed countries;

- increase the quality of health care services in the fields of promotion, prophylactics, treatment and rehabilitation; and
- stabilize the health care funding system.

Public health reform has been significantly supported and impacted by many donor-driven projects. The World Health Organization (WHO), European Union PHARE Program, World Bank, Swiss Agency for Development and Cooperation, United States Agency for International Development (USAID), and Government of Spain are among the foreign donors that have provided training or technical assistance (Makara 1998).

The Bulgarian health system administration is of the so-called “integrated type,” with health care officials designated by and directly accountable to the Ministry of Health. The structure of the public health service is predominantly hierarchical. Like many other Eastern European countries, Bulgaria currently devotes only 1% of national health expenditures to health promotion and disease prevention.

At the present time, the social status of public health professionals has not changed significantly despite the changes in the public health field. Public health specialists have no clear identity. They are usually medical doctors with a community medicine, occupational medicine, or similar specialty that is considered peripheral in the medical field. This identity/image/status problem is accompanied by an inadequately funded career structure.

In the public health sector, institutional reform took shape in 1998 when the Hygienic-Epidemiological Service was transformed to lead the implementation of public policies in the areas of health promotion and prophylactics, sanitation control and epidemiological activities. The Service has functional authority in the implementation of various public health policies, e. g., campaigns against HIV, smoking, sexually transmitted diseases, breast cancer, and thyroid diseases. The Hygienic-Epidemiological Service is supported by the following national centers with research and consultancy objectives: Public Health Center; Center of Hygiene, Medical Ecology and Nutrition; Center of Infectious Diseases and Parasitology; and Center of Radiology and Radioactive Protection.

4. Public Administration/Management Education³

Public administration programs are a relatively new phenomenon in Bulgaria. Before 1989, the discipline was not deemed to be a significant part of the academic curriculum; subjects relevant to the public administration field were taught in different human and social science disciplines ranging from constitutional law to political science. Public administration programs at different levels started to evolve in the mid-1990s and have continued to grow rapidly ever since. A vast majority

³ This section and the following sections in this chapter were finalized with additional information provided by Polyá Katsamunská, University of National and World Economy, Sofia, and by the Network of Institutes and Schools of Public Administration in Central and Eastern Europe (NIS-PAcee), Bratislava, Slovakia.

of public administration programs are integrated into the academic curriculum of public or private universities.

Public administration education follows the general framework of the Higher Education Act (1995), which sets out a three-tier degree system:

- Bachelor's degree – minimum of four years of studies;
- Master's degree – five years, or one year in addition to the bachelor's degree; and
- Ph. D. degree – minimum of three years in addition to the master's degree, or as a four-year degree after the bachelor's degree.

Although there are national standards for curriculum and content for the numerous specialties in the Bulgarian higher education system, the public administration programs in the different universities show a stunning variance in the courses that are offered to the students. Typically, the students will have compulsory or voluntary classes on subjects like Basics of Public Administration, Macroeconomics and Microeconomics, Research Methods and Statistics, Local Government, Political Theories, Administrative Law, Constitutional Law, Tax and Financial Law, and European Studies. Four disciplines dominate the curriculum – law, political science, sociology and economic studies. Generally, the focus is placed on the disciplinary area in which the particular university has the strongest background, e. g., technical and business oriented universities emphasize management and economic courses, while classical universities put the emphasis on law, political science and sociology. Depending on the availability and capacity of its faculty, a public administration program would offer a wide range of selective courses that follow a particular policy area, with an emphasis on macro management, e. g., Management of Criminal Justice, Management of Public Procurement, or Management of Education.

The public administration academic education and training system in Bulgaria consists of many institutions of different types. Universities play a very important role, but other institutions participate as well, especially in training. Public administration/public management education is delivered by at least the following Bulgarian schools:

1. Bourgas Free University, Faculty of Law
2. Economics Academy Dimitar Tzenov, Svishtov, Faculty of Management and Marketing
3. Gabrovo Technical University, Faculty of Engineering and Business
4. New Bulgarian University, Master's Faculty
5. Rousse University Angel Kanchev, Faculty of Business and Management
6. Southwestern University Neofit Rilski, Faculty of Law
7. University of National and World Economy, Economics of the Infrastructure Faculty
8. University of Plovdiv Paissi Hilendarski, Faculty of Economic and Social Sciences

9. University of Sofia St. Kliment Ohridski, Faculty of Philosophy and Social Sciences
10. University of Sofia St. Kliment Ohridski, Faculty of Law
11. Varna Free University, Faculty of Administration, Political Science and International Relations
12. Varna Technical University, Faculty of Law
13. Varna Technical University, Centre for Public Administration in Sliven

In comparison to other countries of Central and Eastern Europe and the former Soviet Union, Bulgaria currently has numerous universities that seek to provide degree and professional development programs for public administration officials. In fact, there are more programs at present than are actually needed, thereby draining human and financial resources.

The government of Bulgaria sought to control the curriculum of public administration programs through the issuance of state standards; in doing so, however, it created guidelines that are quite strict due to a lack of understanding of the field. Public administration scholars and professionals must work with the government to ensure that these standards are revised to become more interdisciplinary in nature. At present, 75% of these standards coincide with the requirements for business administration programs. This creates an overlap between law, business administration, and public administration that is not advantageous to the field of public administration. Public finance, for example, is not simply based upon cost-benefit analysis, but must also consider social aspects. Therefore, a business studies course may not adequately prepare students to meet the needs of the civil service.

At the national level, all Bulgarian ministries and executive institutions routinely organize qualification courses in public administration for their employees. These are generally short-term, in-service training courses, offered on weekends and evenings. Courses tend to be organized when new laws and regulations are adopted or a new administration takes over various institutions. During the last year, longer and more in-depth qualification courses focusing on particular managerial skills have been organized due to the government's demand to raise the level of administration in connection with plans for European integration. In some areas (e. g., health management), the government has introduced special requirements for successfully completing such courses in order to hold managerial positions. As a result, all public managers and higher-ranking civil servants in such institutions must obtain adequate training to continue to hold their positions.

For nearly two decades, the Ministry of Regional Development (the National Center for Territorial Development and Housing Policy's Consulting and Experimental Sector) has organized qualification courses for local municipal staff, including mayors, deputy mayors and civil council members. A special "School for Staff Qualifications" has been set up within the center to train public managers in all governmental and local power spheres. Unfortunately, the National League of Municipalities lacks its own training institution.

At the local level, training is organized at the request of either particular municipalities or, more often, local associations of municipalities. Academics (law professors, or economics and business professors) are often invited to conduct lecture series. The Varna Technical University's branch in Sliven, the Varna Free University and the University of Plovdiv are known as qualification course providers. The New Bulgarian University and Sofia University provide in-service or distance learning training activities. Sofia University and the University of National and World Economy regularly provide qualification courses throughout the country. In general, the academic schools of public administration have the potential to expand their training activities.

The British Know-How Fund and USAID have been the most active international training providers to date. However, the courses sponsored by these organizations have not involved large groups of Bulgarian civil servants. A few non-governmental organizations (NGOs) and private firms, some focusing on business administration, also provide qualification services. Since there is no coordination between these various training efforts, it is impossible to offer a detailed description of their activities.

5. Health Management/Policy Education

Since health managers, except for a small number of people working directly in public administration offices, are not public servants, the rapid growth of programs and courses in the public administration area has left the health management and policy field largely untouched. Among the university programs that grant bachelor's, master's, or Ph. D. degrees in public administration, only recently have health management specializations or courses been created, and health policy is still not covered.

At least two major factors contribute to this gap. First, the above-mentioned relationship between specializations in public administration programs and university disciplinary strengths partially explains the lack of public management specializations or programs. The old system of independent medical universities broke the links between medical science and other sciences, and consequently such multidisciplinary fields as health management were regarded as peripheral, if not alien, to public administration programs. A second influential factor contributing to the absence of these programs from the health management field is the lack of qualified lecturers able to present public administration courses to medical students.

Currently, there appears to be only one example of a health management program delivered by a public administration institution, namely, a master's degree in health management provided by the Institute for Postgraduate Studies, University of National and World Economy, Sofia. The applicants must have a bachelor's degree, with a major in economics or another field of science. Depending on the major area, the program is completed in three or five semesters in distance-learning form; students must cover all courses in the program and defend a diploma paper.

Alternatively, health management education and training can be found within the curriculum of the medical universities and schools. The curriculum development approaches and teaching methods in the public health/health management degree programs are still heavily oriented toward theoretical and factual knowledge. Most of that tendency can be attributed to the legacy of the traditions in Bulgarian academic education, which is characterized by a minimal focus on skills acquisition and training. Most public health courses are not tailored to the needs of students but to teachers' styles and theoretical paradigms. Another consequence of the structure of Bulgarian higher education is the isolation of medical education into separate medical science universities (Des Marchais *et al.* 1992). Hence, the education provided by other universities and educational institutions is not sufficiently integrated into public health education.

The program of the Public Health Faculty in the Sofia Medical University is a good example. The Faculty prepares specialists in the following fields: health care, health management, economics of health care, health care marketing, medical ethics, medical pedagogy, epidemiological methods, and patient rights. Those diverse specialties, however, are not significantly differentiated from one another, and they are all oriented toward the practical aspects of health care delivery to hospitalized patients, with very little or no attention to the original health management or public health disciplines, such as prevention, promotion, patient education, effectiveness, and quality measurement.

A content analysis of the public health degree programs and training programs shows a clear emphasis in the existing curricula on communicable diseases and hygiene. Des Marchais *et al.* (1992) cleverly define the current stage of Bulgarian public health education as one of "curriculopathy." The concept defines a state of continuous disorder in medical education programs and is characterized by "excessive course content, teaching nearly restricted to lecturing, and poor congruence between evaluation techniques and educational objectives" (Des Marchais *et al.* 1992).

As some authors have pointed out (Apostolov and Ivanova 1998), a serious problem of medical education is the overproduction of physicians. This phenomenon directly contributes to the natural trend of staffing public health institutions with physicians, who generally have a low level of formal training in public administration/management and policies. On the other hand, the good skills and abilities of the physicians in social medicine, hygiene, and occupational medicine can be envisioned as a potential basis for the development of a critical mass of public health professionals who will boost the implementation of public health policies. On that base, a strong human capacity in health management can be developed – but only after considering the discipline as an integral part of both public administration and medical programs.

Appendix A lists the academic programs in public health management and policy in various Bulgarian universities; Appendix B lists training programs in public health management and policy taught at the postgraduate qualification training sites.

6. Conclusions and Recommendations

In general, higher education in health management and public health in Bulgaria suffers from particularization and the lack of a multidisciplinary approach. The lack of health management courses and specializations (and almost no attention to health policy) speaks eloquently to the underdevelopment and immaturity of the field. An analysis of the content of the degree programs shows that they are scarcely oriented toward existing public policies; rather, they emphasize theoretical courses that predominantly belong to the fields in which the particular university has developed expertise in terms of faculty, research and experience. The fact that the policy-based courses are usually treated as peripheral by students and faculty is self-explanatory, given the curriculum development processes in public administration programs.

The lack of experienced tutors, literature and research funding in the field of health management and the fact that medical professionals are not deemed to be part of the civil service corps combine to provide few incentives to public administration programs to develop the field and to offer health management education. Most health managers come from medical backgrounds, forming a closed circuit that is difficult to penetrate. Hence it is practically impossible for public administration students and scholars either to get empirical knowledge about health management issues or to find practical applications for such knowledge. Not surprisingly, the motivation for teaching and studying health management is low.

Health management is currently envisioned as part of public health programs. In the traditional medical universities, medical programs (including dental and pharmaceutical programs) rarely, if at all, include courses on public health disciplines, such as health promotion, health prevention, and patient education. Where there are separate public health programs, the topic of health management emerges, which means that the course is deemed to be part of the public health curriculum. That fact reinforces the belief that health management is not popular among public administration programs because it is regarded as a medical rather than as a managerial discipline. Moreover, in courses delivered by medical schools, it is totally forgotten that health management is closely interrelated with public management and public policy areas.

Furthermore, an analysis of the public health programs in medical universities reveals a relatively comprehensive structure of courses, which are usually grouped around a major health management course. These courses introduce to the students major organizational, legal and economic concepts and strive to put these concepts in a more integrated framework of health management. Within these programs, some of which grant a master's degree in public health, the internal tension is between the health management and public health streams.

Interviews by the authors with medical professionals have shown that there are major differences between these two streams concerning the goals of the programs. One stream asserts that these programs must be strongly oriented toward public

health issues in order to prepare a critical mass of public health professionals. The other stream asserts that there must be a balance between health management and public health in order to provide students of the program with a more diverse set of skills and abilities. One issue that emerged during the interviews, for example, was that a separate health management program is not worth organizing because it would be too narrow and would lack applicability. With such a heavy stress on public health issues, it is very surprising that health policy issues are more or less neglected, both in the structure of degrees offered and in the curricula of existing courses. The key question is thus: How is it possible to teach public health, without any course in health policy?

Recommendations

- A needs assessment of the skills, abilities and training gaps in the health management sector in Bulgaria should be carried out. The needs assessment results and an analysis of further developments in health care reform will be instrumental tools in designing health management programs and assessing the current and prospective needs of such education.
- A multidisciplinary approach should be introduced and promoted in health management education and training. The current practices of strict isolation between medical and other sciences should be abolished in order to design fully integrated health management programs.
- Introduction of learning-by-doing methods, distance learning approaches, more re-training of existing human resources, and an emphasis on management and policy analysis and evaluation skills should be priorities.
- Public administration programs in the CEE region should overcome the vision that the public sector is limited to the activities that are performed by civil servants and embrace systematically the major public policy areas, e. g., education, health, social security, and public order. By concentrating on primary public policies, health management education will gain status in public administration programs and provide the basis for a greater program focus, which eventually could lead to the development of more health management concentrations within public administration programs.
- Health management education should be based on iterative processes to prevent “re-inventing the wheel.” A working group on health management should be established at the Central and Eastern European level (using the NISPAcee model), with its main objective being to provide for the transfer of experience, knowledge acquisition and methodological guidance.
- More emphasis should be placed on information technology applications in public health, as well as in public health education (e. g., statistical applications, Geographic Information Systems, data mining and warehousing).
- More emphasis should be placed on the development of analytical skills to assess and evaluate health care public policies in existing public health courses (e. g., courses on policy analysis, cost-benefit analysis, program evaluation, project management, legal aspects of the public health, international health care).

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Appendix A.

Academic Programs in Public Health Management and Policy

1. Public Health Faculty, Sofia Medical University

The Public Health Faculty trains specialists in the following fields: health care (B. Sc.); health management (M. Sc.); economics of health care; health care marketing; medical ethics; medical pedagogy; epidemiological methods; patient rights (postgraduate courses).

The disciplines taught comprise:

- Health Management
- Social Medicine
- Medical Ethics
- Medical Sociology
- General Epidemiology
- Pharmacological Economics
- Health Management
- Critical Situations Medicine
- Organizational Behavior
- Health Care Economics
- International Health Cooperation
- Computer Sciences in Health Care
- Evidence Medicine
- Applied Epidemiology
- Health Legislation
- Communication Skills
- Optional Classes

2. Medical and Biological Sciences Department, New Bulgarian University, Sofia

The Health Care Management master's program trains health care managers by providing knowledge and skills in the mechanisms for the establishment of favorable working environments; development of health care reform and mechanisms for cooperation with the National Health Insurance Fund; logic and factors pre-determining the evolution of health care in a modern humanitarian context; and working in the administration of the health care system.

Requirements:

- Preparatory Courses – 16 credits
- Compulsory Courses – 16 credits
- Optional Courses – 12 credits
- Workshops, Practicums, Research – 10 credits
- Master's Thesis – 15 credits

Preparatory Courses:

- Management of Financial Resources in Health Care – 30 h., 2 cr.
- Health Projects: Methodology for Design, Implementation and Analysis – 30 h., 2 cr.
- Labor and Insurance Law – 30 h., 2 cr.
- Quality Evaluation and Management in Health Care – 30 h., 2 cr.
- Medical Law and Health Legislation – 30 h., 2 cr.
- Civil and Administrative Law – 30 h., 2 cr.
- Medical Deontology – 30 h., 2 cr.
- Ergonomy of Medical Labor – 30 h., 2 cr.

Compulsory Courses:

- Health Insurance (Bysmark system) – 30 h., 2 cr.
- Public Health Care (Beverage system) – 30 h., 2 cr.
- Private Health Care (USA health care system) – 30 h., 2 cr.
- Plural Health Care – 30 h., 2 cr.
- Applied Sociology in Health Care – 30 h., 2 cr.
- Operational Methods in Health Care Management – 30 h., 2 cr.
- Conflict Resolution – 30 h., 2 cr.
- Human Resources Management – 30 h., 2 cr.

Optional Courses:

- Organizational Behavior in Health Care – 30 h., 2 cr.
- Studying Health Needs – 30 h., 2 cr.
- Health Policy in the Process of Reform – 30 h., 2 cr.
- Public Humanitarian Organizations – 30 h., 2 cr.
- Analysis of Health Care Systems and Health Insurance – 30 h., 2 cr.
- Reproductive Behavior and Demographic Policy – 30 h., 2 cr.
- Modern Health Care System Reforms: Trends and Risks – 30 h., 2 cr.
- Euthanasia: Dilemmas and Reality – 30 h., 2 cr.
- Working with NGOs – 30 h., 2 cr.
- Social Gerontology – 30 h., 2 cr.
- Management of Private Entrepreneurship in Health Care – 30 h., 2 cr.
- Medical and Social Rehabilitation – 30 h., 2 cr.
- Computer Models in the Public Health System – 30 h., 2 cr.
- Medical Chronobiology – 30 h., 2 cr.
- Modern Technologies in the Health Care Management

3. Public Health Department, Varna Medical University

Training in Health Management:

- Postgraduate courses – 224 hours;
- M. Sc. Program for medical doctors – 6 semesters, 1368 hours;
- M. Sc. Program for economists – 5 semesters, 1074 hours;

PART II

– B. Sc. Program

Academic Curriculum for the B. Sc. Program in Health Management:

4. Pleven Medical University

Management of Nursing Care Specialty:

- Education level: Bachelor of Science;
- Professional qualifications: 1. Manager in nursing care; 2. Lecturer in practice in a medical college;

Discipline	Hours Theory/Practice	Total
1. History of Medicine	30/15	45
2. Quantitative Methods	90/60	150
3. Informatics	60/60	120
4. Medical Terminology	/45	/45
5. Human Biology and Intro to Human Pathology	45/30	75
6. Foreign Language	/225	/225
7. Sport	/30	/30
8. General Medical Psychology	30/30	60
9. General and Special Economics	150/90	240
10. Management Basics	60/60	120
11. Law	90/90	180
12. Organization of Health Care Establishments and Health Professions	45/45	90
13. Organizational Behavior	30/30	60
14. Public Health	105/95	195
15. Medical Technique	30/15	45
16. Medical Ethics and Deontology	30/15	45
17. Local Self-Government and Local Authorities	15/15	30
18. Finances	45/45	90
19. Business Communications	15/15	30
20. Office Equipment	15/15	30
21. Public Relations	30/30	60
22. Statistical Methods in the Management of Health Care Establishments. Medical Statistics	30/30	60
23. Hygiene of Health Care Establishments and Hospital Catering	30/30	60
24. Accounting	45/45	90
25. Organizing Care for the Patients	30/30	60
26. General Medical Sociology	30/15	45
27. Marketing	45/45	90
28. Business Planning	75/60	135
29. Quality Management	30/30	60
30. Data Bases and Hospital Information Systems	30/45	75
31. Basics in Pharmacology and Pharmacological Economics	30/15	45
32. Organization and Management of Insurance Funds	30/30	60
33. Human Resources Management	30/30	60

- Duration of studies: 4 semesters for full-time students and 6 semesters for part-time students alternating study periods and work; the last semester includes 15 days of practical assignment in health institutions and 15 days in a medical college;
- Curriculum: 17 obligatory modules: History of Medicine and Nursing Care; Medical Ethics and Deontology; Health Economics; Principles in Health Care Management; Management of Nursing Care; Epidemiology; Informatics and Statistics; Law; General and Medical Psychology; General and Medical Pedagogy; Public Health; Hygiene and Ecology; Ergonomics; Disaster Medicine; Introduction to Research; and some optional subjects.
- Certification: two final theoretical state exams - the first one in medico-social sciences, economics and law; and the second one in pedagogy and psychology. Practical assignment is certified by two practical state exams.
- Areas of activity: Graduates will be eligible candidates for the posts of chief nurses and nursing directors in hospitals, primary health care centers, nursing homes, managers of nursing care in hospital wards, etc. They also could apply for the faculty posts in medical colleges.

PART II

Academic Curriculum for the specialty “Management of Nursing Care”:

I. Obligatory subjects	Hours Full-time students	Hours Part-time students
1. Management of Nursing Care, with a module Health Projects	270	120
2. Law (administrative, occupational and health legislation)	135	60
3. Health economics	135	45
4. Social medicine and public health	120	40
5. Health management	90	30
6. Medical statistics and informatics, with a module Introduction in methodology of health research	90	45
7. Hygiene and ecology	90	30
8. Medical ethics and deontology	90	30
9. Pedagogy	60	20
10. Methodology of practice training in medical college	90	30
11. Psychology	45	15
12. Applied psychology	90	30
13. Medical pedagogy	90	30
14. Ergonomics in health institutions	45	15
15. Epidemiology	60	20
16. History of health and nursing care	30	15
17. Disaster medicine	30	15
Practical training in management	125	125
Practical training in pedagogy	125	125
II. Optional subjects		
1. Health promotion	15	15
2. Public relations	15	15
3. Communication skills	15	15

5. Program in Health Management at Sofia University of National and World Economics

Microeconomics
Macroeconomics
Fundamentals of Law
Informatics
Fundamentals of Management

Fundamentals of Marketing
Labor Economics
Statistics
Finances
Accounting
Business Planning

Social Management
Health Policy
Managing Health Protection

Economics of Health Protection

Financing of Health Organization

Accounting of Health Organization

Health Marketing

Organizational Behavior and Communication in Health Organization

Medical Statistics

Hospital Management

Managing Human Resources in Health Organization

Civil and Trade Law

Law Regulations of Relations in Health Protection

Organization and Management of Insurance Systems

Management of Compulsory Health Insurance

Appendix B.

Training Programs in Public Health Management and Policy

Courses Taught at Postgraduate Qualification Training Institutions:

1. Health Management Basics – module I; 12 days, 30 students
2. Health Management – module II; 12 days, 30 students
3. Management of Health Care Resource – module III; 12 days, 30 students
4. Innovation and Technologies in Health Management – module IV; 12 days, 30 students
5. Health Management – module IV; 12 days, 30 students
6. Computer Preparation of Scientific Publication and Posters – 5 days, 10 students
7. Biostatistics and Computer Methods for Data Processing – 5 days, 10 students
8. Computer Training – 12 days, 30 students
9. Introduction to Pedagogy – 5 days, 20 students
10. Empathy – 5 days, 15 students
11. Docimology – 5 days, 20 students
12. Health Care Problems in Peace and War – 5 days, 10 students
13. Organization of Medical Insurance of the Population in Disastrous Situation – 5 days, 10 students
14. Empirical Sociological Surveys and Their Application in the Medical Practices – 5 days, 10 students

Public Health Management and Policy Education and Training: Czech Republic

Ivan Malý¹

1. Introduction

The general status of the health care (HC) system in the Czech Republic has been determined by a quite radical and rapid reform process that started in the early 90s. It was shaped by the relatively high capacities of the old Czech HC system and a widely shared willingness to increase HC resources in the first year of the reform. The reform itself has introduced a new system of public health insurance and changed completely the situation with respect to HC providers' autonomy and financial conditions. The reform has introduced a new system of public health insurance and changed completely the situation of HC providers in terms of their autonomy and financial conditions. It also reversed the set of measures and tools available to public authorities reformulating health policy. It brought a new player into the system – an independent payer -- health insurance companies (HICs).

The ability to respond to major system changes has proven to be quite remarkable within the community of health care providers, as well as within HICs. In spite of the constant concerns of many interest groups, including politicians and patients' associations, there has not been any deep crisis of the system. On the contrary, the quality of care was evaluated as "good" in many public polls in the first years of the reform. Needless to say, there are certainly many shortages and other issues in the Czech health care system. Wasted funds, the growing indebtedness of many health providers (especially hospitals) and the still unclear role of new regional authorities in the system are among them.

The reform has not been completed yet and one can see government attempts to reverse some of fundamental principles, i. e. putting the control over the system back in the government's hands, bringing back a larger role for government, diminishing "harmful and contradictory" competition that is no longer ideologically desirable in public services, etc.

Education and training programs seem to have had a growing influence on enhancing the capacities and skills necessary for managing such changes. First, programs were mainly run by foreign aid agencies (i. e., Project HOPE), and they addressed top management, such as directors of large health facilities, in order to provide them with managerial skills important for the new "market" economy. Very rapidly, several national institutions (universities and others) developed their own programs. Most of them combined business and management education and

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training² with an introduction to health care economics. Their target groups were current and potential managers and administrators of health care facilities as well as health professionals (e. g., physicians and nurses). This orientation was quite understandable. It was the consequence of the significant increase of autonomy and decentralization in the system.

The other relevant field of competence – public health administration and policy – seems to have fallen behind (not only in terms of number of programs and their graduates, but in comparing their real impact on the system). There is a widespread belief that public authorities' abilities to create and implement visions, strategies, policies and preferences resulting from thoughtful analysis are limited. Naturally, there are many reasons for this, and a failure of education and training programs in this field is definitely not the main one. However, given the current situation in public health administration, management and policy education and training programs, increasing the quality and availability of “pure” public health administration and policy programs for (mainly) public officials at the regional and the central level should be a priority for the next several years.

2. Public Administration System and its Reforms

The Czech Republic (CR) and its public administration (PA) followed the same orientation and ideology as the other socialist countries of Central and Eastern Europe after the World War II. There was a centralized, hierarchically organized system of regional, district, and local “National Committees” (NCs). Formally, it was a joint model of public administration (NCs were institutions of self-government as well as state administrations). However, since there was virtually no split between professional administration and communist party structures, the self-government part of this model was marginal.

After November 1989, there was an urgent need to rebuild the whole system. Democracy could not be fully achieved within the old environment. An increased role for local self-governments and the decentralization of government responsibilities and financial resources, etc. were seen as the main means for reaching the following objectives:

- giving greater credit to effective PA within the public sector;
- changing PA from a tool of the state to a modern concept (i. e., view “PA as a service for citizens”); and
- fighting corruption and improving accountability.

Local and Regional Public Administration and its Reform

In 1990, the structure of National Committees was abolished and a new Municipal Act (367/1990 Sb.) was adopted. At that time, the only level of regional self-government was the municipal level, although a potential second level was frequently

² Examples of courses were human resources management, planning, and financial management.

discussed. It took several years of political battles to reach a political consensus on the major issues, which included:

- whether the primary principle should be to respect territorial aspects or to renew the historical “countries” of Bohemia, Moravia, and Silesia;
- the number and size of regions (including the very controversial issue of a “capital” of each region); and
- whether to use a traditional joint model of governance or to apply a separate model that divided self-government and state administration into two different bodies.

On the other hand, state administration itself was executed at three levels at that time:

- the local level, executed by municipalities (again, the so-called joint model of PA);
- the district level, where new District Offices (DOs) were established as executive bodies, with a general jurisdiction; and
- the central level, with a Cabinet.

There also were special (so called “de-concentrated”) executive bodies in the districts and even former regions founded and administered by particular ministries (e. g., Labour Offices, Offices for Social Security, etc.). There was no coordination between ministries, however, and this vertically organized scheme of state administration suffered from a lack of cooperation between the different branches of state administration.

There was a clear lack of proportionality in this system, as well as a lack of opportunity for comprehensive regional development. This was accepted by the Cabinets that followed. As a result, a second-level of regional self-government was finally established in 2000. Fourteen regions were set up. The government chose the joint model of PA. The logical consequence was the proposed abolition of the District Offices in 2002. This step raised a serious concern and was heavily criticized as too risky, because DOs were probably the most stable and most effective part of state administration. There is still a concern about the ability of municipalities to handle all necessary responsibilities.

Although it is too early to evaluate the outcomes of these changes, the main issues linked to this part of the PA reform can be identified:

- with respect to property matters, the entire process consists of numerous complex transfers (mainly top-down) of ownership, liabilities, and rights among various levels of government;
- regarding financial flows, determining a proper share from centrally imposed taxes to be transferred to regional budgets to support the new responsibilities at this level seems to be a task that will require several years of negotiations, evaluations, and analysis;

- delimiting the responsibilities of former district officers is an example of the naturally colliding interests of different levels of government; the regions and municipalities fought hard against a centrally managed shift;³ and
- the “state” (the central level) has to learn how to pursue national priorities and policies within a different environment; with the shift of former “state” institutions to regional ones, the central government seems to be slow in preparing legislation to enable it to maintain national standards in various branches of public services.

Reform of State Administration at the Central Level

The central level of the state administration has seemed to be out of focus for a long time - with the European Commission, the OECD, and the Council of Europe repeatedly criticizing government decision making processes as overly centralized, too complicated, and unclear. Human resources at this level were criticized, also. However, until 2001 changes were just marginal. “There was a fundamental failure in a wrong belief [about the government] that there is no need for reform on a central level ...” (Vidlakova 2001: 41).

In 2001, the Cabinet adopted the “Conception of Modernising the Central State Administration” in which short-term and middle-term priorities were presented. Harmonization of the internal organization of ministries and other central offices was to be achieved by 2002. Increased efficiency and coordination of horizontal responsibilities and processes, better management, and the enhancement of strategic and conceptual functions were set as middle-term priorities.⁴

Since 2002, the new government has declared the “beginning” of the central state administration’s modernization as its priority program. The government’s main objectives are greater efficiency, more rational decision making, the broader use of advanced technologies (including e-government), and the introduction of managerial methods.

Education and Training for Public Officials

In 2001, the European Commission criticized the Czech Republic for a “regrettable” absence of the proper legislation needed to insure sufficient professional status for public officials -- including a system of permanent education and training. Several attempts were made to pass the Public Service Act addressing this issue. Parliament always blocked the government’s proposals, even though major political forces generally agreed on the necessity to increase the professional abilities of officials. Thus, there was no coordinated system of education and training for the PA and human resources management was poor. An essential objective of PA reform was to solve these issues through the compulsory education and training of public administration officials.

³ More than 14,000 working places had to be shifted.

⁴ The European Union PHARE project is essential for this effort.

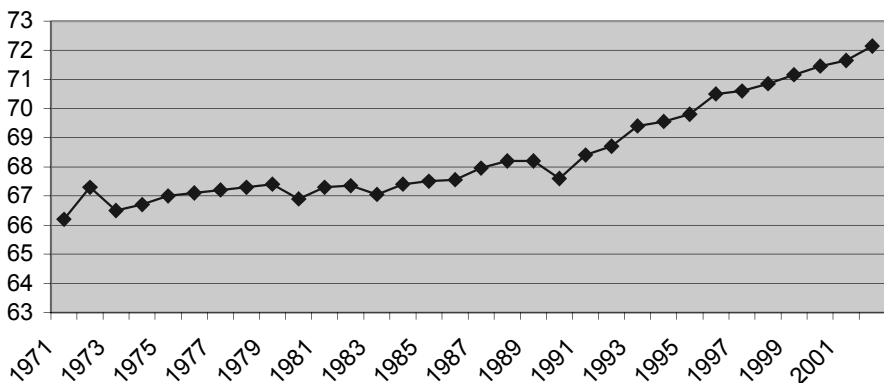
The year 2002 represented a breakthrough in this respect. Two major acts were passed: the Civil Service Law (218/2002 Sb.) and the Public Service Law (312/2002 Sb.). As a result, the position of public officials has become more solid; at the same time, compulsory education and specific duties were imposed on them.

A sophisticated permanent education and training system was established by the latter act. Officials must participate in specific programs that are approved and monitored by a special government agency but that may be provided by various accredited institutions. The process of accrediting training institutions and programs began in 2002; the programs themselves began in 2003.

3. Health Care System

Although the transformation of the Czech health care system is not yet complete, it can be described as a relatively well-equipped system, providing high quality health care as well as relatively equal access to health care. The health status of the population is improving, and a significant prolongation of expected life span has occurred (see Graph 1).

Graph 1. Life Expectancy at Birth for Czech Republic Males (in years)



Source: UZIS (2002).

There is definitely not an alarming crisis of the health care (HC) system in the Czech Republic. There still are, however, several unpleasant failures in the system. The entire system seems to suffer from growing financial instability. The Ministry is said to have inadequate capability to control the system. The same (or perhaps an even worse) situation exists at the level of the newly created regions since their roles and responsibilities also are not clear.

Health Care Reforms

There was a need for significant changes in the HC system even before 1989. Health professionals spoke openly about a rising crisis in the system. The fall of the former Communist regime opened the door for radical reform. The first reform proposal

was published in 1990. The Working Group for Reform (SKUPR), representing a large part of the health professionals' communities (mainly physicians, academics, and economists, etc.) advocated the following reform principles, which were more or less realized through future reforms (SKUPR 1990):

- transparency;
- economization;
- democratization;
- humanization; and
- a higher standard of quality of care.

The new system brought especially radical changes in organizational and institutional structures, funding, and reimbursement methods.

Changes in Organizational and Institutional Structures

An important part of the reform was the separation of payers and providers of care. A new participant in the system was established – Health Insurance Companies (HICs). A contractual model replaced an integrated one. Existing institutions (so-called National Institutes of Health, or UNZs) were transformed into a network of independent, relatively autonomous health care facilities that became regular legal entities making decisions in their own name. While there were only about 430 health care facilities in 1991, by 1995 more than 22,000 existed (a physician's private practice was considered to be an independent health care facility). New non-state and private facilities were founded. State institutions were transferred to municipalities, some hospitals were privatized, and most outpatient care was privatized, also.

Changes in Health Care Funding

The transformation from a NHS model funded through the government budget to a system of compulsory, universal public health insurance was possibly the most important element of the reform. There were several reasons for this strategic change:

- It was important to keep the current level of broad access to care for all citizens as a central pillar in the new system.
- Health insurance has had a long tradition in Czechoslovak history and also is quite common for the Czech Republic's neighbouring countries in Central Europe.
- There was a widespread belief in the need to introduce new methods of reimbursement for medical care which reflected the quantity and quality of care.
- Insurance (a contractual model) created an environment that was much more friendly for the privatization of medical services.
- The need to make financial flows more transparent in order to make the public more aware of the real costs of (i. e., the expenditures on) medical care; the belief was that this approach would create an incentive for the general public to be more responsible and take better care of their own health.

The system was designed as a multiple payer one. HICs are not-for-profit, public-law, self-administered entities, although special legislation (adopted in 1991-1992) strictly regulates their functioning. HICs are open; citizens may choose their insurers.

Health care is funded from several sources (see Table 1). The main source is public insurance premiums collected by HICs. Employees, employers, and the government pay insurance premiums, with the amounts based on income. Out-of-pocket payments represent less than 10% of total expenditures (mainly for drugs); and public budgets have played a more important role here.

Table 1. Health Care Expenditures (million CZK) *

YEAR (1)	TOTAL	PUBLIC				PRIVATE	
	(2)	(3)	Total, including		Total ²⁾		
			Total (8)				
(3) + (8)	Central and Local Budgets		Health Insurance Comp.				
	Total (4)	Non-Investment (5)	Total (6)	Health Care (7)			
	45,652	43,552	43,552	36,971	32,479 ¹⁾	32,023	2,100 ³⁾
1993	73,062	69,262	13,027	6,114	56,235	52,290	3,800 ³⁾
1994	86,418	81,136	13,791	7,052	67,345	63,633	5,282
1995	100,675	93,309	15,076	7,674	78,233	74,168	7,366
1996	110,662	102,400	12,641	7,212	89,759	86,088	8,262
1997	118,914	109,033	11,459	7,015	97,574	93,145	9,881
1998	129,871	119,267	11,769	6,408	107,498	101,450	10,604
1999	134,928	123,453	13,128	7,418	110,325	106,351	11,475
2000	141,871	129,626	13,708	7,164	115,918	111,397	12,245
2001	158,799	145,096	13,960	8,052	131,136	126,649	13,711

* Excludes expenditures of other government departments (approximately another 1,000 million CZK).

1) Reported in the central government's budget (the year 1992 had a special financial regime).

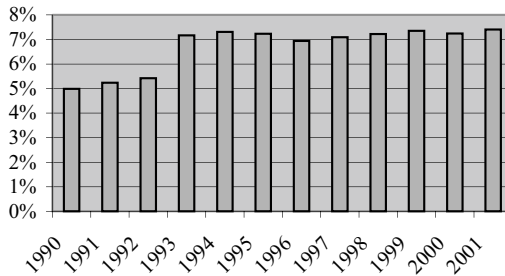
2) Calculations by ÚZIS ČR, based on regular statistics of "households' budgets" (ČSÚ).

3) Estimated by ÚZIS ČR.

Source: ÚZIS (2002) (modified by author).

The impact of the reform on the system's overall financial situation is clear from Graph 2. The introduction of the new insurance scheme was associated with a sharp increase in expenditures. The system has had to search for a financial balance, and this is still a major issue.

Graph 2. Health Care Expenditures as Share of GDP (%)



Source: UZIS (2002).

Changes of Reimbursement Methods

Formerly, national health system institutions were paid from annual general budgets based on historic cost patterns. Even in the late 1980s, this method was criticized as providing strong economic disincentives. There was no linkage between either quantity or quality of provided care and reimbursements for physicians and the health facilities.

The new system applied a fee-for-service scale, with a cap on total health care expenses. It applied to all services, including in-patient and general practitioner (GP) care. This appeared to be a mistake after a short time, and important changes were adopted in 1997. A combined capitation-performance payment was introduced for GPs, and hospitals began receiving mostly lump sum payments - based on their output in the previous year.

Impact of Reform Changes on Health Care Managers' Professional Profile

In the past, the typical hospital director was a physician with some postgraduate training and special attestation. Health care services were considered to be a field of "social consumption"; the system was highly centralized, with each facility having limited autonomy. This naturally had certain direct implications on the prevailing professional skills of managers. Since the only economic task was to stay within the budget, there was absolutely no data on cost of services, and managers had limited knowledge about actual output. Economic criteria played only a marginal role in decision making, especially with respect to investment, new equipment purchases, and the like.

The reform created an entirely new environment for health care providers. Skills essential for the successful management of independent health facilities (e. g., financial analysis and management, strategic management, managerial/business accounting, marketing, information systems management), were lacking. Essential skills in the field of public health policy and administration were missing, too, but this absence was less evident and, except for a few academics, nobody was overly concerned.

Starting from the first years of the reform, filling this gap was an objective of many education programs. Some foreign aid agencies (e. g., USAID, Project HOPE, World Bank) initialled pioneering programs in this field. The supply of managers with the necessary new skills increased, driven mainly by local universities and professional education agencies.

Nevertheless, as the Czech Republic faces probably its biggest health care challenge in the past five years, namely, the introduction of the regional level of self-government and the determination of its proper role within national health policy (under growing pressure due to resource scarcity), the persistent lack of public policy and administration skills is more apparent.

4. Public Administration Education and Training Programs

Skills and knowledge are essential for the successful implementation of reforms. The education and training system in public administration/public management (PA/PM) has three main target groups:

- regular students – young people looking for future careers; universities and other schools within the education system primarily provide programs for them;
- current state administration officials at the central level – they seek mainly short-term training and education programs that are offered by various institutions. Part-time university degree programs are available to them; and
- current regional and local public administration officials – a system for their training and education is an important element of the reform. Special legislation (Public Service Law, 312/2002 Sb.) was adopted to build up a comprehensive system of education and training for this group.

Academic Programs in Pa/pm

Programs in public administration/public management are offered by high schools, upper vocational schools, and universities. These institutions primarily offer basic education for future public administration officials, but they also provide more advanced education for officials and offer some training courses.

Universities represent the main part of this system. In 2003, there were eight faculties/schools (in Prague, Brno, Pardubice, and Ostrava) with comprehensive bachelor's, master's, or doctoral programs in public administration or regional development. Courses in public administration or in related subjects like public finance, local finance, public economics, and administrative law also are regularly incorporated in many other programs (Wokoun and Nemeč 2000).

There is growing interest in PA/PM study in the Czech Republic. In addition to the traditional schools (University of Economics in Prague (3 faculties), Charles University in Prague, Masaryk University in Brno, University Ostrava, University Pardubice), new private universities are seeking to provide bachelor's programs in PA/PM. One of these institutions, for example, "Vysoká Škola Finanční

a Správní” (The School of Finance and Administration), focuses exclusively on public administration officials.

Given the relationships between public administration and the formerly underestimated regional problems, on the one hand, and the provision of graduates in territorial administration, on the other hand, schools have begun to provide a common major field of study in public administration and regional science.

The universities’ main role is to prepare future employees for public administration. They also offer part-time programs (mostly at the bachelor’s degree level) for current public administration employees and play an important role in the new system of education for regional self-government officials by offering short courses and special training programs under the supervision of the Ministry of Interior. In addition, universities serve as important centers for research and development.

Training for State Administration Officials at the Central Level

The Civil Service Law created a basic framework for this system; however, the law will not be fully implemented until 2004. It addresses the obligation to provide education and training activities for officials and to organize them for state authorities. The State Official Examination is defined in great detail.

There are three different categories of education and training:

- that provided by the special educational institutions; in particular, government departments;
- programs conducted directly by the institution employing an official; and
- education and training purchased by authorities from other institutions, domestic as well as foreign ones.

Central authorities establish departmental training institutions whose task is to provide special training for officials working within the departments. The Diplomatic Academy, Police Academy, and Institute of Postgraduate Education for Health Care Professionals are examples of such institutions. The Institute of State Administration (IMS) has a special position. It was founded as a result of the Civil Service Law and is supposed to fulfil special tasks, e. g., organize cross-sectional programs, provide information services for all central authorities, and guarantee the quality of the entire national training system. The IMS also is participating in the definition of requirements concerning the educational profiles of state officials. [This role of the Institute is significantly underdeveloped, according to some of its employees.]

Various ministries frequently use foreign aid resources (e. g., the European Union PHARE program; individual donor nations) to provide advanced education for their officials.

Training for Regional and Local Authorities’ Officials

A completely new, comprehensive training system for regional and local officials was initiated in the Public Service Law (312/2002 Sb.). The law provides that

officials have an obligation to take part regularly in proper training under an individual qualification plan. Authorities are either supposed to provide an accredited program for regional and local officials, or to purchase them. There are four kinds of programs:

- “entrance training” for new employees;
- required “Special Professional Abilities” (ZOZ) courses, which include special final examinations, for certain officials;
- “general training programs,” which include a variety of programs enhancing officials’ special knowledge of administration; and
- education for executive officials -- to be completed within four years by any official who leads subordinates.

Programs include modules that can be combined in different ways. Institutions offering any program to public administration authorities, as well as programs themselves, are subject to the approval (accreditation) by the Ministry of Interior and its Special Accreditation Commission.

The Commission started its work in October 2002, and thus far it has approved several hundred programs offered by very different educational and training institutions. Almost all regions have created their own educational capacities in order to provide at least entry-level training for their employees and for the municipalities in their jurisdictions. Many private companies compete for this stable and interesting education and training business; not-for-profit organizations, including universities, also are involved (the number of entitled officials is in the tens of thousands).

Problems of Accreditation Process

The system of accreditation (relating to the right to deliver training programs for civil servants within the framework of the Civil Service Law) illustrates issues of rhetoric and reality regarding public policy and its implementation (issues that are symptomatic of the entire Central and Eastern European region). The accreditation process has been implemented in a way that can easily serve as an example of typical government failures, primarily due to limited control over the bureaucracy and the limitations imposed by political processes (Stiglitz 1988). The government is hardly able to implement its policy in a consistent way; it especially has failed to transform generally relevant and desirable principles into proper legislation.

The new civil servants’ education and training system is supposed to be built upon the progressive principle of managed competition. A new market of education and training programs provided by public and private entities was envisioned. Regional and local authorities were supposed to have the opportunity to choose the most appropriate programs for their civil servant employees relative to the prices and orientations of the programs.

Quality assurance is clearly a key goal of this system. Many education and training programs and providers in the past have been evaluated by their participants, or by public authorities, as incompetent, of poor quality, obsolete, and worthless.

Lecturers often know little about public administration, and their pedagogical skills were low. Local and regional public administration representatives sought a clarification of the education and training market, and the setting of rules to avoid the problems of the past.

Consequently, the new system of education and training introduced a process of accreditation (analogous to the accreditation system that works well in the field of university education). A special Accreditation Commission of the Ministry of Interior was created to approve training programs as well as the institutions offering them.

During the process of approving the relevant legislation in the House of Representatives, the text prepared by experienced officials from the Ministry of Interior was substantially changed. Due to the influence of public administration employees' trade unions, almost all provisions requiring officials to pass any examinations "disappeared" from the proposed bill.

In addition, the process of the gradual "specification" and "clarification" of the formal requirements for accreditation proposals, as well as conditions for approval, have greatly limited the opportunities for any real assessments, evaluations, and decisions by the Accreditation Commission. Its role has come to be quite formal. Even some members of the Commission (who are nominated from respectable academic and/or professional quarters) admit that they deal more frequently with the purely formal requirements of applications rather than assessing a program's real value in terms of the quality of the content, lecturers, and the like. Accreditation is sometimes granted even though none of the Commission members truly believes the applicant is able to deliver a quality program. The entire process seems to have a typical Czech, "Kafkaesque" feature: the new law is obeyed, but the old reality stays the same.

5. Current Education and Training Activities in The Area of Health Care Administration, Management, and Policy

The need for a higher level of managerial skills, including knowledge of public health management and policy, has been evident from the beginning of the reform. Until the early 1990s, only one institution offered postgraduate education in the management of health care facilities and public health, the Postgraduate Education Institute for Medical Professionals – School of Public Health (IPVZ). Its curricula reflected both the different ideologies and the different positions of the entire health care industry.

Some health policy or public health courses were taught at medical schools. Programs addressing health care administration, management and policy, as currently understood, generally did not exist.

This gap was filled for several years in the following ways:

- IPVZ modernized its study programs, underwent substantial changes, and became a more flexible, demand-oriented institution.
- International aid was essential for strengthening early initiatives, especially the program provided by Project HOPE, through which many hospital directors were trained; programs supported by the World Bank (Flagship programs) and USAID/AIHA also significantly improved the professional skills of health care workers and academics.
- Later, universities, and some private firms, entered the market, offering MBA and other programs for health services managers as well as short-term courses such as business accounting and financial management.

The current scope and scale of education and training activities for health managers and policy makers is much broader (see Appendix A and Appendix B). However, the dominant segment of current programs focuses mainly on managerial skills (and these programs are primarily offered to health care administrators and hospital managers), rather than on necessary public administration and public policy knowledge. An ability to design a public health policy and to implement it in a given region or community is simply not covered sufficiently.

There are several reasons for this lack of coverage, both on the demand side and on the supply side. The demand for managerial skills was much stronger and was driven by several key “players,” including medical facilities (mainly hospitals), physicians interested in setting up their own practices or private clinics, health insurance companies, nurses, etc. The demand for health policy skills was driven only by the central government for many years, and this demand was not intensive. But there is now a growing demand for such skills. Today, the situation has changed – regional offices need to find specialists knowledgeable in designing and implementing regional health policies and able to deal with the many acute problems (e. g., a reduction in the number of beds, emergency services organization and funding, medical transportation). At the same time, however, a shortage on the supply side can easily occur. Teaching management seems to be much easier than teaching policy, especially within the changing, turbulent environment that now exists.

“Standard” Academic Program in Health Management

Since there was no required curricula to educate health managers, international know-how was used to start such programs (for example, universities in Jindřichuv Hradec, Hradec Kralove, and Olomouc and also IZVP Prague were involved in a USAID/AIHA project to establish sustainable academic programs in health services management and economy). There were two U. S. partner universities: the University of Nevada and the University of Virginia. As a result, most schools now use similar curricula and program structures, usually realized at the bachelor’s level program, and delivered by the school of economics or the medical school.

The “standard” program has typically been designed as a specialization of some broader program in economics or management. The following subjects (or fields of study) can usually be found in the curricula:

- health care economics (introduction to HC economics; medical markets analysis; demand for and supply of medical care and health insurance; rationing supply and demand; adverse selection; methods of economic evaluation, etc.);
- finance and health finance (funding, reimbursement methods, economic incentives, financial management, pricing);
- health care systems (organization, comparison, capacity assessment, reforms);
- managerial epidemiology;
- medical quality;
- statistics for health care information systems;
- management (planning, organization, leadership, motivation, control), clinical management, human resources management;
- health policy, including objective and preference setting and evaluation of health care systems;
- medical law; and
- public administration and health care.

Training Programs in Health Management

The first activities conducted or supported by foreign aid institutions (e. g., Project HOPE in 1992-94) were oriented to current hospital managers and high-level public officials. [It should be noted that, both at that time and now, there have been no explicit compulsory requirements to keep or hold managerial positions in the Czech Republic in terms of special health management education.]

The second wave of training programs was aimed at the middle management level – nurses, physician’s practice administrators, and the like. The basic hypothesis was that the role of this management group would increase significantly. The formation of group practices of private physicians was expected, and the emergence of a new profession of health services administrator was anticipated. This prediction has not yet been fulfilled, though. Czech private physicians still prefer an individual practice, and most of them deal with necessary administration on their own or with the help of their families. They see few benefits from having a professional do that job, given their own low level of remuneration for their work. In addition, hospitals have not created additional administrative jobs since mid-level management is conducted effectively by current personnel, mainly by registered nurses. Due to limited demand, then, the supply of training programs, as well as academic programs, decreased at the beginning of the 21st century.

A boom in training activities might occur since the system of public administration has changed. The role of regions as well as municipalities is greater; correspondingly, there is a greater need to teach officials how to deal with their new regular agendas effectively as well as to offer courses for health departments’

managers. Officials are likely to seek evaluation, assessment, and planning skills, as well as logistics, crisis management, and public relations skills.

At the moment, though, this does not seem to be a priority for the new regional authorities. They struggle with a lack of money as they seek to solve their most urgent problems (e. g., the indebtedness of former state hospitals). While dealing with emergencies, they do not have sufficient power to establish their own regional health policies and the related system of education and training.

6. Conclusions

The Czech Republic is one of the most developed of the transitional countries and is expected to join the European Union in 2004. Its health system was heavily reformed after 1989, with privatization and the introduction of a health insurance-based system of financing as main features. An important outcome of the health care reforms is a more or less privatized health care system (from the point of view of producers of services), but one that is still based on the principle of universal access (i. e., health services are more or less accessible for everybody through social health insurance). Most recent problems of the system are connected with finance; other elements, including access, quality, and the health status of the population, reflect positive trends.

With the privatization of the delivery of health services and the use of market-based instruments to finance health care, the need for health managers is evident. Decentralization also increases the need for greater numbers of well-educated and trained health policy makers; policy making and implementation currently are the weakest parts of health care reform in the Czech Republic.

In the current Czech health care system, there are many positions that should be occupied by health managers and policy makers. For this reason, it is difficult to develop any single “optimal” health manager’s profile that fits all of the potential requirements of the current system – and thus it also is difficult to describe what kind of education and training is most required.

Despite the fact that there are many excellent, well-skilled and successful health managers and hospital directors who are trained as physicians, it is likely to be more effective and less expensive to educate economists, managers, or administrators to understand health services specificities than to educate medical doctors to be managers. However, since effective management often is due to factors other than knowledge, especially during the turbulent and changing times of health care reform, teaching health care management and policy to current hospital directors (mostly physicians) has had good results in terms of the management of health care facilities. Managerial skills are not generally considered to be a major issue in the Czech health care system.

More and more frequently, politicians are said to be incapable of designing a better health care system, with financial instability by far the most intense issue. However, the main finance-related reform failures can be found on both sides of

the “battlefield” – caused by the failures of executive managers in the system, as well as by the negative external influences of poor government policy. When both policymaking and system management do not perform properly, it is not surprising that certain expected outcomes of health reform (privatization, and the introduction of a social health insurance financing system) do not adequately occur, and, consequently, the reform has failed in some of its dimensions.

A future vision of the health care system is not yet clear in terms of the roles of the state, the regions, health insurance companies, and autonomous health care facilities. Yet this situation should have only limited influence on the training that health managers and policy makers should have, since the key skills are quite universal. Nevertheless, this uncertainty causes some difficulties for health policy education programs. Future target groups are not clear; moreover, the demand for these programs seems to be too low.

The increased roles of the regions and municipalities are expected to introduce a new stimulus. Municipal and regional self-governments must seek proper programs in order to learn how to deal effectively with their new agendas. Evaluation, assessment, and planning skills, as well as logistics, crisis management, and public relations skills, are likely to be in increasing demand.

The current system for delivering health management education and training in the Czech Republic is relatively comprehensive and diversified. Yet the limited demand for academic and training programs (due to a lack of newly created managerial posts in the medical establishment and doctors remaining in their current management positions) and the limited demand for training delivered by non-health care institutions in the training market have negative impacts on its structure (e. g., some universities have recently ceased their programs). The link between health management education and training delivered by medical institutions and that delivered by public administration schools, created in the earlier phase, is threatened in such conditions, although new impulses (like decentralization and de-monopolization of the training market) may help revive it.

The main gap in the Czech Republic is in the field of health policy education and training. Although there are key institutions (e. g., Charles University in Prague, Masaryk University in Brno, Health Policy and Economics Institute in Kostelec), this subsystem does not, in reality, function. The Czech Republic has already paid a significant price for this situation through reform failures, and it is hoped that further decentralization will increase the status of policy making and implementation theory and practice generally – and in health care, particularly.

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- Zákon č. 148/1998 Sb., o ochraně utajovaných skutečností a o změně některých zákonů

- Zákon č. 101/2000 Sb., o ochraně osobních údajů a o změně některých zákonů
- Zákon č. 349/1999 Sb., o Veřejném ochránci práv.

Appendix A.

List of Current Academic Programs in Public Health Management and

Institution	Masaryk University BRNO School of Econ. and Admin.	Charles University PRAGUE School of Humanitarian Studies	University of HRADEC KRALOVE School of Informatics and Management	Military Medical Academy HRADEC KRALOVE	University of Economics, JINDRICHUV HRADEC School of Mgmt.	Palacky University OLOMOUC Medical School	University of OSTRAVA School of Health and Social Matters	University of OSTRAVA School of Health and Social Matters	Charles University PRAGUE 3 rd Medical School
Program	Public economy and administration	Social policy and social work	Health services management	Military health management	Health services management	Economics and management of health care	Public health	Economics and management of health care	Public health
Specialization	Health care economics and management	Management and supervision of health services facilities				HC management	Public health protection		
Kind of degree	BC	MA	BC	BC	MA, BC	others	BC	BC	BC
Form	part-time	full-time part-time	full-time part-time	full-time	full-time part-time	full-time	distance	distance	full-time
Standard length (years)	3	3	3	3	2, 3	3	3	3	3
Started	1995	2002	1998	N/A	1997	1999	2002	1993	1993
Cancelled (if applicable)	2002		2003						
Graduates, students (avg./year)	30	59 (enrolled in 02/03)	16	5	24; 5	5	26	40	15
Graduates profile	administrators PA officials	top managers administrators	administrators	administrators	administrators, PA officials	all levels managers and PA officials	PA officials, state health administration supervisors	PA officials	PA officials
Target group	secondary school graduates registered nurses	BC graduates registered nurses	secondary school graduates	registered nurses	secondary school graduates	BC graduates	secondary school graduates, registered nurses, managers	secondary school graduates registered nurses	secondary school graduates
3 main skills, fields of study	administration, economics, health policy	analysis, economics, field work	human resources management, sales management, marketing	n/a	health policy, law, economics	n/a	medicine, law	economics, public health, management, (nursing)	medicine, hygiene, management
Economics/mgmt.: HC policy; other (approx. ratio)	10:6:6:12	7:12:11:9	11:5:12:9	n/a	2:1:7:1	13:9:6:8	1:10:3:40	6:7:1:7:5	2:2:2:5:5
Greatest advantages	theoretical background in HC economics, finance	innovations, research activities, international relations	co-operation with Univ. of Nevada (AIHA project)	n/a	complex and balanced preparation to solve real problems	n/a	interdisciplinary program	comprehensiveness	n/a

Appendix B.

List of Main Training Programs in Public Health Management and

Institution	Title of the Course	Length	Admission	Specification	Link
Military Medical Academy Hradec Králové	Organisation and management of military medical services	26 weeks	15	Ministry of Defense	
	Organisation and management of military pharmacy	weeks	3	Ministry of Defense	
	Hygiene, occupational sickness	6 weeks	5	Ministry of Defense	
	Medical services	6 weeks	6	Medical services management in the Army	
Postgraduate Education Institute for Medical Professionals – School of Public Health Praha	State administration reform: 2003 special course	1 day		Disability-assessing physicians	www.ipvz.cz
	Special seminar: Public health care and medical law for 1st grade attestation	1 day			
Local Administration Institute Benešov u Prahy	Preparation for a special professional ability examination of public officials			Rule MVR . 345/2000 Sb.	www.mvcr.cz
CMC Graduate School of Business Čelákovice	Health care management	9 days	80	Medical facilities' directors and top management	www.cmc.cz
	Dynamic manager in medical services	13 times-3 day modules in 2 years		Middle and upper levels of management	
Project HOPE	1-day seminars on management of medical services				www.projecthope.cz
	Management of changes: Increasing the role of middle management	16 days	3-member-teams from 20 facilities	Medical facilities management	
Prague International Business School (PIBS)	MBA in Health Services Management	n/a	n/a	Managerial teams from large hospitals	

Public Health Management and Policy Education and Training: Georgia

Nana Sumbadze and Khatuna Dolidze¹

1. Introduction

Deterioration of the population's health in recent years is acknowledged as one of the biggest recent problems in Georgia. Poverty, a meager state social safety net provided to an extremely limited segment of the population, poor environmental conditions, improper diet and food scarcity, exposure to high levels of stress, ineffective health policy, improper management of health care facilities and the low accessibility of health care – all have contributed to this decline in health.

The dissolution of the Soviet Union caused the disruption of the existing system of health care. Health care reform was launched in 1995 to answer the need to establish a non-centralized system of health care. In 1996, new laws established the foundation for launching health care reform. The main focus of the reform was on the privatization of health care facilities and the transition to coverage of the population by a state insurance system. The reform entailed reorganization of medical education, creation of a licensing system and accreditation of courses, and continuing medical education. It also sought to reduce the number of medical facilities and to decrease the number of people employed in the health care sector.

Today, 32 medical universities/colleges (2 state and 30 private) grant degrees in medicine. Two offer academic/semi-academic programs in public health/public health care and management. Students at most of the medical schools have to pass 18 to 96 hours of courses in public health care and management. Many training courses in health care management are delivered by education and training bodies; however, public administration schools and/or programs offer none of them. There also is no health policy program offered in Georgia.

Head doctors of all clinics are physicians by education (this is an unwritten rule), but starting last year they are required to have a certificate in public health care, management and organization. The certificate is obtained by passing an exam. The system of continuing education fully launched in May 2003 seeks to ensure that medical staff personnel are upgrading their theoretical knowledge and skills. Initial certification, and then re-certification every subsequent five years by earning credits or passing exams, is now required for obtaining and retaining a license to practice medicine.

2. Country Profile

Georgia is situated south of the Caucasian mountains, bordering Russia on the North, Turkey and Armenia on the South, and Azerbaijan on the East. Its western

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region is adjacent to the Black Sea, while the northern region is dominated by the high mountains of the Great Caucasus range, where some of the highest peaks reach above 5,000 meters. The climate ranges from subtropical Mediterranean to continental. The location and the differences in altitude contribute to the diversity of relief, climate and soils, which in turn determine the diversity of agriculture, ways of living, and traditions.

After more than a century of Russian occupation and 70 years of being a part of the Soviet Union, Georgia declared its independence in 1991. Its population is about 4,600,000, of which 57.8% is urban. The majority are ethnic Georgians (70.1%), while the largest minorities are Armenians (8.1%), Russians (6.3%), and Azeris (5.7%).

Georgia adopted Christianity in the 4th century. The majority of the population belongs to the Eastern Orthodox Church. There are also significant numbers of Armenian Gregorians, Catholics and Muslims. The state languages are Georgian and Abkhazian (spoken in the territory of the autonomous republic of Abkhazia). The Georgian language has its original alphabet, dating back to the 5th century AD or even earlier.

Georgia is a presidential republic. The Parliament has 235 seats, elected through a mixed-proportional and majority voting system. Georgia is striving for integration with Europe, and in 1999, it became a member of the Council of Europe.

3. Health Care System

Before Georgia declared independence in 1991, its health care system was part of the Soviet health care system, which operated on the basis of the “Basic Law on Health in the USSR and Soviet Republics” enacted in 1964. This was a totally centralized, entirely publicly owned and controlled system. All planning, allocation of resources, and control were concentrated in Moscow. The system guaranteed free access to health services, although “out-of-pocket” payments for received services were quite common. Every person was registered at a district polyclinic and, according to her/his residence, was assigned to a doctor that was not possible to change. In addition to general practitioners, polyclinics had specialists, but in the case of serious problems polyclinics referred patients to public hospitals. Hospitals provided treatment, medication and food free of charge. Patients paid for the medication prescribed in polyclinics. Polyclinics and a majority of the hospitals, despite their large capacity and large number, were usually crowded.

Health Care Reform

After declaring its independence, the financially and organizationally weak Georgian state was not able to maintain an expensive, overstaffed and oversized health care system. It was impossible to cover the costs. The deterioration of the system was further aggravated by improper administration (Gzirishvili and Mataradze 1999).

In 1993, Georgian experts, in close cooperation with the World Bank, designed a Georgian health care reform package, and the reform was launched in 1995. Its enactment was based on legislation passed in June 1995, as well as on several decrees issued by the President and the Cabinet of Ministers in 1994 and 1995. The legislation outlined the principles of the privatization of health care institutions – either by allowing the employees to buy shares, or by the auctioning of the shares. Institutions were given one of three options: keeping inpatient profiles for 10 years; maintaining outpatient profiles for 10 years; or being privatized unconditionally.

The main reform objectives can be summarized as follows (Gzirishvili and Mataradze 1999):

- decentralization of health care;
- innovation in financial and economic foundations, including program-based funding;
- prioritization of primary care;
- transition to medical insurance coverage;
- privatization;
- accreditation and licensing of all medical institutions and personnel; and
- restructuring medical education, medical science, information service, and drug policy.

Health care reform has proven to be one of the most controversial of all reforms carried out in Georgia since independence. In fact, it has pitted doctors and patients against each other and resulted in discontent on both sides. Seven years have passed since its launch, and although health care reform undoubtedly has been necessary, so far it has not brought any relief to the population, with morbidity steadily increasing across almost all nosologies.

Health Status Of Population

Reliable conclusions about the dynamics of mortality and morbidity in Georgia cannot be drawn from the country's inefficient registration system. According to official statistics, mortality has declined; however, experts estimate that the mortality rate has increased steadily from 6.4 in 1996 to 8.2 in 2000 (Tsuladze and Maglaperidze 2000). The difference may be explained by the fact that a considerable number of deaths are not registered. In rural areas, for example, there is no real need to register deaths, which are associated with expenses.

The numbers reflecting cases of diseases per 100,000 inhabitants are also not absolutely reliable due to inefficient registration and the unreliability of data on population size. Prior to the 2002 census, the last census was conducted in 1989. After 1989, considerable migration occurred, which was largely unregistered. This, together with the low rate of attendance at health care facilities, points to morbidity rates higher than those reported through registration and presented in

statistical compendia. Nevertheless, the data show some trends in the dynamics of the population's health.

Data from the Center on Health Statistics and Information (Healthcare 2002) demonstrate the steady deterioration of the health of the population, beginning from the onset of reform (see Table 1).

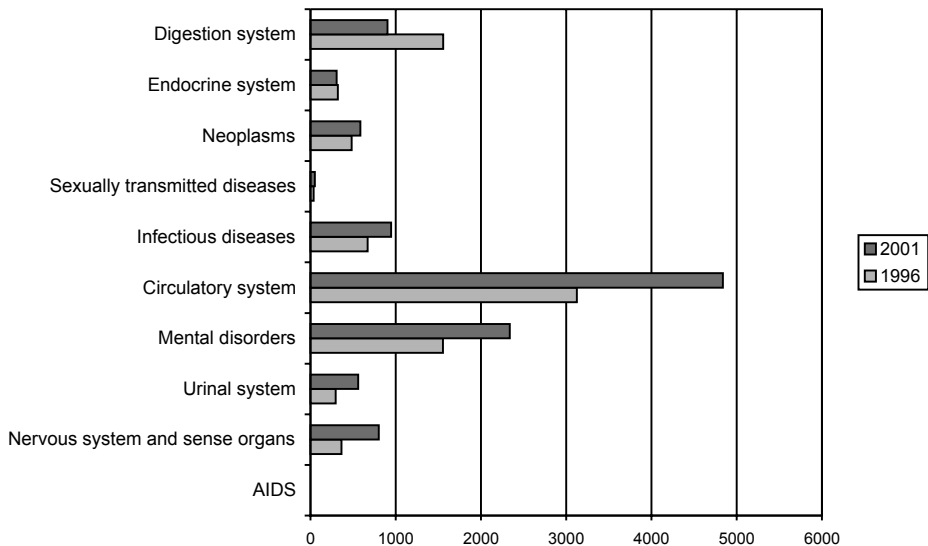
Table 1. Number of Cases of Diseases by Nosology Per 100,000 Inhabitants

No.	Disease	1996	1997	1998	1999	2000	2001
1	Infectious and parasitological diseases	671.3	738.2	729.1	715.9	659.3	945.3
2	Tuberculosis	*	*	*	*	133.4	128.8
3	Sexually transmitted illnesses	37.2	66.2	77.6	45.6	33.5	50.3
4	AIDS and HIV	0.2	0.4	0.5	0.7	1.8	2.1
5	Neoplasms	482.5	475.1	501.9	539.9	557.4	586.6
6	Diseases of endocrine system	320.2	329.7	246.8	313.2	333	306.5
7	Mental disorders	1554.9	1689.	1850.9	2193.2	2192.6	2338.5
8	Diseases of circulatory system	3124.1	3221.3	3527.1	4524.7	4257.4	4838.1
9	Diseases of respiratory system	*	*	*	*	3382.8	3532.7
10	Diseases of urinal system	296.8	304.7	351.2	529.5	476.9	569.2
11	Diseases of digestion system	1555.7	1021	863	899.4	628.9	902.7
12	Diseases of nervous system and sense organs	363.7	459.9	644.9	781.9	718.6	800
13	Traumatism and poisoning	*	*	*	*	*	535.1

* Data are not available.

A comparison of morbidity rates in 1996 and 2001, presented in Graph 1, shows clear increases in all nosological groups for which data are available, except in digestion system diseases and, to a much lesser extent, endocrine system diseases.

Graph 1. Number of Cases of Diseases in 1996 and in 2001 Per 100,000 Inhabitants



Reasons for Increase in Morbidity

The reasons for the deterioration of the health of the Georgian population do not lie entirely in ineffective health policy and improper management (discussed later in this chapter); the health of the population also is due to the wider spectrum of problems the country now faces.

The budget of the country is meager. Poverty, which is spread among more than one-half of Georgia's population, has a manifold and complex impact on health. It does not allow a person to seek professional assistance in case of illness, and it also causes illness or contributes to its development due to malnutrition, low education, lack of exercise, bad sanitation conditions, air pollution, and water and soil contamination. Environmental factors, the consequences of the country's health policy, and the health-related behavior of the population are all interlinked, but for clarity they will be discussed separately.

Environmental factors. By different estimates, environmental factors contribute to 20-22% of a population's health. The political and economic conditions in Georgia have resulted in the closure of industry, which has had a positive effect on the environment; the amount of toxic substances emitted from immovable sources in 2000 constituted 24,200 tons. At the same time, however, pollution from transportation has increased, with 192,700 tons of toxic substances emitted into the air. An abundance of old and badly kept automobiles, the bad quality of fuel, and bad road conditions all have contributed to such a high index of air pollution by transport facilities.

Recent years have been marked by a decrease in potable water resources. According to data from the State Department of Statistics, the index of the use of clean water has decreased significantly since 1999. Contamination of water by waste increases. Although there is high coverage by the central sewerage system (78% of houses), the system is in very bad condition. Water purification systems in the country do not work. In many water supplies, a high proportion of chloroform is found, which often poses risks to a population's health. 60% of the water supply system is old and in unsatisfactory sanitary and technical condition. In 70% of the system, water is not treated with chlorine. The bad condition of pipes in water and sewage systems, and the pipes' proximity in these systems, results in the mixing of sewage with potable water, causing hepatitis infections, amebiasis, and diarrhea in different regions of Georgia. In addition, there have been many cases of contamination of surface waters by industry. For example, in 2000 copper and tin contaminated the river Kazretula.

Concentration of waste, and a lack of treatment and use of waste, results in the contamination of soil. In 2000, accumulated waste comprised 64,500,000 tons and 98 chemically dangerous facilities were operating in Georgia; on their land were concentrated 2,893.6 tons of toxic chemical substances. Domestic and medical wastes pose considerable risks to the health of the population. The majority of health care facilities do not sort medical waste according to the threat classes. Medical

waste in 2000 comprised 52,724 cubic meters. In many locations, especially in rural areas, there are no dumps. Moreover, 64.6% of existing dumps have no special techniques, and 98.4% have no special sites and water supply for disinfecting and washing waste-collecting transport. There is no immunization of animals against foot and mouth disease and brucellosis, which also causes soil contamination.

The bad condition of the Roentgen equipment, 50.2% of which was produced before 1985 (the useful life is 5-10 years), is a source of serious concern. Also of concern is the radioactive contamination of ex-military bases of the Soviet army, which have caused a number of serious radioactive incidents among army personnel. Testing in Tbilisi and West Georgia has revealed Chernobyl radiation patches.

Health-related behavior. Besides the accessibility of health care, health status is associated with nutrition, especially among children. The nutritional status of children under five years of age also serves as an indicator of nutritional problems in a population. Two commonly used indicators are “wasting” (i. e., acute malnutrition) and “stunting” (i. e., chronic malnutrition). Chronic malnutrition, the result of a diet of insufficient quality to allow a child to reach its growth potential, is a problem in Georgia.

Nutrition is a potent factor in health, with 51.8% of the population consuming food providing fewer than 2,500 kilocalories per day. Recent years have been marked by a decrease in the use of animal products. In 2002, the annual per capita use of milk and milk products was 213 kilograms; meat, 19.8 kilograms; and fish, 1.2 kilograms. Food security is an issue of much concern. The violation of norms and standards is observable at all stages, from food production to its consumption; 14% of checked food products did not satisfy the food security norms.

The population is not well aware of health hazards and does not follow a healthy lifestyle. Poverty and stress as well as the lack of sports facilities push the population to cheaper, immediate sources for stress relief and pleasure, primarily smoking and drinking. By its scope and growth rate, smoking can be considered the main menace for the nation’s health. According to the World Health Organization (WHO), Georgia is in first place among the Newly Independent States (NIS) with respect to tobacco consumption per capita.

In Georgia, cigarettes are widely advertised. Huge posters advertising different brands can be found along the highways and main streets. After midnight, there is advertising on TV as well. Cigarettes can be purchased anywhere, including in the vicinity of schools, at almost any time of day or night. There are no restrictions on smoking in public places.

A nationwide survey, carried out by the Department of Statistics in 1999, estimated that 31.1% of the population over 14 years of age smokes. The average daily consumption of cigarettes is 14.5. Especially dangerous is the spread of smoking among students. A recent study on smoking among pupils of Tbilisi schools (Sumbadze and Kitiashvili 2002) demonstrated that a bit less than one-half of the questioned pupils (42%) smoked on average eight cigarettes a day. At the age of

ten, more than one-half (55.1%) of the pupils already smoked. Among smoking pupils, 60.4% have a negative attitude to smoking and are to a considerable degree aware of its adverse effects on health; indeed, a majority links smoking with cancer and lung problems. Many of them want to quit, but are not able to do so. The Department of Statistics survey demonstrated an even greater negative attitude toward smoking among adults; 71.4% of respondents were against smoking, and 59.9% had a wish to quit smoking. In Georgia, an anti-smoking campaign does not exist, though, and there are no programs for those who want to quit.

In Georgia, 74% of the population is not engaged in any sport activities. The enrollment in sports in rural areas and among the poor is especially low (Sumbadze and Tarkhan-Mouravi 2003).

State health policy and financing of health care. As an outcome of the health care reform, all health care institutions now are independent legal entities. They function as either private or joint stock companies and are administratively and financially autonomous from the state budget.

The state finances only a limited number of programs. Expenditures on health care as a percentage of GDP in Georgia fell from 4.1% in 1991 to 0.59% in 1999; in 2001, these expenditures comprised US\$7.30 per capita, while the minimal expenditure for performing basic functions set out by WHO is US\$60 per capita.

In 2001, the state expended US\$25,214,306 to finance three main activities. These were:

- public health programs – 19.8%;
- provisional, so-called “other,” health programs – 6.8%; and
- state program of mandatory health insurance – 73.4%.

The state budget also funds special institutional medical networks, allocating them US\$5-8 million. These are the medical networks of the Ministry of Internal Affairs, Ministry of Defense, Ministry of Security, Department of Borders Defense, Governmental Defense and Academy of Ministry of Security (Bregvadze *et al.* 2002).

In addition to budgeting only meager levels of funding, the state does not fulfill its budget liabilities. For example, in 2000 the health programs did not get 19% of their budgeted funds, and in 2001 they did not receive 9.8% of the planned sums (Ministry of Labor, Health and Social Protection 2002). Moreover, funds that are provided often are not transferred to clinics in a timely manner. This results in clinics being unable to pay salaries to their employees and to buy medications, thus preventing hospitals from carrying out their responsibilities. One recent example, widely covered by the media, is the case of the Joann Medical Center; the hospital refused to perform urgent heart surgery on children due to the lack of resources.

As seen in Graph 2, the largest share of funding supports the state program of health insurance. The creation of the State Medical Insurance Company was

based on the Law of Medical Insurance, enacted in 1997. Special health care taxes, which include 3% of wages paid by employers plus 1% of employees' income, and transfers from the state budget, fund the company. The Ministry selects clinics and contracts with them to serve patients holding state health insurance. The criteria for selection of clinics are not known, as there are no Hospital Performance Indicators in Georgia on which objective selection could rest.

In Georgia, the number of people covered by health insurance is negligible – 615,165 in a population of about 5 million, or about 12.3%.

Graph 2. State Financing of Health

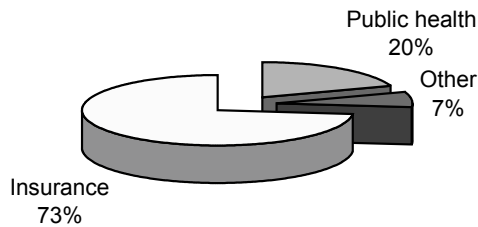


Table 2. Rank Order of State Programs of Health Insurance

No.	Program	Share of received funds (%)
1	Medical assistance to children	24.2
2	Medical assistance to vulnerable groups	19.1
3	Delivery	15.3
4	Physiatric assistance	7.5
5	Psychiatric assistance	7.3
6.5	Treatment and prevention of oncological diseases	6.3
6.5	Dialysis	6.3
8	Provision of medication for specific diseases treated by drugs (e.g., diabetes)	5.0
9	Treatment of infectious diseases	3.9
10	Organizational expenses of insurance company	2.9
11	Treatment of heart ischemia diseases	0.7
12	Medical service of internally displaced persons residing in Samegrelo - Upper Svaneti region	0.6
13	Treatment of population of Tskhinvali district	0.5
14	Transplantation of organs and tissues	0.3
	Total	100.0

The health insurance program is mainly targeted at vulnerable groups (65%) and children (23%). Vulnerable population groups can get a basic health package and other services on a cost-sharing or co-payment basis. Co-payment in some cases is a fixed amount that an insured patient pays to obtain a pre-determined procedure provided by the program service. In other cases, co-payment means a patient shares expenses with the state on a fifty-fifty basis, i. e., a patient pays one-half of the expenses out-of-pocket. The treatment scheme for each nosology

is determined by state standards, and the patient covers any addition to it. The children's assistance program contains several subprograms – acute cases of children under three in Tbilisi, children's cardiosurgery, and assistance to orphan infants, orphans, and children needing continuous treatment.

The National Health Policy target is insurance coverage of the entire Georgian population by 2010. A slight increase in the scope of coverage has occurred as more organizations offer their employees (and their families) health insurance packages. The coverage is still very low, however, and does not exceed 0.9% of the population. State institutions, e. g., Tbilisi State University, have contracts with health facilities through state insurance companies, while private organizations usually contract with private insurance companies. Private insurance companies themselves choose the clinics to serve the insured; some more expensive packages also offer hospitalization abroad. The process for choosing a medical facility is not the same among the private insurance companies.

Although clinics, which are now half empty due to the population's inability to pay for medical services, are happy to get a contract from the Ministry, the resulting delays in the transfer of funds create real problems for clinics and require them to cover their costs from patients' payments, which is a source of tension in patient-doctor relationships. In 2001, for example, the State Insurance Company was not able to pay clinics for US\$1.6 million worth of services that they had provided.

Table 3 presents a ranking of 15 state public health programs according to the amount actually allocated to them in 2001. About two-thirds of the finances of the public health programs went for medical assistance for the rural population, the population of high altitude regions, immunization and safe blood programs.

Table 3. Rank Order of State Public Health Programs

No.	Program	Share of received funds (%)
1	Additional medical assistance to rural population	37.2
2	Additional medical assistance to population of high altitude regions	12.5
3	Immunization	12.3
4	Safe blood, prevention of AIDS and sexually transmitted diseases	11.5
5	Monitoring of epidemiology, prevention, control and management of infections	3.9
6	Prevention of drug addiction	3.8
7	Check-ups for iodine deficiency related diseases	3.6
8	Massive check-ups of population	3.4
9	Prevention of malaria	3.1
10	Cancer diagnostics	2.0
11	Prevention of circulatory system diseases	2.0
12	Establishment of healthy life style	1.9
13	Medical examination of citizens called up for military service	1.3
14	Service costs of public health program	1.2
15	Prevention of traumas	0.3
	Total	100.0

As seen in Table 4, more than one-half of the budget of provisional, or so-called “other,” health programs went to cover rehabilitation of health care facilities and support of medical science and education.

Table 4. Provisional Health Programs

No.	Program	Share of received funds (%)
1	Rehabilitation of health care system institutions	29.1
2	Support of medical science and education	24.1
3	Liquidation of the effects of catastrophes and renewal of medical reserves	15.6
4	Unpredicted expenses	10.1
5	Provision for statistical and informational systems	8.3
6	Management of medical institutions and support of reform	7.6
7	Hygienic standards and their control	2.7
8	Monitoring state programs	2.5
	Total	100.0

The newly formulated health policy has several consequences relating to the health of the population. The increase in morbidity is to a considerable degree determined by the fact that people usually visit medical facilities when an illness is already advanced. The inability of the population to cover medical costs, distrust of doctors, and a lack of basic medical knowledge are the main reasons that hinder the population from seeking professional help. As a result of the very low health care budget, the extremely low coverage of the population, and the services provided by insurance companies, hospitals have to rely mainly on out-of-pocket payments from patients.

Doctors refuse to carry out treatments, even in emergencies, without prepayment by patients. To increase their own income, doctors often offer patients unnecessary treatment schemes, diagnostic tests, and even operations. This leads to serious arguments between doctors and patients and to feelings of resentment, and it also creates an atmosphere of distrust toward doctors.

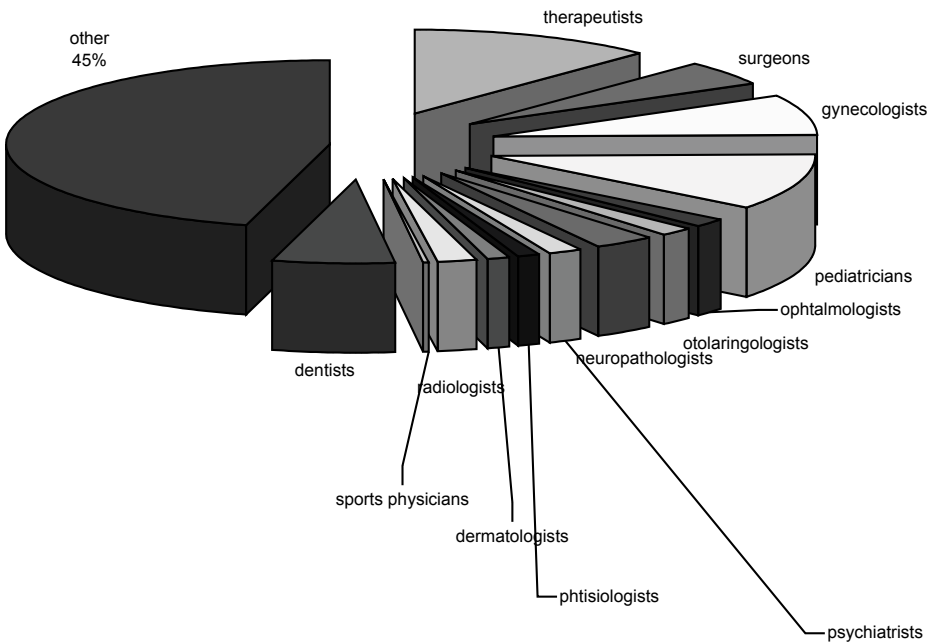
High medical costs relative to income do not allow much of the population to seek professional help. According to a UNDP survey, only 27.5% of those who said they needed medical help visited the doctor (UNDP 2002). In 1991, 179,377 persons underwent surgery, while in 2000 the number was only 69,360. In 1991, 1,164,685 persons used emergency services, while in 2000 only 150,645 did. Persons now go to medical institutions only in extreme cases, when effective help is often already impossible. Rather, people seek informal advice from friends about how to treat the symptoms, and then they take medications on the basis of such advice. This pattern often leads to further aggravation of patients' health conditions. The purchase of drugs without prescriptions and without consultation with doctors is a common practice in Georgia. The business of private pharmacies is flourishing. In 2001, for example, US\$51 million worth of drugs were imported, although part of it was re-exported. In addition, US\$2 million worth of local pharmaceutical products were distributed (Healthcare 2002).

Health Care System

The Ministry of Labor, Health and Social Protection coordinates the work of health care facilities, actively participates in health policy setting, controls the quality of medical service, and is responsible for licensing and accreditation. The Ministry consists of the Minister’s staff, sixteen departments, four inspection offices (State Control Inspectorate of Sanitary and Hygienic Norms, State Sanitary Control Inspectorate in the State Border Customs Office, Inspectorate of Quality Control of Medical Assistance, Labor Inspectorate), two centers (Center for Implementation of Health Care and Social Protection Projects, Center for Forensic Medicine), two committees (Committee of Pharmacopeia, Committee of Pharmacology), and a Foundation for Hospital Restructuring.

There is an apparent surplus of doctors in Georgia. In 2000, there were 21,100 registered physicians (47.4 per 10,000 population) and 26,200 registered paramedical personnel (58.8 per 10,000 population). The ratio of doctors to paramedical staff is 1: 1.2, which is quite low; in France, for example, it is 1: 1.7. Theraputists and pediatricians constitute the biggest groups of physicians (see Graph 3). The monthly salaries of medical personnel in successful clinics vary from US\$30 to US\$400 per month. On average, doctors get US\$130 a month.

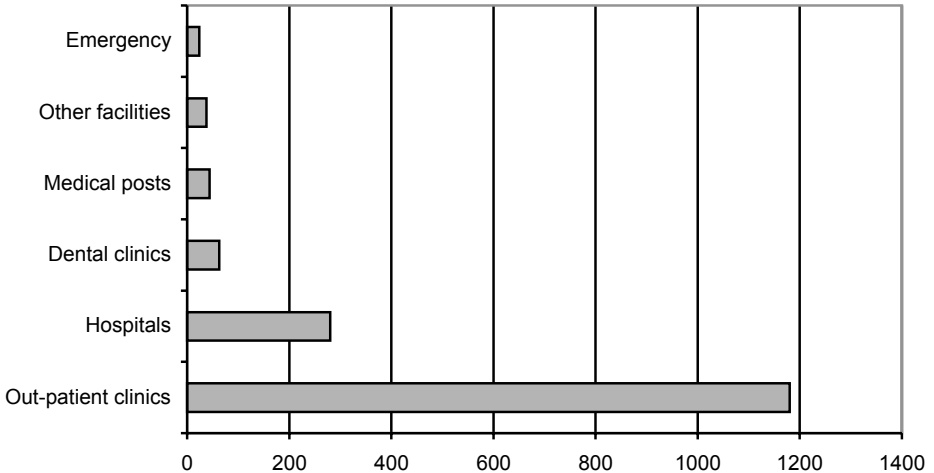
Graph 3. Share of Physicians in Basic Specialties



The population receives services from 1,629 health care facilities. Among these facilities, the most numerous are outpatient clinics and diagnostic centers (1,180)

and hospitals (229, with 21,200 beds). The distribution of medical institutions is reflected in Graph 4.

Graph 4. Number of Medical Institutions



In 1998, Georgia's Health Care National Policy was drafted; it delineated the priority areas and main directions of health care. A number of international organizations were involved in drafting the health policy and in its reevaluation, as well as in the improvement of health care facilities management.

In 2000, the World Health Organization (WHO) supported three programs: a reevaluation of the components of Georgia's Health Care National Policy; the strategic development of primary health care; and the development of a health care information system. The United States Agency for International development (USAID) supported two programs: a project on primary health care, and health education and the teaching of health care management. The Swedish International Development Agency (SIDA) supported a program in hospital management. The Canadian International Development Agency (CIDA) funded three projects targeted at improving the quality and management of health care information.

4. Overview of Public Administration Education Practices

Four universities in Tbilisi, one in Kutaisi, and one in Batumi award master's degrees in public administration. The best known is the Georgian Institute of Public Affairs (GIPA) and its School of Public Administration (SPA). The Institute was launched in 1995. Its course of study lasts for one year. To be admitted to the SPA, a university diploma is required. The regular program has 30 students; also, more than 30 students study annually in the Evening Department. The teachers are from the United States as well as from Georgia. GIPA also provides short-term training in various public administration topics (e. g., financing, decision making) and had

a program in local governance in which representatives of local governments were trained in public administration. The cost for the one-year regular program of study is US\$600, and for the evening program it is US\$1500. Among the GIPA School of Public Administration graduates, 27% work in state organizations.

In the Humanities Department of the Georgian Technical University, students are able to study for the bachelor's degree (four years) and the master's degree (two years). The department has existed since 1976. Annually, it has about 70 students studying for the bachelor's degree and 15 students studying for the master's degree. Some students study for free, while others pay US\$650 annually. The Public Administration faculty has five permanent staff members and teachers employed through contracts.

Similar to the Georgian Technical University, Robakidze University offers both bachelor's degrees (four years) and master's degrees (two years). The program has four main subject blocks: legal sphere, economics and business, management, and psychology.

Public administration program graduates do not serve as health managers due to the general view that only medical professionals should manage health care facilities. None of the public administration institutions discussed above offers courses in health care management. In fact, health care management is taught only at medical schools. The main reason is straightforward – there is limited interest on the demand side because of the character of the health care system in the country.

5. Overview of Current Education Practices in Health Care Administration, Management and Policy

Georgia has two state and thirty private medical schools that are registered in the country. They prepare general practitioners and dentists. Almost all of these schools are located in the capital, Tbilisi; only three are in the regions. Most medical schools offer a pre-graduate course lasting four years. Persons with a bachelor's degree can work at the medical facility, but not as a doctor. A restricted number of universities offer graduate courses. To get a master's degree, students must study for an extra two years beyond the bachelor's degree. Medical universities also offer a residency course.

After obtaining a degree to work as a doctor or a manager, a person must pass an exam to get the certificate. The Council of Post-University and Continuing Education, operating at the State Medical Academy of Georgia, organizes the exams.

About one-half of all registered educational medical institutions provide courses in public health care and management. These are most often 36 to 96 hour courses, sometimes combined with epidemiology or hygiene, and more rarely with health statistics. With only one exception -- the Medical University "Aieti," where teaching is in English and the course of study follows textbooks used in U. S. medical universities -- all other institutions teach using a Georgian textbook (Gerzmava 1998) or use no core textbook. The program covers such issues as the main char-

acteristics of health and illness, indices of the population's health, demography, medical statistics, the main factors of illnesses, the policy and strategy of health care, the economics and financing of health care, and the basics of health care management.

Two state universities (Tbilisi State University and the State Medical University) offer a formal program in public health and public health management. Both courses are in the initial phase and have no graduates yet, though, so it is difficult to judge their success.

The duration of the master's degree course of study in public health in Tbilisi State University is two years. Students with a bachelor's degree are eligible to take the course. They study disciplines like the organization of public health care, clinical epidemiology, management, law, medical insurance, medical social expert opinion, innovative technologies, and mathematical modeling. The university has its own textbook for the course on the organization of health care (Urushadze 2002). As a graduation requirement, students present a thesis. The number of students presently is six.

The State Medical University has a residency course (a post-master's degree program), which was launched in 2000 as part of the reform in medical education. This is somewhat similar to a postgraduate course after the diploma course, but unlike the postgraduate course it is more oriented toward acquiring practical skills. The course lasts three years. Students are placed at clinics or other health care facilities. There are four students in this course now. The Medical University "Aieti" also offers a long-term course in public health policy, management, and epidemiology and statistics (180 hours for fifth- and six-year students).

Health Management Training

The reorganization of medical education and post-degree training was one of the main reform issues. This emphasis was reflected in a number of executive decrees and legislative acts, including order No. 379 of the President of Georgia (11 June 1996) on "additional measures for improving medical education"; the requirement to have a state certificate for carrying out medical services, as reflected in the Law of Health Care; order No. 478 of the President of Georgia (1 October 1999) on "measures for the development of the medical education system and improvement of human resource management"; and the Law on Medical Service.

These initiatives laid the foundation for the implementation of the concept of continuing education, which is becoming more important in the country (Council of Post-University and Continuing Education 2002). Continuing education is defined as education that follows the diploma phase of professional education, lasts for the entire period of a person's professional activity, and is aimed at harmonizing the theoretical knowledge and practical skills of doctors with modern achievements and technologies in medicine. The central unit for continuing education is the State Medical University of Georgia. The activities are coordinated by the Council of

Post-University and Continuing Education, which is headed by the Minister of Labor, Health and Social Protection.

According to the Law on Medical Service, beginning in June 2001 each doctor must have a certificate either to begin or to continue medical practice; this certificate is obtained by passing certification exams. By March 2002, 1,800 doctors had passed the exam. According to the law, the certificate should be renewed every five years through re-certification. Due to the low quality of the certification exams conducted until now, however, the re-certification exams will be held as certification exams until 2006, but with the requirement to have the necessary re-certification credits. The procedure for re-certification involves two possibilities: collection of credits, or passing a certificate exam. But in order to have the right to be reexamined, the doctor must still earn a certain amount of credits. The Council of Post-University and Continuing Education administers a commission that awards credits to programs. Since the credit system just became effective at the end of 2003, existing courses do not have credits associated with them.

The head of all clinics in Georgia and the heads of other medical facilities have a medical education. It is not a written law that health care managers must be doctors; there are no legal obstacles preventing public administrators from becoming head doctors of a clinic. But none of the health care facilities are led by people who lack a medical education. This practice is rationalized, first, by the large number of doctors for whom employment must be found and, second, by the fact that the big clinics have other managers (e. g., in finance management and in public relations) who do not usually have a medical education.

As part of health care reform, the registration of a medical institution requires a license. The Ministry of Labor, Health and Social Protection issues a license. One licensing requirement is that the head doctor must have a certificate in public health management. This requires that the doctor must pass an exam, which is in the form of test questions with optional answers. The questions cover 25 areas of public health management, such as public health, health law, health care reform, morbidity of the population, prevention of illnesses, health care management, licensing and certification, labor law, primary medical assistance, organization of outpatient and inpatient services, quality control, economics and financing of health care system, financing of state programs, medical insurance, marketing, information systems in health care, biostatistics, organization of emergency service, and organization of dental service.

Several venues are open for individuals seeking this certificate in public health administration and management. One option is to graduate from a course of study abroad, with subsequent nostrification of the certificate in Georgia. A second is to graduate from the master's course in public health at Tbilisi State University. A third possibility is to follow the course of study in the National Health Management Center. A fourth is a residency in public health management at the State Medical University, while a fifth is taking a course in the Academy of Medicine.

Additional institutions also deliver training courses in public health management in Georgia. One of the most important is the National Health Management Center, which offers two to three week courses in public health management every three months for head doctors and their deputies. The National Health Management Center prepared the course in cooperation with Scranton University, Pennsylvania, through a Health Management Education Partnership (HMEP) sub-grant agreement signed in March 2000. The program grant was awarded by USAID to the American International Health Alliance (AIHA), which chose the University of Scranton as the subcontractor. Up to now, the Center has prepared about 900 managers.

6. Conclusions

The existing practice of selecting hospital directors and other top managers leaves no opportunities for non-medical personnel to be appointed to high managerial positions in health care facilities. This in turn does not stimulate the advancement of health policy or health administration courses in schools of public administration, which now are establishing themselves in the country. In the educational settings from which managers are hired, i. e., medical institutes, the health administration courses (which usually are delivered by doctors) focus mainly on epidemiology. Little attention is given to management and marketing. The situation is even worse with regard to health policy, which is not taught at any institution.

The sphere of health service is almost entirely occupied by people with a medical education, and there is no understanding among them of the need for professional managers in health care settings. Doctors do not waver from their objective to secure as many positions in health care as possible for people with a medical education, and at present they have full power to do so. There is some (professional) rationale underlying the reluctance to accept people outside the medical profession as heads of healthcare facilities; doctors often say that “there are so many professionals unemployed, so why seek out others.” The medical knowledge serves as an added value in the case of a top manager. So the possibility of breaking down the professional barrier seems improbable in the immediate future. Rather, it is much more fruitful in the short term to seek changes in the education and training of health professionals. The introduction of licensing and the practice of accreditation for the medical staff open some venues for improving the situation.

Stringent criteria should be provided for licensing doctors in health administration. Courses for retraining, as well as for primary training, should be much more focused on management and marketing. Completing practical management skills training should be a requirement. Specialists in management and marketing should teach these courses, not doctors. There is a need to coordinate the health management courses delivered in different higher education institutions. Also, courses in health policy should be developed with the help of international experts, as there is little capacity in the country.

In conclusion, public health care and management is gaining importance in a reformed system of health care in Georgia. But medical workers still do not fully

recognize the necessity for organizers of public health and managers of health institutions to have solid managerial knowledge and skills. This is to some extent very surprising, since most providers are now private institutions that are expected to behave (according to traditional economic theory) in the most rationale way.

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Appendix A.

List of Academic Courses and Training Programs In Public Health Management and Policy

No.	Course name	Affiliation	Address	Participants	Duration	Status
1	Public health management	State Medical University	Tbilisi. 33, Vaza -Pshavela str. Tel.392613 Otar Gerzmava Dali Kitovani	Undergraduate physicians; Undergraduate dentists	96 hours 76 hours	
2	Public health management and epidemiology	Georgian State Medical Academy	Tbilisi. 29, Chavchavadze av. Tel.230387, 231593 Mamuka Jibuti	Physicians continuing education	Intensive, one month course	The course is in the process of development
3		National Health Management Center	Tbilisi. 51, Iv.Javakhishvili str. Tel. 956680 Otar Gerzmava	Managers of health institutions	Intensive course	The course was developed in cooperation with Scranton University, PA
4	Public health care	Tbilisi State University	Tbilisi. 1, Chavchavadze av. Revaz Urushadze	Fifth year physicians and dentists; MS course in public health care	75 hours 3 semesters	
5	Public health care and management	Georgian medical institute Dostakari	Tbilisi. 74, Uznadze str. 961678	Third and four year students		
6	Organization of public health and management	Georgian State Medical Academy, affiliated with the state institute for qualification of physicians	Tbilisi. 29, Chavchavadze av. Tel: 230387	Fifth year students	18 hours	
7	Social hygiene, organization of public health and management	Tbilisi E. Pipia medical institute	Tbilisi. 6a, Vaza -Pshavela av. Tel: 985362	Second, fourth, and fifth year students; physicians; and second and third year dentist students		
8	Public health policy, management, epidemiology, and statistics	Tbilisi medical school Aieti Irakli Sasania	Tbilisi. 29, Vaza -Pshavela str. Tel: 516898	Fifth and sixth year students; physicians	180 hours	
9	Management	Medical institute Panacea	Tbilisi. 42, A. Tsereteli avenue. 294395	Third and fourth year physicians and dentists		
10	Organization and management of public health	Tbilisi academy of classic and traditional medicine	Tbilisi. 16, Kavtaradze str. Tel: 305575	Third year physicians and dentists	72 hours 36 hours	
11	Organization of health care and management	Medical institute Clinacist	Tbilisi. 2, Chiaureli str. Tel: 520976	Third and fourth year dentists		

PART II

12	Organization of health care and management	Tbilisi medical institute Tsodna	Tbilisi. 47, Kostava str. Tel: 936940	Fifth year physicians		
13		Tbilisi civil medical institute	Tbilisi. 53, Marjanishvili str. Tel: 950296 Goderzi Tabatadze	Physicians and dentists		
14		Medical institute affiliated with the center Panaskerteli	Tbilisi. 68, Uznadze str. Tel: 956956	Third year and fourth year physicians and dentists		

Appendix B.

Programs in Public Health Care and Management

Program in Public Health Care and Management, State Medical University

1. Public health care as a science
2. Main theories on the influence of social processes on health
3. Health of the population – the main indicators
4. Demography
5. Health statistics
6. Social problems of spreading non-epidemic illnesses
7. Main social problems as factors of diseases
8. Life-style
9. Healthy life-style and its development
10. Policy and strategy of health care
11. Health care in Georgia
12. Economic foundations of health care
13. Marketing
14. Characteristics of privatization process; forms of ownership
15. Planning in health care
16. Financing systems in health care
17. Insurance
18. Financing systems of health care in different countries
19. The foundation of health care organizations and the principles of management
20. Primary medical and sanitary assistance
21. Medical-ambulatory assistance
22. Doctor-patient relationship; medical ethics and deontology
23. Organization of ambulatory-policlinic service in Georgia
24. Hospital as a social institution
25. State system of mother-child protection
26. Organization of dental care
27. Medical-labor expertise

Program in Public Health, Tbilisi State University

1. The goals and aims of the discipline
2. Content of the discipline:
 - Public health care
 - Control of contagious diseases
 - Creation of healthy environment
 - Health care for special groups of population
 - Health promotion
 - Supporting effective treatment

- Health economics
- Management
- 3. Epidemiology
- 4. Sanitation

Topics of Health Management Course Test for Licensing

[Test questions have 4 to 5 answer options from which to choose]

- Health law (16 questions)
- Health reform (7 questions)
- Public health; health of population and factors influencing it (13 questions)
- Morbidity of population (24 questions)
- Characteristics of the development of illnesses (28 questions)
- Prevention of illnesses (89 questions)
- Health care management: general management and management of health care personnel (91 questions)
- Licensing and certification (23 questions)
- Labor law (19 questions)
- Primary medical care (27 questions)
- Organization of out-patient service (23 questions)
- Organization of medical service for rural population (10 questions)
- In-patient service (43 questions)
- Organization of mother-child service (52 questions)
- Quality control (8 questions)
- Medical-social expert opinion (57 questions)
- Economics and financing of health care system (69 questions)
- Financing of state programs (25 questions)
- Medical insurance (33 questions)
- Marketing (42 questions)
- Information systems in health care (38 questions)
- Biostatistics (55 questions)
- Organization of emergency service (18 questions)
- Organization of dental service (22 questions)
- Different subjects (200 questions)

Appendix C.

Short-term Training Programs in Public Health Care Management

Short Term Training Course For Certificate, State Medical University

1. Public health as a science
2. Main characteristics of health and illness and the methods of their study
Main theories of the influence of social environment on health
Indices of population's health
Demographic development of population medical statistics
3. Main factors influencing health
Social problems of the development of illnesses
The healthy life-style and characteristics of its formation
4. Policy and strategy of health care
Policy and strategy
Health care in Georgia
5. Economics and financing of health care
Economic foundation of health care
Marketing
Characteristic features of privatization; forms of ownership
Planning of health care
Systems of financing health care
Insurance
Systems of financing in different countries
6. Foundations of the organization of health care and management
Foundations of health care management
Primary medical and sanitary assistance
Medical ambulatory assistance
Doctor-patient relationship; medical ethics and deontology
Organization of ambulatory and policlinic service in Georgia
Hospital as a social institution
State system of mother-child security
Organization of dental service
Medical work expertise

Public Health Care, Management and Organization of Health Care, State Medical Academy

The Chair of Public Health and Epidemiology

Course for health care system managers and epidemiologists; 27 days duration

Course design: 10 modules, each containing lecture materials and practical work

1. Basics of epidemiology (3 days)
2. Basics of biostatistics (3 days)
3. Concept and practice of public health care (3 days)
4. Policy and planning of health care (2 days)

PART II

5. Information system of health care management and monitoring of diseases (3 days)
6. Financing of health care (3 days)
7. Principles of management of health care (3 days)
8. Human resource management (2 days)
9. Fiscal aspects of health care institutions and financial accounting (3 days)
10. Legal aspects of health care institutions (2 days)

Appendix D.

Programs in Public Administration

Georgian Institute of Public Affairs, School of Public Administration: Courses in 2003

Economics - 45 academic hours

Budgeting and Finance - 45 academic hours

Research Methods - 45 academic hours

Statistics - 16 academic hours

Organization and Public Management - 45 academic hours

Human Resources Management - 45 academic hours

Case Studies - 45 academic hours

Policy Analysis - 45 academic hours

Introduction in Public Administration - 45 academic hours

Administrative Law - 45 academic hours

Tax Law - 16 academic hours

Basics of Law - 16 academic hours

Basics of Management - 20 academic hours

Conflict Resolution and Negotiations – 36 academic hours

Society and Politics - 10 academic hours

English Language - 100 academic hours

Computer Science - 100 academic hours

Presentations - 10 academic hours

Georgian Language – 16 academic hours

Democratic Development History – 30 academic hours

Internship - 4 weeks

Georgian Technical University: Curriculum for Public Administrators (Four-Year Bachelor's Degree)

	<i>Hours</i>
1. Informatics	125
2. Russian language	28
3. History of governance in Georgia	124
4. Basics of law	74

PART II

5. Georgian Constitution law	154
6. Foreign language	616
7. Philosophy	110
8. Georgian language	248
9. History of religion (non-compulsory course)	55
10. Georgian state (non-compulsory course)	248
11. Documentation and office management	124
12. Speech making	107
13. Microeconomics	84
14. Administrative law	74
15. Ecology	124
16. Logics	55
17. History of world civilization	110
18. Politology	76
19. State management of international relations	124
20. International relations and politics	124
21. Civic code	74
22. Sociology	55
23. Global ecopolitics	248
24. Law of intellectual property	74
25. Defense of cultural heritage and state policy	124
26. World economy	124
27. Organizational and managerial development	248
28. Art of discussion	124
29. Interpersonal skills	124
30. Financial law	74
31. Social policy	248
32. Psychology	55
33. Mass media and public policy	95
34. International economic relations	121
35. History of state management of foreign countries	124
36. Business law	74
37. Social psychology	55

38. History of Georgian and world culture	124
39. Labor law	74
40. Theory and practice of state management	248
41. Etiquette	124
42. Management	112
43. Conflictology	110
44. Municipal law	74
45. International law	74
45. Problems of international security	124
46. Political analyses of public sector	248
47. Informational and computer law	74
48. Management systems of tourism industry	248
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50. Information bases of organizations and management	124
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Appendix E.

List of Medical Universities Registered in Georgia in 2002

In Georgia, two state universities, i. e., the State Medical University and Tbilisi State University, give degrees in medicine. In addition, 30 private medical universities give degrees; 27 of these are located in the capital, Tbilisi.

No.	University	Address	Telephone Area code:+99532
1	State Medical University	Tbilisi. 33, Vaza -Pshavela str.	392613
2	Tbilisi State University	Tbilisi. 1, Chavchavadze av.	943454
3	Georgian medical institute Dostakari	Tbilisi. 74, Uznadze str.	961678
4	Tbilisi medical pediatric institute	Tbilisi. 21, Lubliana str.	529535
5	Tbilisi medical institute	Tbilisi. 4, Lubliana str.	
6	Tbilisi medical stomatological institute	Tbilisi. 1, Baku str.	957911
7	Medical institute Clinicist	Tbilisi. 2, Chiaureli str.	520976
8	N. Kakhiani Tbilisi medical institute	Tbilisi. 5, Lubliana str.	527915
9	Medical institute Panacea	Tbilisi. 42, A.Tsereteli av .	294395
10	Tbilisi academy of classic and traditional medicine	Tbilisi. 16, Kavtaradze str.	305575
11	Tbilisi medical institute Skhivi	Tbilisi.16, Kavtaradze 16	
12	Medical academy affiliated with the state institute of qualification of physicians	Tbilisi. 29, Chavchavadze av.	230387, 231593
13	Tbilisi institute of biological medicine and ecology	Tbilisi. 22, Kazbegi av.	
14	Stomatological institute affiliated with Academy of Sports	Tbilisi. 49a, Chavchavadze av.	
15	Tbilisi medical institute Medicor	Tbilisi. 49, Chavchavadze av.	253408
16	Georgian independent medical institute Iveria	Tbilisi. 9, Tsinandali str.	
17	Tbilisi independent medical institute Vita	Tbilisi. 8a, Navtlugi str.	
18	Georgian medical institute of physiotherapy	Tbilisi. 9, Gorgasali str.	720467
19	Tbilisi medical institute Tsodna	Tbilisi. 47, Kostava str.	936940
20	Tbilisi medical institute Momavlis eqimi	Tbilisi. 4, Gudamakari str.	
21	Tbilisi medical institute Sakartvelo	Tbilisi. 1b, Budapeshti str.	384072
22	Tbilisi E. Pipia medical institute.	Tbilisi. 6a, Vaza -Pshavela av.	985362
23	Tbilisi institute of critical medicine	Tbilisi. 27b, Vaza -Pshavela av.	398046

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24	Tbilisi medical school Aieti	Tbilisi. 29, Vaza -Pshavela str.	516898
25	Tbilisi civil medical institute	Tbilisi. 53, Marjanishvili str.	950296
26	Medical institute Tbilisi	Tbilisi. 4, Kostava str.	
27	Medical institute Kavkasia	Tbilisi. 16, Al.Kazbegi av.	
28	Medical institute of plastic surgery and dermocosmetology.	Tbilisi. 3, Kapanadze str.	
29	Medical institute affiliated with the medical center Panaskerteli	Tbilisi. 68, Uznadze str.	956956
30	Batumi medico-ecological institute	Batumi. 16, Asatiani str.	
31	Kutaisi medical institute Kutaisi	Kutaisi. 13, Dvalishvili str.	
32	Telavi stomatological institute.	Telavi. 1, Freedom square	

Public Health Management and Policy Education and Training: Russia

*Tatiana V. Chubarova*¹

1. Introduction

The goal of the current health care reforms in Russia is to establish a sustainable and equitable health care system compatible with new societal realities. Major problems have been created by the current economic situation, which makes it very difficult to raise revenues for health care. Consequently, it is especially important to maximize the efficiency and effectiveness of the current system.

Health sector reforms have been focused principally upon changing organizational structures and financial flows for health care. However, it is unlikely that these reforms will be successful without improved and more effective management. This becomes even more important in that the main trend in state policy toward health services is to increase institutional freedom with respect to operational issues.

In the Russian health care system, the public sector has traditionally played a leading role; thus making developments that are taking place in public administration especially important. However, these developments are not now central to Russian health care because presently health services are managed by physicians, many of whom have no managerial training. Given the changing conditions of Russian health care, and the increasing role of management in carrying out health care reforms, the present system of educating health managers needs to be improved. Health managers need training in the new skills that are required to implement successfully these reforms.

Since medical universities have a monopoly in educating doctors, these universities also have succeeded in monopolizing the delivery of health management (HM) education and training. While some medical universities have started to develop HM programs, they have been slow in responding to the emerging needs for highly trained health care managers. In addition, most medical universities lack experience in teaching management disciplines.

Public administration (PA) schools have the potential to educate health managers – and, in fact, some do offer programs in health management as one area of specialization. However, with the doctors' monopoly of the health care sector, such programs are unlikely to have much influence and they will not gain popularity without the cooperation of the medical profession. PA faculties must change the situation by raising awareness among doctors as to the importance of management science and of interdisciplinary knowledge for the effective management of health care systems.

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2. Country Profile and Public Administration Overview

Russia is a vast country of about 144 million inhabitants. It is a federation of 89 regions. Recently, Russia has gone through difficult reforms aimed at creating a democratic society based on a market economy. The transformation of society impacts upon every aspect of national life, including the growing public sector. The system of public administration in Russia is undergoing serious changes as a part of the market-oriented reforms occurring in the country. The role and effectiveness of the state – what the state should do, and how it should do it – is at the center of a more general discussion about the role of the state in economic and social development. Thus, the efficiency and effectiveness of the public sector – and how it is managed – are on the political agenda of the country's national and regional governments.

Despite wide-scale privatization in Russia, the public sector is still very significant in scope. Indeed, about 37% of employed individuals still work in the public sector. Nevertheless, the major policy trend in Russia has been the minimization of the role of the state – especially as a direct provider of social services (including health) and increasing the efficiency of the state administration. Government is to focus on core public activities and to develop incentives to enable public officials to do their jobs better. Russian scholars and policy makers are well-acquainted with the discussions on these issues carried out in the international arena, including by such international organizations as OECD and the World Bank. With Russian reforms though, often the rhetoric is not reflected in practical measures: implementation has always been a weak point of the Russian policy process.

One of the major problems in the Russian public sector is coordination – both in terms of vertical relationships between different levels of government and horizontal relationships between various ministries and departments. Another major problem is the dispersion of authority, especially in the financial field. Although new tax and budget codes were adopted in the late 1990s, the power of the regions to raise money to carry out their functions – so-called fiscal federalism – is not yet clearly defined. Regional disparities in social and economic development are substantial, and the federal government faces the problem of creating effective mechanisms for the redistribution of resources between regions.

In Russia, "public administration" refers to both the civil service and to the state-owned organizations that are widespread in the social sector.² In fact, the distinction between public administration and management in Russia is rather blurred, especially in practice, although the word "administration" is more often used to denote management in the public sector, while management tends to refer to "management in the private sector." Nevertheless, it is common to find the position of manager in public sector organizations. This distinction is probably more strictly followed in educational programs.

² The basic legislation that regulates the activities of civil servants is the Fundamentals of the Civil Service, adopted in 1995.

Managing a public bureaucracy in Russia is a very challenging task because of:

- low financing (state organizations are usually underfinanced in terms of both the planned budgetary appropriations and the actual amounts received during the fiscal year); and
- low salaries (in practice, this means low morale), because there is a special salary scale for staff of state organizations.

Presently, the government is promoting reforms that would reintroduce separate salary scales for each government branch (i. e., education, health care, science, etc.). Civil servants are in a slightly better position, since they are entitled to certain privileges, e. g., better pensions. Currently under discussion is a proposal that people working in state organizations in the social sector (e. g., doctors, teachers) should be treated as civil servants and thus obtain the privileges of civil servants.

The issue of corruption is very acute for Russian public administration. There is a general belief that low salaries in the public sector make bribes attractive to public administrators. In open debates, a number of remedies have been offered; however, the problem still persists and Russia is frequently characterized as one of the most corrupt countries in the world.

3. Public Administration Education

Russia has many faculties and programs where students can obtain a master's degree in public administration or public management (MPA/MPM) or a PA/PM-equivalent bachelor's degree. In general, the structure of PA education in Russia is the same as in other humanitarian/social science specialties. In Soviet times, students studied in the university for five years to get a graduate degree. At present, higher education in Russia is being reformed along Western lines: bachelor's degrees (four years) and master's degrees (one or two years more, for a total of five or six years) are being introduced everywhere. Postgraduate education includes doctoral degrees (Ph. D.) and retraining courses to improve skills in areas often unrelated to the area of the basic degree.³ Business management education is now much more popular in Russia than PA/PM, however, primarily because working in the private sector is more prestigious and financially rewarding for young people.

Public administration/public management is taught at:

- faculties of public (and municipal) management/administration which offer degrees in PA; and
- chairs at other, mostly MBA-type, faculties which offer degrees in management with a public management specialization.

Among the most popular educational institutions in the field of PA education are Moscow State University (Faculty of Public Administration) and the Academy of Management in Moscow (Faculty of Public/Municipal Administration). They both offer undergraduate and postgraduate training in PA. Other important

³ In Russia, there are two doctoral degrees – *Candidat nauk* and *Doctor nauk*.

schools are, for example, the Higher School of Economics in Moscow (Faculty of Public Administration); Piatigorsky State University in Pyatigorsk (Faculty of Civil Service and PA); and Pomorsky State University in Arkhangelsk (Faculty of Management).

The best-known PA/PM chairs are at the Diplomatic Academy (Moscow) – chair of PA and IT; the Russian Economic Academy named after Plekhanov (Moscow) – chair of PA in the Faculty of Management; the Russian University for International Friendship (Moscow) – chair of public and municipal management in the Faculty of Humanitarian and Social Sciences; St. Petersburg State University – chair of PA in the Faculty of Management; Siktivkarsky State University (Siktivkar) – chair of PA in the Faculty of Management; Tomsky State University (Tomsk) – chair of PA in the Faculty of Management; and Cheliabinsky State University (Cheliabinsk) – chair of theory and practice of PA. It is impossible to describe fully the country's various PA/PM programs, but this small sample shows that there are different institutional approaches to delivering PA/PM education.

The leading role in postgraduate retraining in PA belongs to the State Academy of Civil Service, established under the auspices of the Office of the President. It issues special certificates in PA for people working as public administrators but holding graduate degrees in other disciplines. The State Academy of Civil Service is based in Moscow and has branches in several Russian regions. At present, this is the most popular form of staff development in the public sector. It enables people to improve their managerial capabilities and adopt new information technology, and, in so doing, also improve significantly their career prospects. This type of education also is more efficient in that graduates of retraining programs return to their work while no one is certain about the careers of students graduating from PA faculties. The other important training institution is the Academy of National Economy, under the government of the Russian Federation – it is the faculty for top public administrators. There also are many other training centers, but they are too numerous to list, given the scale of the country.

A strategic aim of PA education in Russia is to change public sector bureaucrats who are spending public money into cost-conscious managers who are accountable for results. Russia is following the actions taken in developed countries by emphasizing the importance of management development in the public sector. Although PA education in Soviet times was not well-established in the classical Western sense, Russian educational programs in the field are now highly influenced by Western analogues, and lecturers often have undergone training in Western universities. But this is where the contradiction arises between Western-based theories and practices and Russian reality. The Russian educational tradition tends to favor more academic knowledge, while in managerial training there is a need to take a more practical approach and use case studies. As a result, many Russian PA education programs have a stronger policy than management component. A major problem in analyzing the successes and failures of PA education in Russia, however, is the

difficulty, given the very large number of new programs, of assessing the quality of teaching.

4. Health Care in Russia: From the Semashko Model to Compulsory Health Insurance

The problems discussed above generally apply to state health services which, as a result of past history, are the predominant majority of Russian health services. When Russia was an integral part of the USSR, almost all health care was financed and provided by the state (the so-called Semashko model), with the private practice of medicine the rare exception. While significant achievements of this earlier system are generally recognized, major drawbacks are also well known. The Semashko model showed positive outcomes in times when the principal aim of health care was to fight infectious diseases but it could not ensure the proper level of treatment of chronic illnesses. Thus, chronic illnesses constituted an increasing share in the morbidity structure. The health care system continued to expand and become broader (e. g., setting up new polyclinics and hospitals, training more professionals). However, Soviet leaders and researchers did not give adequate attention to the problems associated with increasing the health care system's efficiency when the resources allocated by society to health care decreased due to slowdowns in economic growth (Korchiagin 1990; Preker and Feachem 1994; Sheiman 1995; Stains 1999).

The transition to a market economy and the decentralization of decision-making inevitably led to reform in health care. This reform has been strategically carried out through the introduction of compulsory health insurance (CHI) and the decentralization of health care financing and management. The principles of CHI and the mechanisms of its implementation were articulated in legal documents that include the 1991 Law on CHI. The following was introduced:

- universal CHI coverage;
- health insurance contributions paid by employers, with local administrations paying for the unemployed;
- a basic CHI program of compulsory medical insurance (CMI), including a minimum set of medical services provided by the CMI system, adopted at the federal level - with regional programs having a similar scope as the federal one;
- individuals and organizations could participate in voluntary health insurance; and
- the system of CHI funds – the federal fund of CHI and the regional funds of CHI – were to be set up as independent state non-commercial credit and monetary agencies committed to comprehensive CHI, social justice and equality, and the financial stability of the system. The CHI funds were to accumulate contributions and transfer these resources to health services either directly or via special health insurance companies (HICs) (as independent non-profit organizations). The main functions of HICs were to conclude contracts with

health services (e. g., hospitals, polyclinics); to reimburse them for medical services provided for the insured; to defend the interests of the insured; and to control the quality of health care.

By the year 2000, the federal CHI fund, 90 regional CHI funds (with 1,129 branches), and 362 HICs had been set up in Russia. At present, CHI funds are regionally based in two respects: first, regional CHI funds are independent bodies but not branches of the federal CHI fund, as is the case, for example, with the Pension Fund.⁴ Second, CHI funds collect contributions from both employers and regional administrations. The employers' CHI contribution is fixed at 3.6% of payroll, divided between the federal CHI fund (0.2 percent) and a regional CHI fund (3.4 per cent) covering only the employees and not including their dependents. The CHI contributions of regional authorities cover medical treatment for those not employed (e. g., children, pensioners).⁵

By the end of the 1990s, it had become apparent that CHI had failed to bring about clear positive results, especially improvement in access to and/or quality of medical services. In fact, the quality and scope of medical services, as well as the health status of the population, had continued to decline. Hospitals and polyclinics suffered from a lack of equipment and medications. People had the same problems of access to and quality of medical services. Facilities, in many cases, needed major renovations and new equipment. In many hospitals, patients had to provide medication, food, and even bed linen for themselves.

The CHI itself had encountered serious problems. First, there was the grave problem of using insurance policies issued by a regional fund to get medical treatment outside the fund's area. Moreover, by 2000 only about 30%, or 8,210 health services that included 5,649 hospitals, 1,900 primary care/polyclinics and 661 dental clinics, had joined the CHI system.

As a result, three CHI models have emerged during the course of health care reform. In some Russian regions, reforms have developed as planned by the relevant legislation. Regional CHI funds accumulate resources and conclude contracts with HICs, which act as insurers and directly provide health services. However, in 15 regions, the only CHI funds that function are those that collect money and act as insurers. HICs have not been set up and health services receive money from the CHI or their branches directly. In the rest of the regions, a combined system has evolved, with CHI funds and their branches, as well as HICs, acting as insurers. Their shares vary substantially, though, depending on the region.

A second serious problem encountered in the development of the CHI concerns the collection of payments. Enterprises, as well as regional administrations, often do not fulfil their commitments. In many regions, health authorities are unwilling

⁴ Social funds in Russia include four out-of-budget funds: The Pension Fund, The Employment Fund, The Social Security Fund and funds of CHI.

⁵ In accord with the new Tax Code, starting in 2000 CHI contributions are collected by tax inspectors as a share of a new unified social tax.

to make contributions for the economically non-active population. According to the federal fund data, the share of payments by employers amounts to about 60% of all CHI receipts, whereas contributions for the unemployed are about 26%.

At present, on average, more than 65% of the resources to cover health care needs come from the budgets of different levels, including 80% from local budgets, with the remaining resources (close to 35%) being CHI's share. There are substantial regional variations in CHI's share of total health care expenditures; percentages fluctuate from 2% in the Saratov region to nearly 78% in the Samara region.

The reforms in health care have not been accompanied by relevant organizational changes. In fact, new structures – the CHI funds – were simply embedded into the old administrative system, which remained practically intact. Understandably, this has led to conflict between various players in the health care field, including the Ministry of Health, regional health authorities, the federal CHI fund, regional CHI funds, health insurance companies, and health services. This conflict has added to the ineffectiveness of health care reform.

Relations between the CHI agencies and the regional and local health authorities have not developed smoothly. Both sides have been fighting for supremacy in the health care system and they often cannot come to a mutual understanding or achieve compromise. The structure of the health care system itself has not improved: the number of excess beds, a target of criticism from the Soviet model, has not, in fact, substantially lessened, and no significant improvement in primary health care has occurred.

The number of medical personnel, mainly nurses, has, however, declined, primarily due to the fact that wages/salaries in the health care system are still among the lowest in the country. The average wages for health care personnel amounted to about 60% of the average nominal wage in the national economy in 2000, while that of doctors amounted to about 80%. As a result, many medical professionals have to occupy two positions simultaneously. This enables them to get two salaries but definitely leads to work overload and poor quality medical treatment. Such a situation also leads to the widespread practice of giving “gratitude” payments to medical staff in Russia.

The main reform innovation in primary health care has been the introduction of the general practitioner (GP). At present, this is said to be the major development in the organization of health care in Russia. Despite the positive experiences with GPs in other countries, its introduction in Russia is likely to bring about many problems, the solution of which will require considerable additional investments.

The main problem with the health reforms underway in Russia is that they were not well thought through conceptually, and there was inadequate preparation for their implementation (Grigorieva 1998; Nazarova 2000). For example, regional administrators are entitled to define the amount of their contributions, taking into account the structure of the regional population and its health status. At the same time, contributions by enterprises and organizations are fixed by federal legisla-

tion, and a fine is imposed for non-payment. Although the dependency ratio is increasing, the contribution from regional authorities is only 31% of that paid by employers. Regional administrators have been, in practice, cutting down expenditures on health care by paying CHI contributions for unemployed individuals from their health budgets, thus simply redistributing budget funds.

As a result, even the proponents of CHI recognize the necessity to introduce changes into the health care system. It is not clear, though, what will happen as different proposals are discussed. One proposal, for example, has promoted the idea of combining social and health insurance by merging the CHI funds and the Social Insurance Fund. In addition, the Pension Fund is strongly lobbying to manage the CHI funds for pensioners, and it is very likely to succeed. But whatever proposal is successful, it is likely to support the general trend of developing CHI in Russia.

5. Health Management and Policy Education

Today the importance of health management education is acknowledged by virtually all of the relevant actors in Russia. Statements made by various health officials – from members of the State Dumas (Lower Chamber of the Russian Parliament) to the Minister of Health and heads of CHI funds – stress the need to improve the organization and management of health care services as they provide a vital link in the efficient delivery of quality care. Such statements result from increased recognition that competent management is essential in organizations and programs at every level. Thus, changes in the organization and financing of health care have created a need for well-qualified people who can manage health services in the new environment and who are trained in cost containment, quality assurance and strategies of access to health care. However, similar pressure concerning health policy knowledge and skills generally does not exist. This produces a gap in the education system, which as reflected in the discussion that follows, focuses entirely on health management education.

At present, there are about four million people working in health care in Russia in the system overseen by the Ministry of Health. This includes 680,000 doctors and 1.6 million nurses and other medical staff, or 45 doctors and 100.2 other medical staff per 10,000 population (a ratio of 1: 2.5). Traditionally, people who occupy managerial positions in the health care system are almost all doctors. In fact, the health care system in Russia is managed by physicians. There is a very strong belief in the medical profession that only doctors can manage health services. It is reinforced by the fact that the Minister of Health, other senior health officials and members of Parliament who work in the Health Committee are all doctors. As a result, the dominant culture of health services has been static for years.

Most doctors work in the public sector and are salaried state employees. The salary of health administrators depends on the size of the institution, which is determined by the number of beds for hospitals of various types and the number of doctors' positions for polyclinics and other primary care health services. There

are five qualification groups. Doctors working in dangerous conditions are entitled to extra payments; for example, doctors working in tuberculosis wards are entitled to an extra 15% payment; in psychiatric wards, 25%; and in leprosariums, 30%.

Health service administrative/management positions include:

- chief physicians (heads);
- deputy chief physicians;
- senior nurses; and
- heads of departments, laboratories, and units.

Health management (HM) education in Russia occurs in both medical universities/faculties and in non-medical universities/faculties. Both types of institutions offer graduate and postgraduate degrees in what is traditionally understood as HM education. Because top-level administrators in the health services delivery system are MDs, most health management programs are physically and organizationally located in medical schools, under the administrative control of the Ministry of Health.

In general, medical education is under the strict control of the medical profession. There are 59 medical institutes, universities and academies in Russia, all controlled by the Ministry of Health. In cooperation with the Ministry of Education, the Ministry of Health develops the curriculum. A special higher medical and pharmaceutical education group (UMO, the teaching and pedagogical unit) in the Ministry of Education adopts medical education standards.

The three basic stages of medical education in Russia are

- graduate degree (six years of study);
- postgraduate professional training (two years either *ordinatura* or *internatura*) and postgraduate studies to apply for a research degree (Ph. D.) (*aspirantura*); and
- professional retraining (often in a new speciality).

Every year about 100,000 people graduate from medical universities. Beginning in 1994, the admission rate has been fixed in accordance with planned needs for doctors with various specialities – about 21,200 every year in total, including 19,800 full-time doctors. There is also a system of so-called targeted admissions for specific regions and programs; this involves a separate competition. Overall, the competition to enter medical universities is quite high – about five people per place, on average.

In addition to medical schools, several universities traditionally have had medical faculties (e. g., the Moscow State University named after Lomonosov, and the university named after Patrice Lumumba in Moscow). Medical faculties also exist in other Russian universities (e. g., Petrozavodsk, Chebiksari, Nalchick, Saransk, Yakutsk, Tula, Novgorod) – altogether there are 20 medical faculties in non-medical universities. But these medical faculties mostly offer biological specializations, psychology, social work in health, and (to a limited extent) health economics and management.

The Ministry of Health uses its authority to insure the leading positions of doctors in health management. For example, it issued a special decree (n337/1999) stipulating the medical qualifications that managers need to have in order to be appointed to administrative/management positions in health services. These are:

<i>Administrative/Management Position</i>	<i>Medical Qualification Required</i>
Chief doctor	Social hygiene and organization of health care* (or any clinical speciality)
Deputy chief doctor	Social hygiene and organization of health care* (or any clinical speciality)
Head of department	Clinical speciality of the department

*"Social hygiene and organization of health care" includes therapy, surgery, trauma and orthopaedics, endocrinology and physiotherapy.

In spite of the dominance of medical schools in educating health managers, at present a number of non-medical universities – both general and polytechnic – offer health management programs. It is virtually impossible to tell how many such programs exist, although the general view is that the number of such programs is likely to grow. There are two basic types of health management programs, according to the degrees awarded:

- graduate (bachelor's, master's) degrees; and
- postgraduate degrees.

Graduate training in health services administration is a relatively new phenomenon in Russia. In fact, until the mid-1990s there was no graduate program in health management for people to be appointed as health managers. Doctors usually had no special managerial training, except that they were required to take retraining courses – as are all state employees – every five years.

The first degree-granting health management program in a medical university was established in 1996 at the Faculty of Health Management in the Moscow Medical Academy named after Sechenov (MMA). It is equivalent to a two-year *ordinatura*, for the training of health managers. The faculty also provide retraining courses for health managers and lecturers in health management. The program actively uses funds provided by international organizations (e. g., TACIS).

Health management programs offered by non-medical universities are designed along the standard lines for humanities/social sciences education programs (see the earlier section on PA education). Health management is offered as a specialization for managers focused upon public and municipal administration or management in the social sector.

One major problem is that medical universities do not grant management degrees. Students graduate as "social hygiene and organization of health care" specialists and the curriculum is definitely dominated by medicine-related disciplines. This is apparently done to stress that the graduates are doctors first. The Ministry of Health plans to introduce a new degree in public health and management. With regard to non-medical universities, the situation seems to be the opposite. They

usually introduce health management as a specialization within management and/or public administration degrees. This means that students graduate, first of all, as managers and do not have any training in medicine.

These factors, together with the weak state standards for educational management, lead to a situation in which universities have much freedom in developing a health management curriculum. For example, the Moscow Medical Academy program includes a six-month placement with one of the health services or a local health administration. The curriculum includes courses in public health, health policy, health economics and statistics.

A number of postgraduate/retraining courses are designed for those who currently hold administrative positions. A major advantage of these courses is that most who finish this training will return to work at their original institutions. At present, these courses are mostly offered by specialized retraining centers affiliated with medical universities. They provide students with formal certificates that are valid for a five-year retraining cycle. Currently, it appears that retraining courses developed by non-medical universities are mostly informal – people obtain new knowledge but receive no formal certificates, or at least none that are recognized by the health care authorities.

Changes in health management have produced a good opportunity for nurses to increase their status within the Russian health care system. After graduating from nursing colleges, they now can study at medical universities for four years and receive graduate degrees in management. In 2000, 22 Russian medical universities offered students such a degree (full-time, part-time and distant learning format). Graduates from Russian medical universities during the period 1996 to 2000 included 947 graduate nurses (managers); every year about 250 nurses (managers) receive degrees. About 748 nurses (managers) are working for health authorities and in health services. However, graduate nurses (managers) are not able to take administrative positions in the doctors' managerial hierarchy; rather, they can work as chief nurses or directors of nursing homes or hospices, or (subject to having five years of work experience) can move up the hierarchy within nursing.

Finally, it is important to note that here is a clear lack of cooperation between medical and non-medical universities in training health managers. Moreover, neither side seems to be willing to promote such cooperation. The medical profession considers any attempts by other professionals to develop education in health management as a threat to its dominance in health care.

6. Conclusions: Main Dilemmas in Health Management Education

Effectively managing the changes resulting from new and emerging public policies will be the most significant future responsibility of health services managers. This will require a broad knowledge of issues and options, as well as new approaches to management.

Having doctors serve as managers makes it difficult to reconcile managerial and professional cultures. Doctors have always regulated access to health care; they have always made the decisions as to whether patients should be treated and with what level of intervention. “Clinical freedom” assumes that doctors make decisions in the best interests of the patients. Professionals are guided in their activities, first of all, by the interests of their clients, while managers must think about the interests of the organization as a whole, and often society at large. In health care, this “conflict” is even more evident, since there is a need for both professional and managerial expertise when making decisions that affect quality, access and efficiency.

Russian health managers are usually medical professionals who perform management functions. This means that they typically perform clinical work – from the Minister of Health, who travels on a regular basis from Moscow to St. Petersburg to operate on patients in the St. Petersburg military hospital, to heads of the departments or units in hospitals or polyclinics. These individuals have had to combine general managerial tasks with the management of clinical activities and physicians.

Normally, physicians have had little, if any, management training prior to assuming this responsibility. Their expectations are established by means of an education that is hospital, technology and specialty centered. Thus, balancing managerial and professional functions puts additional pressure on physicians. For example, a study on the social profile of health managers in Krasnoyarsk showed that health administrators often lack knowledge about how to deal with people.

Professional and managerial careers are interlinked in the Russian health care system. To a large extent, an administrative position is a form of recognition of a doctor’s talents and qualifications. Doctors are salaried employees of a state-run organization, and a managerial position means that the doctor is moving up the career ladder. Today, administrators not only need specific managerial knowledge, but also the ability to be proactive and risk-taking. By becoming managers, doctors get a higher salary and more prestige, but on the other hand, they often need to change some of their approaches to people and work.

It would be too strong to state that doctors are incapable of managing health services. But a number of reservations need to be considered in resolving this doctor-manager dichotomy:

- Professional and managerial cultures differ. Doctors focus on treating patients, while managers are concerned with institutional sustainability.
- Cost considerations also are important. It is much more expensive to train a doctor than a manager. Therefore, diverting doctors from performing their primary tasks is quite expensive for a society that lacks adequate resources for health care.

- The lack of formal managerial education makes the life of a doctor-manager difficult. He or she has to learn from their mistakes without having access to the vast experience in the field accumulated elsewhere.

There currently are four major dilemmas in health management education in Russia. First, there is the tension between the doctors' monopoly on health administration, on the one hand, and, on the other, the promotion of a new culture that emphasizes the increased role of effective management in the new environment of decentralization and, in so doing, promotes and raises the status of managers. This raises the issue of the need for physician-managers as opposed to full-time general managers/public administrators with no clinical functions. Here, economic considerations should be taken into account, since it might be more efficient and effective in terms of time, money, and quality of service to use doctors to perform their original tasks rather than employing them as managers.

The complexity of the challenges facing, and the consequences for, communities requires that there be purposeful preparation for a career in health services management. Previous training in medicine or nursing is useful, but not sufficient. Individuals with clinical backgrounds need an in-depth knowledge of management and social sciences as they are applied to health. Those with management training need a systematic knowledge of medicine and health. As a rule, medical schools do not teach management, and management schools do not teach health. The solution might be to establish partnerships between medical schools and management schools in training managers for health care. But at present this is a challenging task, as the medical profession tries to preserve its ultimate control in health care.

In fact, PA schools – if they want to continue to offer health management education, whether for prestige and/or money, need to lead the process of establishing effective cooperation with the medical profession in educating health managers. Useful starting points might be new domains in education that are now gaining popularity (as well as moral and financial support from state authorities) which include

- joint training of doctors and social workers to promote interdisciplinary work with socially vulnerable groups of the population; and
- retraining personnel for CHI bodies.

Second, the state monopoly in health care – both in financing and delivery – is being seriously questioned in Russia. There are already numerous private clinics in the country, and their number is increasing. Charging fees for service has also become quite common, even in the state health services; which means that patients who can pay are likely to be favored. What model of management, public or private, should Russia adopt in promoting health management education? Or, should health management education be diversified according to the needs of a particular organization? Regardless, programs should combine the content that is essential to successful management in the health sector.

Third, there are different layers of health management – e. g., Ministry of Health, chief doctors, heads of departments. Thus, it makes sense to have different health management degrees. At this stage, health management education should also address the needs of health policy makers, since there is no other opportunity for them to gain any health policy making knowledge other than through health management programs. Unfortunately, public health policy is not popular with faculties of political science, and thus health management programs are able to raise their status by introducing health policy components. Moreover, including health policy may help promote professional health management programs.

Fourth, in order to further develop health management education it is first necessary to have relevant information about its current state in Russia. However, at this stage it is very difficult, if not impossible, to evaluate the quality of teaching and to follow graduates' careers. The diverse health management courses offered by various higher education institutions, as well as the lack of communication and experience-sharing among these institutions, suggest that the quality of programs, in terms of structure and content, may not fully comply with international standards. On the other hand, it is unclear whether health management program graduates have an opportunity to use their knowledge at their workplaces and whether they really occupy managerial positions in health services.

To conclude, managing health care in modern Russia poses challenges to all parties concerned; including public administrators and the medical profession. Regardless of the challenges, however, it is clear that, given the complexity of the health care system, health care reforms are unlikely to be successful without the development of well-established health management and policy education and training opportunities.

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Public Health Management and Policy Education and Training: Slovakia

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1. Introduction

Slovakia is a relatively small country with 5.5 million inhabitants located in the center of Europe. The Gross Domestic Product (GDP) per capita is approximately 50% below the EU average but, in certain areas, the standard of living is relatively very high. In the Bratislava region, the GDP per capita is above the EU average and, when taking into account local purchasing power, significantly above the EU average.

The health care system in the country is based on the principle of free access at the point of delivery for most services, with costs financed predominantly from a compulsory social health insurance. The performance of the health care system in Slovakia was recently evaluated by the World Health Organization (WHO) and shown to be similar to other Central and Eastern European (CEE) accession countries (Table 1).

Table 1. Ranking of Health Care Systems in Selected Countries*

<i>Country</i>	<i>Life expectancy: 1970-1975</i>	<i>Life expectancy: 1995-2000</i>	<i>Change (%)</i>
Slovenia	69.8	75.0	+ 7.4
Czech Republic	70.1	74.3	+ 6.0
Slovakia	70.0	72.8	+ 4.0
Poland	70.4	72.8	+ 3.4
Hungary	69.3	70.7	+ 2.0
Romania	69.2	69.8	+ 0.9
Lithuania	71.3	71.4	+ 0.1
Bulgaria	71.0	70.8	- 0.3
Latvia	70.1	69.6	- 0.7
Ukraine	70.1	68.1	- 2.9
Russia	69.7	66.1	- 5.2

Source: World Health Organization (2001).

* Based on 1997 data for 191 countries (highest = 1).

** Based on total spending per capita in international dollars.

The process of reforming the Slovak health care system started immediately after the “Velvet Revolution” in 1989. Key elements included privatization and a change from general taxation to a social health insurance system of financing care, but the reforms are far from being finished. Policy making and implementation

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failures during the reform have created additional large-scale problems; many of them today are connected with finance. No consistent central health policy in Slovakia yet exists. However, as a result of development trends - both in society and in the health care sector, the need to create real health making policy implementation and analysis capacities in the country is becoming more urgent.

To support these changes, a system of academic education and training for health management was created and/or updated relatively quickly, but its current quality and capacities are still not sufficient. There are two main approaches to the preparing and/or training of health managers. The first, represented by the Faculty of Economics of Matej Bel University, is a more generalist approach with the graduates being given a comprehensive base of economics, management and health care courses. However, the number of such graduates is very small and there is only a limited effort to increase enrollment. The second, represented by the Faculty of Health Care and Social Work of the University of Trnava and the School of Public Health of the Slovak Health Care University, is predominantly based in medical disciplines and health management courses represent only a marginal part of the curriculum. This type of education and training, coordinated mainly by medical doctors, also has very limited chances of producing new, effective health managers.

Under these circumstances, the capacity of education/training institutions to influence the quality of management of health care establishments is very limited and there will be significant problems in attempting to change this situation (which perhaps can only be brought about by introducing more private funds into the system and creating real conditions for a public-private mix in the delivery of health management training).

Health policy does not exist as a specific curriculum or system of study and only a few hours on this subject are taught at Banska Bystrica or Trnava. There is a specialized health policy center at Banska Bystrica, but there is no permanent staff, and the capacities of this center are mobilized only on a case-by-case basis. As independent health policy research is unlikely to be financed from private resources, and public finance capacity will be limited for some period, this area should be considered as one of the important fields of future foreign aid.

2. Country Profile

In early medieval times (after the defeat of the Moravian state by Hungarian troops), Slovakia was a part of the Hungarian Empire. The system of public administration in Slovakia was an integrated part of Hungarian public administration, characterized by the relatively strong position of municipalities. Many of the basic features of Austro-Hungarian public service became the basis for the public administration system of the first Czechoslovak state, which was established on 28th October, 1918.

The period 1918-1939 was characterized by the development of a democratic civil service in a market economy environment. In spite of the relatively centralized management of public administration from Prague (the capital of Czechoslovakia), the public service system of the country showed many features of modern public administration (including a well-developed civil service law and the strong status of municipalities) which led to the development of an impartial and professional civil service system.

In 1945, after the Second World War, Czechoslovakia was re-established as a unitary state. The Communist Party of Czechoslovakia won the democratic elections of 1947 and then, in February 1948, took over all powers of the state. The period between 1948 and 1989 may be characterized as the period of so-called "socialist democracy" and a planned economy. The public administration system was re-organized to serve the interests of the Communist Party and became fully dependent on its political masters.

After the Velvet Revolution in 1989, the process of a gradual transition to a pluralistic, democratic public administration system started in Czechoslovakia. Most tasks of formal restructuring according to western standards were realized in the early stages of the transition period. The first public administration reform in Czechoslovakia was defined according to the most important tasks of revitalizing democracy (Nemec, Berčík and Kukliš, 2000):

- to create real self-government institutions;
- to divide executive and legislative power on all levels;
- to create a new organization of the civil service with two levels of administration;
- to change the territorial structure of Czechoslovakia; and
- to restructure the central government and the system of control of the civil service.

The first democratic elections were held in June 1990 and became the basis for most of the changes in the public administration system in Czechoslovakia. The self-government of municipalities with high levels of independence was re-established. The system of National Committees (a socialist form of local government, combining in one office both local state administration and self-administration functions) was abolished and replaced by 38 district general state administration offices and 121 sub-district general state administration offices. Local self-government, with representatives elected directly by the local population, was constituted through municipalities which were established as territorial and legal entities. Within limits set by the law, local governments have their own budgets and assets. Local governments may issue ordinances which are binding on all individual or corporate bodies within their jurisdiction. These ordinances may be superseded or invalidated only by parliamentary acts. In some cases, local governments may be delegated additional powers necessary for the administration of the state and financed by

state funds. Interference with the powers of local self-government is possible only by legislation passed by the Parliament.

On January 1st 1991, Slovakia became an independent country after the friendly and smooth splitting of the former Czechoslovakia. Later, in 1996, a second wave of public administration reform began. It was characterized by the parallel imposition of a radical change in the territorial and administrative structure of the state, and by the establishment of the uniform two-tier (regions and districts) system of offices of general state administration with a broad range of tasks and responsibilities. The reform had the goal of increasing the effectiveness and quality of public administration and creating a customer-friendly and responsive system to serve the citizens. The costs of the reform were much higher than planned and the results have been very limited (Audit ústrednej štátnej správy, 2000).

After the 1998 general elections, the new Slovak government reaffirmed public administration reform as one of its main goals. The primary rationale for the reform was that decentralization would solve all inefficiencies (Stratégia decentralizácie a reformy verejnej správy 1999). The start of the reform was postponed several times because of a lack of political consensus between the political parties. Only the massive interventions of Prime Minister Dzurinda at the beginning of 2001 pushed the process forward; he called the achievement of public administration reform the main government priority.

Subsequently, but perhaps too quickly, the Parliament approved all proposed basic legislation. The following laws were among the most important ones enacted in 2001:

- Civil Service Code (July)
- Public Service Code (July)
- Law on Creation of Territorial Self-Government – Regions (July)
- Law on Elections of Territorial Self-Government Bodies (July)
- Law on Transfer of Competencies of the State to Regional and Local Self-Administration (September)
- Amendment of the Law on Municipalities (October)
- Amendment of the Law on Municipal Property (October)
- Law on the Property of Territorial Self-Government (October)
- Amendment of the Law on Budgetary Rules (October)
- Law on Remuneration and other Aspects of Performing the Position of the Head of Territorial Self-Government (October)
- Law on Financial Control and Audit (October)
- Law on Ombudsman (December)

The important Law on Transfer of Competencies defined the very large set of responsibilities to be transferred to regional and local self-government in 2002-2003. Municipalities received new responsibilities in the areas of road communi-

cations, water management, evidence of citizenship, social care, environmental protection, education (elementary schools and similar establishments), physical culture, theatres, health care (primary and specialized ambulatory care), regional development, and tourism. Regional self-government became responsible for areas of road communications, railways, road transportation, civil protection, social care, territorial planning, education (secondary education), physical culture, theatres, museums, galleries, local culture, libraries, health care (polyclinics and local and regional hospitals), pharmacies, regional development, and tourism. Many of these competencies previously had been the direct responsibility of the ministries (e. g., hospitals, education).

The elections in autumn 2002 gave political power again to the Dzurinda cabinet, and the reforms plans were not changed. The EU enlargement decision, effective May 2004 (when Slovakia is included in the group of countries to become new EU members), created additional pressures to incorporate the main principles of European public administration – openness, participation, accountability, effectiveness and coherence – and the principles of subsidiarity and flexibility into daily administrative practice.

Important steps in this direction have already been taken, but many problems remain or may appear. The main problem with the current reform measures has been an overestimation of the potential for decentralization, which has evolved from a reform tool to a reform goal (as apparent from the reform document and its “strategy of decentralization and reform”), together with a current territorial structure that is too fragmented. The number of municipalities is extremely high (2,875 municipalities), and many municipalities are too small (68.4% of municipalities have fewer than 1,000 inhabitants). Such fragmentation increases the transaction costs of the system and does not create an environment for effective realization of self-government functions on the local level.

3. Health Care System

The objective of the pre-1989 health care system in the former Czechoslovakia was to provide a comprehensive system of health care for all members of society. Decisions about medical care provisions were made by the federal government and by the national Czech and Slovak Ministries of Health – and generally were made on political or administrative grounds. The only accountability in the old system was to the Communist Party.

Under that system, both services and medicines were free to the patient; however, until 1987 there was no individual choice of practitioner. The supply of services was constrained by the plan, and the purchaser and provider were one. Economic resource allocation played no part in determining services; the level and distribution of these services, although influenced by social, medical and administrative considerations, were determined by political decisions. No cost-benefit calculations were undertaken. There were no economic incentives, either for individuals or for

the system, to improve performance, and there was chronic and sometimes acute excess demand for services.

Yet, when the transition began, the Czechoslovak system was far from being in the crisis state of the Polish and Soviet systems (Davis 2001). When necessary, everybody was able to get appropriate health care consistent with a relatively high international medical standard. Most equity considerations were achieved (although there also were special medical institutions that provided higher quality care for high-ranking officials). The old system is often described as obsolete and inefficient, but with approximately 5% of GDP allocated for health care expenditures most demand was covered without significant waiting lists. Relatively high-quality care was a characteristic of the health care system, in spite of insufficient quantity and quality of equipment.

General trends in health policy in Slovakia after 1989 (health care was the responsibility of the national Slovak government and not the federal Czechoslovak state as it had been since 1968) were defined by programmatic statements of government and the main reform document (first published in 1990). The most important goals of the reform were as follows:

- create a system of “health care for everybody” (i. e., a system of public health), as described by the document “National Public Health Program”;
- provide universal access to a defined scope of health services and benefits;
- make the free decisions of citizens the basis for the creation, implementation, and control of health policy;
- eliminate the state monopoly in health care and encourage many providers of health care, privatization, and increased participation of self-government in the health care system;
- establish public health as a dominant part of a health care system;
- ensure that primary care has the dominant position in the health care system;
- ensure that a citizen has the right to choose a provider;
- establish compulsory health insurance;
- promote citizens’ participation in the protection and improvement of their own health;
- develop multi-resource financing of health care;
- improve economic and financial management in health care establishments; and
- end the impairment of the health status of citizens.

Basic Framework for Health Care System

New legislation was soon adopted to achieve the proclaimed goals. Of the many legal documents adopted, the most important for providing a basic framework for the health care system in Slovakia include:

- the Constitution of the Slovak Republic;
- the package of laws related to the creation of an insurance scheme;

- the Law on Treatment Order;
- the Law on Health Care; and
- the Law on Health Protection of People.

The Constitution of the Slovak Republic

The Constitution of the Slovak Republic is the highest institutional guarantee of human rights in Slovakia. Since 1 September 1992, the Constitution is in principle a modern one that provides for a standard system of human rights within a democratic society. In the area of economic, social and cultural rights, it provides for a universal right to the protection of health. On the basis of an insurance system, citizens have a right to free medical care and related medical benefits according to the provisions of complementary law.

The Law on Treatment Order

This law establishes the most important principles with regard to qualifying conditions for services, scope of cash and in-kind benefits and the organization of health care. It regulates the extent of the health care to be provided under a compulsory health insurance plan, the conditions under which it is to be provided, the reimbursement schedule, the categorization of drugs (for different levels of co-payment) and the rules on health insurance coverage of medical aids. It also defines the nature of reimbursement of spa treatments.

The most important parts of this law are:

- With health insurance, health services, medicines and medical aids are provided as indicated on the basis of health needs. This is to be based on current achievements in the medical and biomedical sciences and effective treatment following therapeutic and pharmaco-therapeutic rules is guaranteed. Health services provided according to this law are listed in its annex 1. The list and categorization of medicaments are provided by annex 2. The medical aids list is in annex 3 of the law.
- Insurance companies reimburse contractual health care establishments for the costs of health care provided according to the list of treatments, medicines and medical aids and the prices of service, medicines, and medical aids are to be defined by price regulations (issued by the Ministry of Finance).
- Specialized health care is provided to a patient only on the basis of referral by a general practitioner or by referral by another specialist.
- On the basis of their health insurance, patients shall get only defined daily doses of medicines.

The Law on Health Protection of People

This Law defines the rights and obligations of the state administration, municipalities and other personnel, as well as the responsibility of the state administration and of state supervision in the field of protection of the health of the people.

The Law on Health Care

This law deals with the provision of health services, organization and management of health service and defines the rights and obligations of personnel in connection with health care. It also delegates the main regulatory, planning and managerial tasks to the Ministry of Health. It declares:

- “Everybody has the right to receive health care, including medicines and medical aids. Health care is provided by state health establishments, municipal health establishments, medical establishments run by legal or territorial entities, and is provided on the basis of the existing accessible know-how of the medical and other biomedical sciences.”
- “Health care is provided for citizens:
 - a. free, on the basis of compulsory health insurance
 - b. on the basis of additional insurance contracts
 - c. from state budget resources
 - d. on the basis of the financial resources of charities, legal or physical entities
 - e. based on the co-payment or full participation of the health care receiver.”
- “A citizen has the right to care according to the kind and level of the health problem. She/he has the right to choose the doctor or health establishment. In the case of an emergency, she/he has the right to get medical care in the nearest medical establishment available to provide the appropriate health care.”

The Set of Laws on Health Insurance

Slovakia, similarly to most of the other CEE countries, introduced the so-called “Bismarck” system of social health insurance to replace the old general taxation system of financing health care. The main set of laws regulating health insurance was passed in 1994 creating the basis for the establishment of 13 health insurance companies, most of which disappeared from the “market,” thus leaving five still existing in 2002. The change in the health insurance system was supported by the typical arguments on behalf of plurality, independence and competition. However, the Constitution and consecutive sets of laws guarantee the citizen universal and free access to health care. Thus, this package must be delivered by all insurance companies for a price that is regulated by the Ministry of Finance. Consequently, some level of system plurality and competition was visible only in the starting phase of the insurance system, when the services to the insured were, to some extent, different.

Current Situation of the Health Care System

Health Status in Slovakia

Health status in Slovakia, as measured by the most important indicators during the 1989-2000 period, was similar to other more developed CEE countries (Czech Republic, Hungary, etc.). There is not adequate data to assess what the main factors behind this positive trend were or to what extent this was caused by

an increased quality of health care or other factors such as changes in lifestyle, improving environment, etc.

Table 2 provides the most important indicators of health status development. It shows that life expectancy has significantly improved but is still below EU levels (WHO 2002). The difference in life expectancy between men and women is still relatively large, but has decreased from 1990. The quality adjusted life expectancy in Slovakia was 66.6 years, significantly lower than the lowest level in the EU – Portugal, with 68.9 years (Slovensko 2001, p. 499). Mortality is very slowly going down, but is much higher compared to the EU, especially for cerebrovascular mortality (26.6 % of deaths in Slovakia).

Table 2. Main Indicators of Health Status in Slovakia

		1985	1990	1995	2000
Life expectancy (years)	Men	66.9	66.6	68.4	69.2
	Women	74.7	75.4	76.3	77.2
Death/1,000 Inhabitants	All	10.2	10.2	9.8	9.8
New-born mortality	All	11.1	8.4	7.9	n/a
Infant mortality	All	16.3	12.0	11.0	8.6

Source: UZIS, different tables; see <http://www.uzis.sk>.

An emerging problem since 1990 is the declining natural increase in number of inhabitants. The natural increase in 2000 was only 2,427 persons, compared to 4,821 in 1999, 72.2% less than in 1995 and 90.4% less than in 1990. There are only a few regions where the number of live births exceeds the number of deceased (Zdravotnicka rocenka SR, 2000).

The health status indicators show that negative factors connected with transformation (stress, decreasing standard of living for a large proportion of inhabitants, increased consumption of drugs) were outweighed by other positive factors. The medical quality of health services might be one of them, due especially to significant improvements in the equipment of providers and the medicines available.

Access to Care: Universality and Equality

As already mentioned, according to the legislation, access to most services is free at the point of delivery. Overall, there is no evidence of any group or citizen being denied access to any free service which they have a right to receive. General practitioners, dentists and opticians cannot refuse to treat patients but where waiting lists exist for specialists, unequal treatment may occur because there are no formal and effective rules of access. With hospital care it is common to make additional illegal or non-legal payments for extra services; for example, for a separate room. A systematization of these practices through additional co-insurance is likely to be introduced.

On the other hand, because of corruption and other factors, access is not equal. There are no Patients' Charters, and complaints generally find no responsive addressee. This is important because more than two-thirds of Slovaks claim that they have had to pay a bribe to ensure good care (Miller, Grodeland and Koschechkina, 1998, estimate an 89% likelihood that bribes must be offered to medical doctors in Slovakia). Bribes have been estimated to amount to a tenth of health costs (a recent unpublished study financed by the World Bank estimates this amount to be 3 mld. Sk).

The question of access to health services in Slovakia represents a two-dimensional issue. On one hand, there is the widespread and popular commitment to universal access to health care, free at the point of use. The 1998 Slovak Government Programmatic Statement (www.government.gov.sk), prepared at the time of the increasing financial crisis of the system, reflects this:

“The government will guarantee generally accessible and high quality health care for all citizens. Within the framework of the basic health insurance, any citizen is assured equal access to and equal quality of basic health services”.

On the other hand, real inequality in access is increasing; to a large extent as the result of the deepening financial crisis and the unofficial shift of financial burden to citizens. The increasing inequality of access to health services in Slovakia has already been recognized by most important international organizations, such as the World Bank and the OECD.

Quality of Care

It is very difficult to assess developments in quality of care after 1989, as there are not any good indicators available. Yet, as mentioned in the evaluation of health status developments, there are significant quality improvements on the supply side, mainly in:

- the structure and quality of equipment available in health establishments; and
- the structure of medicines available and used for treatment.

After 1989, several barriers limiting the possibility of importing top Western technologies were dismantled, and the regulations concerning what can be purchased and prescribed were weakened. Contradictory outcomes resulted – on one hand, there were improvements in the technical aspects of the quality of services; on the other hand, there was a relative oversupply of technologies and expensive drugs, which caused one of the financial problems of the system.

Compared to the positive technical developments, the trends in other aspects of health care quality are both more controversial and difficult to prove. In spite of many promises, no Slovak government was able to introduce a systematic medical and organizational audit of health providers which would tell more about how the care is delivered by doctors and the conditions by which it is delivered to patients. A well known case of mis-treatment of the Slovak President in 2000 (Slovensko,

2000) clearly showed the basic weaknesses in the daily delivery of care - but it was not used as an impetus for change.

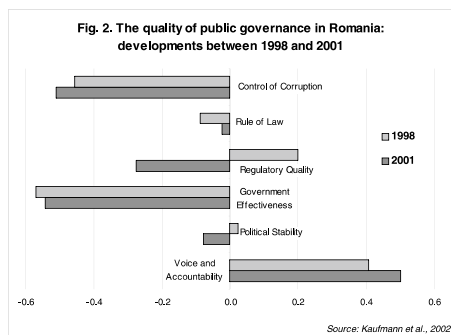
The organizational quality of patient's care is improving, but very slowly. Compared to the old system, there is now a choice in provider, but the patient is still very far from becoming the central subject of the system. The document "Patient Rights" was prepared and published only in 2000 and some establishments still have not developed it to local conditions. Queuing in front of a clinic, without the opportunity for an exact appointment, is still typical for a large proportion of providers, including private providers.

Economic Performance of Health Care System

The main problems of the system after 1989 are connected with finance. The under-financing of the system at the start of the reforms after 1989 and the decrease of the economic performance of the country as the result of transition are critical factors. However, there are significant design and implementation factors that have brought the system close to collapse.

Table 3 describes the overall financial performance of the health care system in Slovakia after 1995, when the financial problems started to be apparent.

Table 3. Economic Performance of the Health Care System in Slovakia (mld. Sk)



Source: Zajac and Pažitny (2002) (2002 data are estimated).

The data show that, in spite of the economic performance of the system and the fact that the system's improvement was on the agenda of all Slovak governments, the actual results are unsatisfactory. From 1997 on, the system systematically has consumed 10-15% more resources than have been available and this trend has not changed in spite of the implementation of many measures. The main sources of this imbalance in the system are analyzed in the sections that follow.

Resources of health care system in Slovakia. As is apparent from Table 4 below, the system depends heavily on public resources – in part from the health insurance

system and in part directly from the state budget. The participation of patients in the form of direct payments/co-payment is still rather limited and much lower than in most developed countries. Compounding this, the total amount of resources has been directly limited by the performance of the national economy which has been much below the EU average (also in purchasing parity terms), and only recently reached the level of the pre-transition period.

Table 4. Resources of Health Care System in Slovakia

		1995	1996	1997	1998	1999	2000	2001
Resources in mld. Sk	Health insurance	20.1	26.1	29.2	32.2	33.2	35.1	37.7
	General taxation	11.2	14.9	15.3	15.2	15.5	15.7	17.9
	Direct payments	1.8	2.6	3.8	4.1	5.4	5.9	6.3
	Total	33.1	43.6	48.3	51.5	54.1	56.7	61.9
Resources in %	Health insurance	60.6	59.8	60.5	62.4	61.4	61.9	60.8
	General taxation	33.9	34.2	31.6	29.6	28.6	27.7	29.0
	Direct payments	5.4	6.0	7.9	8.0	10.0	10.4	10.2
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Zajac and Pažitný (2002).

The insurance premium is currently set at a 14% of income-related base (14% from 2002), but the state is expected to pay for large groups of persons without regular income (children, pensioners, etc.), representing about 3.5 million of a total of 5.5 million inhabitants. As indicated by Table 5 below, for this group of citizens the state contributes on a very low level. The amount to be paid is set on a yearly basis in the Parliament when voting on the state budget. As a result, the rules of the game fare differently for the main participants: the private sector has to pay a fixed rate, while the state has not contributed the minimum full amount (at least 13.7% from the minimum wage) for any of the evaluated years. As a result, the system is not provided with the expected amount of resources.

Table 5. Contributions of the State into the Health Insurance System

	1995	1996	1997	1998	1999	2000	2001
Contribution per insured person, Sk	181	269	269	270	283	283	336
Total contribution, mld. Sk	7.1	10.3	10.4	10.5	11.1	11.2	13.0

Source: Zdravotnícka ročenka SR (2001).

Costs of health care system in Slovakia. As there is limited space to increase revenues for the health care system in Slovakia, the focus should be on cost-containment measures, efficiency and economy of the system in order to balance the demand, supply and resources available. However, very little has been done in this respect since 1989. The most important health sector inefficiencies include excessive employment, the low economic performance of hospitals and ineffective drug regulation policies.

The problem of employment is highlighted in Table 6, which shows that the total number of health personnel is similar to the pre-reform period, despite the fact that “over-employment” was accepted as the main problem of the system

from the beginning of the post-1989 changes. [The decrease in 1995-97 is not real because the methodology did not react to privatization in time.]

Table 6. Employment in Health Care (number of persons)

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
State sector	n/a	n/a	n/a	n/a	n/a	n/a	86,450	86,033	83,188	86,023
Non-state sector	n/a	n/a	n/a	n/a	n/a	n/a	19,919	32,702	32,971	34,750
Total	129,468	125,581	127,414	121,464	108,715	96,935	106,369	118,735	116,159	120,773

Source: *Statistická ročenka SR (2002)*.

As was apparent from Table 3, the costs for drugs rose by 100% between 1996 and 2002 (the data for 1995 do not include the costs of drugs consumed in hospitals). The increase can, in part, be explained by the changing structure of the drugs used (the importation of more effective, but also more expensive, medicines at international market prices). However, it is also caused by the ineffective regulation system for prescription drugs. The tools of evidence-based medicine are still not used for setting the rules for which medicines are to be prescribed, and to whom and under what circumstances -- thus leaving space open for lobbying by pharmaceutical firms, as well as bribing doctors to prescribe more expensive and larger amounts of drugs than necessary. Insurance companies have lists of doctors who prescribe 10-20 times more than average costs, but there is no mechanism to handle this. In this non-effectively regulated environment, the cost for drugs has almost reached the costs of the hospital system.

The most costly part of the health care system in Slovakia is in-patient care which did not change very much during the entire period from 1991 to 2000. Data showing the main performance problems of hospitals are provided in Tables 7-10. Table 7 shows the problem the deficit and the lack of capacity/will to manage fixed costs of hospitals.

Table 7. Performance of Hospitals

	1996	1997	1998	1999	2000	2001
Number of patients	1,055,757	1,090,672	1,109,210	1,059,533	1,063,611	n/a
Change (%)	2.6	3.3	1.7	-4.5	0.4	n/a
Costs (mld. Sk)						
Fixed costs	15.4	17.7	19.3	19.3	19.7	21.6
Variable costs	6.1	6.4	6.3	5.7	6.3	6.5
Total costs	21.5	24.1	25.6	25.0	26.0	28.1
Total costs - change (%)		12.1	6.2	-2.3	4.0	8.1
Revenues (mld. Sk)	19.8	22.9	22.3	20.2	22.5	24.9
Balance (mld. Sk)	-1.7	-1.2	-3.3	-4.8	-3.5	-3.2

Source: *Zajac and Pazitny (2002)*.

Table 8 shows that there are minimal changes in bed capacity and use during the period 1991-2000, indicating that the trends in in-patient care continue.

Table 8. Management of Bed Capacity in In-Patient Care

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Average length of treatment (days)	12.9	13.4	12.7	11.2	11.5	11.3	11.2	10.1	9.1	8.9
Use of beds (days)	276	274	268	280	289	290	286	284	254	258
Beds/number of doctors	8.4	8.1	8.6	7.9	7.9	7.5	7.0	6.5	6.4	6.2
Beds/1, 000inhabitants	7.6	7.6	7.9	7.1	7.5	7.5	7.3	6.7	6.6	6.5
Use of bed capacity(%)	75.6	75.0	73.4	76.6	79.3	79.5	78.4	77.9	69.5	70.7

Source: *Zdravotnicka rocenka SR (multiple volumes)*.

Table 9 indicates that the numbers of staff were not reduced during the period of large deficits, and over-employment persists. Wages are calculated as part of the fixed costs of hospitals and with increased rates for employees, wages account to a larger and larger proportion of the total costs.

Table 9. Structure of Employment in Hospitals

No. of Employees	1995	1996	1997	1998	1999	2000
Doctors	10,567	8,000	9,243	9,416	9,323	9,761
Nurses	30,334	24,546	28,738	28,846	27,497	28,037
Other medical staff	13,036	11,208	13,194	13,396	13,468	12,644
Administrative staff	21,329	17,158	19,193	18,644	17,712	19,982
Others	1,871	1,593	1,810	1,805	1,790	1,181
Total	77,137	62,506	72,178	72,107	69,789	71,605

Source: *Zajac and Pazitny (2002)*.

Table 10 presents detailed data on costs and revenues for selected categories of employees; these data suggest that the more efficient use of manpower has not had significant impacts.

Table 10. Individual Performance of Staff in Hospitals

	1996	1997	1998	1999	2000	2001
Number of diagnoses/employee	1,064	862	844	839	823	835
Number of diagnoses/doctor	8,311	6,729	6,462	6,278	6,041	6,110
Revenues/doctor (Sk)	2,478,107	2,473,468	2,366,756	2,166,794	2,309,061	2,541,271
Revenues/nurse (Sk)	807,704	795,539	772,538	734,652	803,901	889,445
Revenues/employee (Sk)	317,186	316,748	309,053	289,451	314,767	347,342
Costs/employee (Sk)	342,973	332,994	355,175	358,614	363,248	392,534

Source: *Zajac and Pazitny (2002)*.

Coping with deficits: shifting the burden to the private sector. None of several reform measures has been able to significantly influence the negative economic performance of the health care system in Slovakia -- which has been producing large debts every year. Instead of stronger pressures for higher efficiency within the system, the system worked in favor of those creating debts and penalized private sector payees for problems caused mainly within the system by health professionals and health establishments. This solution of shifting the debt burden out of the health care sector clearly shows that the level of development of relations between the state and other sectors is still far from international standards -- thus leaving

too much room for the state to move its own problems (an imbalance between the resources available and the scale of “free” services promised to citizens) on to be the costs of others -- in this case mainly to the private sector and to patients who are pushed to bribery to get appropriate services. Table 11 shows how the deficit is developing and how it is covered.

Table 11. Scale and Structure of External Debt of Health Care System (mld. Sk)

	1995	1996	1997	1998	1999	2000	2000	2001	2001	2002
Non-paid drugs delivered by pharmacies	0.9	0.8	2.1	3.8	3.6	4.0	4.7	5.9	6.6	8.0
Credits and other similar resources	0.6	0.7	1.7	1.9	4.4	4.0	4.4	4.4	5.8	5.9
Non-paid social contributions	0.4	0.4	0.7	1.8	3.0	4.5	4.4	3.1	4.2	4.1
Non-paid drugs from other suppliers	1.2	1.2	2.3	3.6	3.7	3.8	3.8	3.9	3.8	4.5
Non-paid food and other material supplies	0.6	0.7	1.0	1.9	2.6	2.7	2.2	3.5	3.7	4.6
Non-paid energies	0.4	0.4	0.6	1.0	1.1	1.5	1.7	2.0	2.5	2.9
Total	4.0	4.2	8.4	14.0	18.4	20.5	21.1	22.7	26.6	30.0

Source: Zajac and Pazitny (2002).

Clearly, the data on economic performance shows that health care reform measures have not had a significant positive impact on the economics of the health care system. The main problems causing inefficiencies include:

- oversupply of medical personnel, mainly doctors;
- oversupply of facilities, mainly hospital beds;
- lack of capacities to manage demand (rationing);
- ineffective management of hospitals;
- ineffective drug management; and
- limited prevention and lack of incentives to protect the health status of the patient.

These problems persist and are solved largely by imposing costs on the private sector and consumers of health care.

Such development trends indicate important gaps in the area of health policy. The problems of the health system are real, well-known, and still grow; but no government has been able to solve any of them during the entire period since changing to an insurance-based health care system of financing in 1993. The state health policy was, from the beginning, not in an active forward-pushing position; on the contrary, it was not even able to predict potential negative outcomes of the changing environment.

After 1989, pressure groups quickly developed as doctors, hospitals, pharmaceutical companies, health insurance companies, but not citizens,

vied for power and resources. The more conservative nature of Slovak public opinion helped the bureaucracy to retain their policy and operational powers. The choice of insurance-based health funding had been made without public discussion, before the division of Czechoslovakia into two independent republics. Most of the key problems that then emerged were the direct consequences of the funding switch, as the logic of the insurance solution worked itself out through market segmentation, the collapse of pooling solutions, fewer providers, state enforced premium redistribution and less competition.

The lack of capacity in policy making and policy implementation is obvious, and has many negative impacts, paid, in the final phase, by the most important player – the patient, in monetary and non-monetary (decreasing quality and access) form. Some changes seem to have occurred under the most recent (2002-3) Slovak government, but they are very slow. The health policy area was not developed and supported, but was neglected during the whole 1990-2002 period and such capacities cannot be created overnight.

4. Public Administration/Management Education

Public administration was not recognised as an independent academic field of study in Slovakia prior to the 1980s. Top public servants received their education outside of Slovakia (mostly in Moscow), or in special “Universities of Politics” established by the Communist Party in Prague and Bratislava. Middle and low level public servants did not receive specialised public administration education, which had a negative impact on the quality of the civil service. This situation also influences the current structure of public servants as most of them still do not have a university degree in public administration (PA).

The necessity to change the country’s “materialistic” approach to education (in which, according to economic theory, only employees in “material sectors” of the economy – industrial branches, agriculture, forestry, mining, building industries, etc. – created national income) and to start to promote, in addition, the services sector was not recognized until the 1970s. This led to the emergence of public administration/public management (PA/PM) programs.

Academic PA/PM Programs

In 1977, the first faculty preparing university graduates for all branches of the service sector was established as the part of the University of Economics, Bratislava in Banska Bystrica. From the early beginnings of this faculty’s existence, increasing attention was given to the development of study programs preparing specialists for so-called “non-productive” branches of the economy, including public administration. As a result of these developments, the first study program in “Economics of Non-productive Services and State Administration” was established in this faculty

in 1986. At the same time, similar programs were also established in the Czech Republic (Prague, Ostrava and Brno).

In addition, the faculty of Economics of Tourism and Services was a unique university-level institution with a PA program until 1989. However, many subjects from the PA/PM field were also included into the curricula in various faculties of the University of Economics in Bratislava, mainly in the Faculty of the National Economy (high quality courses on public finance, for example).

After 1989, new PA and similar programs were established in Slovakia, as a result of two important factors:

- the society started to feel the need for academically-trained professional public administrators prepared to realise effective public administration and public management roles
- a liberalisation of the system of academic studies in Slovakia - each university gained the right to decide on the structure of its faculties and study programs

On this basis, the current structure of public administration academic programs was established. According to recent legislation (2002 University Law), three levels of public administration/public management (PA/PM) studies are available to students:

- Bachelor's degree studies in PA/PM (3 years); students receive the *bakalar* degree.
- Master's degree studies in PA/PM (2-3 years); students receive the *inzinier* (Ing.) or *magister* (Mgr.) degree.
- Postgraduate degree studies in PA/PM (3-5 years); graduates receive the Ph. D. degree.

The following are academic institutions in Slovakia where specialised PA/PM degree programs are taught:

1. **Matej Bel University Banska Bystrica, Faculty of Economics.** In this faculty (which is more a business school than a school of economics), PA/PM education is delivered through coordination with the Department of Public Economics and the Institute for Local and Regional Development, within the framework of the program "Public Economics and Public Administration"; four specializations are offered.
2. **University of Economics Bratislava, Faculty of the National Economy.** This faculty is between that of a typical school of economics and a typical business faculty. PA/PM studies represent one specialization within the study branch National Economy.
3. **University of P. J. Safarik Kosice, Faculty of Public Administration.** This specialized faculty was established in November 1998; prior to that time, PA studies were realized in this university within the framework of the Faculty of Law by the Institute for Public Administration.

4. **University Trencin, Faculty of Socioeconomic Relations.** This university created its PA academic program as a specialization within the broad study program on human resources.
5. **University of Cyril and Metod Trnava, Faculty of Philosophy.** In 1998, this faculty started two study programs related to PA/PM: Law in the Public Services, and Management and Economics of Public Services. Neither program was accredited (and probably will not be accredited soon) and had to be closed.

There are also other university programs with some features of a PA/PM degree program. These include:

1. Matej Bel University, Banska Bystrica, Faculty of Political Sciences and International Relations
2. Matej Bel University, Banska Bystrica, Faculty of Law
3. Comenius University, Bratislava, Faculty of Philosophy, Department of Politology
4. Comenius University, Bratislava, Faculty of Management
5. Comenius University, Bratislava, Faculty of Law
6. University Presov, Faculty of Philosophy

As regards the structure of PA/PM programs in Slovakia, one must stress that the system of university degree programs (branches and specialisations) is, as the result of a new university law, under heavy reconstruction today. Consequently, the current names and structures of extant programs might be changed in a short time.

Most of the PA/PM academic degree programs in Slovakia are developed on the basis of economic studies and are more (Bratislava) or less (Banska Bystrica, Trencin) dominated by the economic and management disciplines. Only the PA degree in Kosice has a more diverse character involving economics, management, legal and other studies.

In-service PA/PM Training

In-service training in public administration in Slovakia is highly decentralized as a result of a system of personnel management in the public sector that was highly decentralized before 2002 when the new Civil Service Code and Public Service Code were adopted. There are many institutions participating in some form of in-service training. Probably the most important of them (at least according to the number of trained civil servants) is the Institute for Public Administration in Bratislava (an organization of the Ministry of Interior of the Slovak Republic), with branches in Kosice and Banska Bystrica.

This Institute is responsible for the compulsory training of local state administration employees, as per governmental ordinance Nr. 157/1997 on the specific qualification assumptions needed for executing certain activities in regional and district offices. Additional main training courses of this Institute are as follows:

- three-year training in public administration, focusing on legal issues;

- three-year training in public administration, focused on socio-legal issues;
- two-year training in archives;
- training for city managers;
- training in basic principles of auditing; and
- many short courses.

As a result of the decentralised personnel management in Slovak public administration, there are many state-owned training centres, mostly related to various ministries. They include:

1. Institute for Training and Services, Ministry of Building and Public Works (five-day courses on public procurement, housing, regional development, etc.);
2. Institute for Foreign Trade and Education, Ministry of Economy (organizes a 12-day training course for managers in public administration);
3. Secondary School of Fire Brigades, Ministry of Interior;
4. Institute for Education and Technique, Department of Training in Civil Protection, Civil Protection Branch;
5. Agroinstitute, Ministry of Agriculture;
6. Institute for Education and Training in Forestry and Water Economy, Ministry of Agriculture;
7. Institute for Education and Training of Veterinary Doctors, Ministry of Agriculture;
8. Slovak Agency for Environment, Ministry of Environment;
9. Training Center of the Ministry of Labor, Social Issues and Family;
10. Center for Education of the National Labor Office;
11. Training Center for Employees of the Ministry of Finance;
12. Institute for Further Education of Health Care Employees, Ministry of Health;
13. Slovak Institute for Technical Norms;
14. Institute for Further Education of Employees of Justice Branch, Ministry of Justice;
15. Research Institute of Geodesy, Cartography and Cataster; and
16. State Pedagogical Institute, Ministry of Education of the Slovak Republic.

There are also private and semi-private, for profit and not-for profit bodies providing training courses for many specific groups, including public servants. Among the many, especially notable is the Foundation for Self-government Training, founded by the Association of Towns and Municipalities of Slovakia.

Health Care Administration, Management and Policy Dimension of PA/PM Education

Of all the aforementioned institutions, there is only one where PA/PM education is closely combined with health care administration management and policy education and training. As will be noted below, the Faculty of Economics at Matej Bel University in Slovakia has, as part of its PA/PM program, the specialization “Economics and Management of Health Services.”

5. Current Education and Training Practices in the Area of Health Care Administration, Management and Policy

The need to educate health administrators was recognized by the old regime. The first activities in this area were carried out by the training institute of the Ministry of Health of the Slovak Republic (IPVLF) [As indicated earlier, health care was the responsibility of the national states after the federalization of Czechoslovakia in 1968.] Post-graduate training in health administration/management was a prerequisite to be appointed to the position of director of a hospital or polyclinic or to other health care managerial posts. The requirement of “second attestation” in health administration was incorporated in a binding regulative document – Health Care Job Description. However, the training in health administration/management by IPVLF was predominantly focused on aspects of health care organization and included very few management science courses (not surprising, as the hospital directors were not expected to be independent managers in the old centralized system) and was delivered by medical doctors.

The creation of the Faculty of Economics of Services and Tourism (FESCR) of the School of Economics, Bratislava in Banska Bystrica in 1977 represents an important step in the development of health administration/management studies in Slovakia. The important role of services in the national economy was, for the first time, really recognized in academic studies, and the Faculty became responsible for the education (at the master’s degree level) of managers for all service branches, including health care services. This way, in the eighties, health care economics was incorporated into the curricula of the study branch “Economics of Non-productive Services and Public Administration” and a new channel for preparing administrators/managers of health establishments was created. However, as the non-written rule (valid also today) provided that hospital directors are to be medical doctors, the graduates of these studies were usually not able to get hired for any position higher than that of economic vice-directors of health organizations.

Thus, prior to 1989, some system of preparation of health administrators/managers (but not health policy experts, as health policy was the sole responsibility of the Communist Party) existed in Czechoslovakia. However, the content of both types of studies (at the IPVLF and at the FESCR) was based on “socialist ideology” and the rules of a centrally planned and managed economy.

The massive health care reform after 1989 created the need for the education and training of new managers for health care establishments. The reaction of the existing bodies (IPVLF and FESCR) differed in that IPVLF reacted to the changes very slowly and this pushed a small progressive group of medical doctors to establish (while still maintaining their positions in the School of Public Health created by IPVLF on July, 1st, 1991) an independent, private, non-profit organization, the Health Management School (HMS), to deliver management training for medical doctors. FESCR (converted in 1992 to the Faculty of Economics of the Matej Bel University [EF UMB]) reacted very quickly and changed the curricula and the

content of studies over a two-year period (in 1992, the curricula were similar to western master's programs).

The processes of establishing HMS and changing the system of studies in EF UMB were supported by the EU program TEMPUS, and the main partner in supporting the necessary developments was the Academic Hospital in Groningen, Netherlands. Very soon after the TEMPUS health management program finished, a new foreign partner came to Slovakia to help to continue the process of change. The US Agency for International Development (USAID) financed a program establishing health management studies in Central Europe and allocated responsibilities to manage this program to AIHA. AIHA selected, through competition, US universities to execute the program in selected CEE countries, and the University of Scranton, PA was chosen to serve in Slovakia.

The AIHA health management program started in the late nineties with four institutions involved, the University of Scranton, as the donor's representative, two already existing bodies, HMS and Banská Bystrica, and the newly established Trnava University, with its Faculty of Nursing and Social Work (later, the Faculty of Health Care and Social Work).

The AIHA program was very comprehensive and its main phase lasted three years, producing many important outcomes. Among the tools developed to update the system of health management (but still not health policy) education and training in Slovakia were the creation of the *Journal of Health Management and Public Health*, the organization of a yearly Health Management Symposia, the exchange of teachers and students, the support of the participation of Slovak experts in international conferences and the writing of core textbooks, among many others. By the program's end in 1998, all three Slovak partners had become well functioning health management centers and sustainability was achieved.

By the late 1990s, other institutions (new and existing) had also recognized the importance of academic education and training in health care. The current structure of the field is noted below.

Economics and Management of Health Care Studies in Banska Bystrica (EF UMB)

Today, EF UMB is the only institution in Slovakia that delivers health management (and, to some extent, health policy also) education as a part of public administration/management studies. The study branch "Public Economics and Administration" (the name may change and accreditation is to be extended also to the Ph. D. degree level in the near future as the result of a new university law in Slovakia) still represents a unique academic program in the country, fully compatible (from the point of view of curricula) with similar leading programs in more developed countries.

The EF UMB studies include three main phases. The first phase (first three years) includes primarily business administration and economics subjects (e. g.,

Microeconomics, Macroeconomics, Economic Policy, Quantitative Methods, Management, Marketing, Business), plus a few core PA/PM subjects (e. g., Public Economics, Public Administration, Social Policy, Non-profit Management). In the second phase (fourth year), PA/PM knowledge is further developed through courses like Public Finance, Public Services, Non-profit Sector, and others. The last (specialization) phase (fourth and fifth years) overlaps to some extent with the second phase and provides students with specific knowledge in a selected area of public sector management, namely, "Economics and Management of Health Care," through health care economics, management and policy courses.

Most courses are delivered by PA/PM and health economics experts, but some part of them are also delivered by medical doctors working part time for the Faculty (in areas such as Clinical Management and Public Health). Thus, the graduates receive comprehensive knowledge and are able to adapt to different positions in the health care sector and in other public sector organizations, as well as in the private for-profit sector.

EF UMB is also involved in the on-the-job training of health care managers. In past years, it has delivered a one-year training course "Economics and Management of Health Insurance Company". Recently, it conducted a two-year training program for managers of non-profit organizations; some health care managers also participated in this course, since the number of applicants for training in health management was not sufficient to open a specialized course only for this group.

Other Education and Training Practices in Health Care Administration, Management and Policy

Of the other two USAID/AIHA health management programs, only one exists today – the Faculty of Health Care and Social Work of Trnava University (FH-CSW). As it became more and more difficult for HMS to survive as a private body in the health management training system (due to increasing competition and the decreasing influx of foreign aid), the main representatives of HMS decided to turn back and to incorporate their activities within the framework of the training institute of the Ministry of Health (at that time called SPAM) that was converted in 2002 to the Slovak Health University. As a result, the existing School of Public Health (SPH) of the Slovak Health University became the new (real) actor in the field of health management training in Slovakia, and thus the circle IPVLF – HMS – SPH was concluded.

In addition to the dominant actors in the field of health management education and training that already have been discussed, there have been recent attempts to introduce this type of education and training into the activities of the Medical Faculties in Bratislava, Martin and Kosice and also the Faculty of Health in Presov; however, such activities do not go beyond including some specific courses in the curricula of academic education or training courses.

Faculty of Health Care and Social Work, Trnava University

This Faculty has accreditation for the study branch “Public Health”, providing it with the right to deliver a master’s degree in this area (again, this name may change, and the accreditation would be extended also to PhD studies in the field, as the result of recent reform). Within this study branch, the students can choose, in the last (5th) year, the specialization Health Management. The responsibility for this specialization lays with the Department of Health Management, consisting of 50% medical doctors and 50% other specialists.

The curricula of the branch and the specialization are dominated by medical courses, supported by the extensive language preparation of students. The first four years include only two courses related to our topic – Health Policy (12 hours) and Health Management (36 hours). In the specialization phase (one semester), the students take the following courses – Health Policy in Public Health, Health Financing, Organization of Health Care, Public Health Advising, Biostatistics, Ethics in Management, and Insurance.

School of Public Health of the Slovak Health University

As already indicated, the history of this school is an interesting story. It was created in 1991, but with a limited scale of activities in health management training in the beginning and some of its teachers created the private non-profit HMS (while simultaneously continuing in the School) for a certain period to deliver this type of training. Significantly interconnected with Trnava (FHCSW), the same names appeared on the list of members of the Department of Health Management in Trnava and in Bratislava (Dr. Hlavacka also served simultaneously as the top civil servant – director – in the Ministry of Health and as the medical doctor in the hospital).

The most unusual issue connected with the school is the process of the creation of the Slovak Health University. The university was created by the specific law voted in by the Slovak Parliament in 2002 as the result of the lobbying of medical doctors focused on increasing the status of SPAM (the training institute of the Ministry of Health). It is not accredited for any degree yet, in spite of the fact that no academic education institution can be created without preliminary accreditation. It is not part of the standard university system in Slovakia, but is linked directly to the Ministry of Health.

The School delivers (more or less illegally) a master’s degree program in Public Health (three years of studies) and training courses for medical employees. The Public Health program also includes topics on health economics and management. The Department of Management organizes short term training courses, such as Management of Spas, Health Management and Finance, Management of Health Establishment, Health Management, Salaries in Health, for medical employees every year.

Thanks to its direct link to the Ministry of Health, the School of Public Health has a more or less monopolistic position in the training of health professionals, including those in management positions. Other training courses are generally not recognized by the Ministry, and thus are not officially valid for qualification assessments. Because of its character and program, for health management education and training analysis purposes this School is listed in Appendix B as a training institution.

6. Conclusions and Recommendations for new Initiatives

As described earlier in this chapter, the Slovak health care system is currently in a deep crisis, especially from the point of view of finance. There are many reasons for this situation, some of them objective (like the level of performance of the national economy, limiting the amount of resources to be able to allocate to health care), but many could also be solved in the short term - limited quality of managers of health care establishments and lack of capacity in health policy making among them.

Quality of Health Management/Managers and Health Management Education

The low economic performance of health care establishments, especially hospitals, represents one of the important reasons for the financial crisis of Slovak health care, as already shown. The hospital system is, year by year, in “red figures”, as they are not able to balance costs and revenues. There is no doubt that this negative trend is connected to the quality of hospital management and hospital managers. What is the relation between this problem and the system of health management education/training?

To answer this question, we have to focus, at a minimum, on two dimensions. The first dimension is the quality and scale of health management education and training and the second is the capacity of the system to accept well-educated and trained managers.

The earlier analysis shows that the system of education and training of health care managers in Slovakia still has some significant limitations in content and in scale, too. The number of graduates from Banska Bystrica is very small; on average, five to ten per year. The graduates are very good generalists, but need some additional experience from health care system practice. The education and training in Trnava and Bratislava are very much based on medical courses, and the graduates are really not provided with a sufficient knowledge of management and related disciplines.

However, the main problem is (at least today) outside of the education/training system. The tradition that the health establishment’s directors are medical doctors, and that the role of economic managers is limited, still persists in the Slovak health system. Doctors and their interests dominate the system, and space for effective managers is very limited. Because the state was not able to react to the bad economic

performance of hospitals, and simply covered the debts of the public health care system (see Table 2), there have been no real incentives to manage health providers' organizations in an effective way. Under these circumstances, the system is not ready to accept well-educated and trained managers, and the best managers try to find other opportunities in different branches of the national economy. [This is one of the reasons EF UMB and FHCSW did not decide to increase the number of graduates in the field.]

The situation in the sector may change very soon, however. The current Slovak government has decided to privatize most of the health care establishments (the hospital sector remained in the hands of the state until 2002) or to transfer them to local and regional self-governments. It also has promised not to cover any additional debts. If this were to occur, the external environment would change, there would be pressure to change the system of management of hospitals, and the need for effective managers should increase. In this event, the system of health management education and training would need to improve to be able to respond to these developments.

Health Policy Dimension

Many individuals have argued that there is no consistent health policy in Slovakia (Zajac and Pazitny 2001; Zajac and Pazitny 2002). The main causes underlying the problems of the health care system are well-known, often described, and publicly discussed (e. g., the imbalance between the resources available and the scale of care provided free at the point of delivery), but no Slovak government before 2002 was able to respond to them.

The reasons for such a situation can be found by investigating the interests of the main "players" – none of them has promoted the necessary changes. The inaction also is the result of the limited policy making and policy implementation capacity of the public administration system.

Health care policy-making, policy implementation, and policy analysis issues are taught only in a few courses, and there is neither the capacity, nor the demand to improve the situation. There are still few experts on these issues in Slovakia, and this situation is not likely to change quickly. The government demands health policy advice only infrequently; most decisions are not discussed with academic and scientific circles.

There is only one health policy think-tank formally established in Slovakia – The Center for Health Policy and Strategy in Banska Bystrica, a non-profit organization based on voluntary memberships (there is no permanent staff). Because of its structure and territorial location outside of the capital, the capacity of the Center to influence health policy in Slovakia is somewhat limited (the Center provided certain expert studies, mainly on health financing, funded via Phare or The World Bank).

Conclusions and Recommendations

The analysis in this chapter confirms that a basic system of health management education exists in Slovakia, and that its current performance is in accordance with the real demand from the health sector. However, recent changes in the health care system may significantly increase demand for well-educated and well-trained health management professionals; in this event, the current education/training system will face significant difficulties in responding effectively. All existing education/training institutes are public sector bodies, and it is likely that they would not be sufficiently adaptable to increase both their capacity and their quality. [A primary barrier might be the low level of salaries, limiting the chance to hire additional high-quality staff.] The private sector is not yet involved in the area because a mixed public-private system to deliver certificate training is not supported by the Ministry of Health, which still protects the monopolistic position of its training institute in the field.

Taking into account the current situation and possible future perspectives, the recommendation for the area of health management education/training is straightforward – the capacities to deliver health management education/training have to be increased, and a pluralistic delivery system must be created. The main source of financing capacity growth would probably be private finance or external resources as the public finance system cannot be expected to support such processes in a significant way. Much more co-operation between existing institutions is needed.

A system of health policy-making, implementation and analysis has not really been created. Pressure for it may arise very soon as the health care system is closer and closer to collapse and there will be no additional resources to recover its debt from privatization or similar non-regular incomes. Systematic and effective measures to prevent these trends will be needed by any government (as the collapse of the health care system could cause large political changes in a very short period). To react to such a demand will not be simple, and many new young people have to be attracted to contribute (as changing the heritage of a “command society” is not simple), and an additional transfer of knowledge from developed countries might be needed, too. Additional public or external resources have to be found to finance the system, as the private sector is not likely to be able to do so (vested interests are some of the reasons). Finally, given limited local public finance capacity for the area of health policy, the financial assistance of foreign donors/borrowers - either directly by providing funds, or indirectly by providing expertise and know-how – may be required.

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www.government.gov.sk

www.uzis.sk

Appendix A.

Academic Programs in Health Management in Slovakia

Faculty of Economics, Matej Bel University, Banska Bystrica

1. **Name of the program:** Verejna ekonomika a sprava (Public economics and administration), specialization: Ekonomika a management zdravotnictva (Health economics and management).
2. **Accreditation:** full accreditation for bachelor's, master's and doctoral studies.
3. **Contact address:** Helena Kuvikova, EF UMB, Tajovskeho 10, 974 01, Banska Bystrica, Slovakia, kuvikova@ef.umb.sk, www.econ.umb.sk
4. **Established:** 1987
5. **Number of students:** students are regularly admitted for five-year combined bachelor's and master's program, full-time. The average number of full-time students is 10-15 per year. The part-time studies and doctoral studies are not regular and depend on demand.
6. **Degree:** Ing. (Master of Public Management)
7. **Main partners:** University of Scranton (USA); Masaryk University Brno (Czech Republic).
8. **Curricula:**

Main (compulsory) courses, bachelor's level: Microeconomics, Macroeconomics, Mathematics, Statistics, Management, Marketing, Informatics, Public Economics, Public Administration, Economics of Municipalities and Regions, Foreign Languages (2), World Economy, Accounting, Enterprise Management, Human Resources Management, Public Services, Non-profit Organizations, Demography, Public Sector Control/Audit.

Main (compulsory) courses, master's level: History of Economic Theories, European Union, Public Economics II, Quantitative Methods, Social Insurance, Non-profit Sector, Social Development, Logistics, Insurance Mathematics, Public Finance, Business Games, Health Economics, Health Law, Health Policy, Health Insurance, Clinical Management, Health Sociology and Psychology, IT in Health Care, Non-profit Marketing.
9. **Impact in the country:** The program started with high expectations, as there was clear potential for demand. However, the actual acceptance of graduates in the health care system was very limited; as a result, the willingness of students to apply for the program decreased. The program staff represents the core of the Center for Health Policy and Strategy in Banska Bystrica, an independent, non-profit "think tank" in the health policy area. This center is irregularly, from time to time, invited to participate in health policy analysis activities. The primary examples of these activities were the award of one part of a PHARE-financed hospitals program in 1996 and a World Bank-financed program in 2002 that analyzed hospital versus outpatient treatment of minor diseases. Its name and representatives are well-known in the country, but its real impact on health

policy making is still very limited, since the government is not very proactive in cooperating with other sectors when preparing the main policy documents.

Faculty of Nursing and Social Work, Trnava

1. **Name of the program:** Verejne zdravotnictvo (Public Health), specialization Zdravotnicky management (Health Care Management)
2. **Accreditation:** full accreditation for bachelor's, master's and doctoral studies.
3. **Contact address:** Bohumil Chmelik, FOSEP TU, Univerzitne namestie 1, 917 00 Trnava, www.truni.sk
4. **Established:** 1994
5. **Number of students:** students are regularly admitted for five-year combined bachelor's and master's program, full-time. The average number of full-time students is about 10 per year. The part-time studies and doctoral studies are not regular and depend on demand.
6. **Degree:** Mgr. (Master of Health Management)
7. **Main partners:** University of Scranton (USA).
8. **Curricula:**
Main (compulsory) courses, years 1-5 (except for specialization): Anatomy, Biophysics, Biology, Biochemistry, Physiology, Nursing, Health Law, Biostatistics, IT, Philosophy, Psychology, Foreign Languages (3), Hygiene, Microbiology, Anatomy, Internal Medicine, Surgery, Pediatrics, Primary Care, Epidemiology, Pharmacology and Pharmacoeconomics, Oncology, Health Policy, Radiology, Infectious Diseases, Health Management, Gynecology, Social Medicine, Social Work, Risk Calculations, Health Programs, Health Ethics, Public Relations.
Main (compulsory) courses for specialization (year 5): Health Financing, Managed Care, Insurance, Management Ethics, Advising in Public Health, Public Health Policy.
9. **Impact in the country:** The program started as a result of AIHA activities in Slovakia. Similar to the EF UMB program, the graduates have only a limited chance for "fast track" employment in the health management system. Students' interest in applying is limited. Internal staff members involved in the implementation of the program are not significantly involved in health policy making and analysis in the country.

Appendix B.

Training Programs in Health Management in Slovakia

As described in the main text, the primary, essentially “monopolistic,” provider (as a result of Ministry of Health policies) of health management training programs today is the School of Public Health of the Slovak Health University.

School of Public Health of the Slovak Health University

1. **Contacts:** Ladislav Badalik, Svatopluk Hlavacka, Skola verejného zdravotníctva SZU, Limbova 12, 83303 Bratislava, www.doktor.sk/spam
2. **Training programs:**

Master of Public Health (for university graduates – “executive” master’s program)

Main courses: Epidemiology, Biostatistics, Economics and Management of Health Care, Health Protection, Environment, Health Law, Health Sociology, IT in Health Care, Health Pedagogic, Health Education, Health Promotion, Social Pediatric, Social Psychiatry, Social Gerontology, Social Pharmacy, Bioethics, Patient Rights, International Health.

Training for Head Nurses of Spas – 3 days

Contents: managerial tasks, motivation, managerial psychology, conflict management, change management, management of quality, strategic management.

Health Management and Finance – 12 days

Contents: health management and financial management.

Management of Spas – 4 days

Contents: management and marketing of spa organization, balneotherapy, managerial skills of head nurse.

Management of Health Establishment – 3 days

Contents: strategic management, change management, health policy.

Health Management – 3 days

Contents: strategic management, managerial psychology, change management, conflict resolution.

Remuneration in Health Care – 1 day

Contents: remuneration system for public health organizations, financial management, labor relations, performance management and appraisal.

Public Health Management and Policy Education and Training: Tatarstan

Chitchevkova Ioulia Alexandrovna¹ and Shaydullina Leysan Fatihovna²

1. Introduction

Improving health care and health care education in Russia and the Republic of Tatarstan is vitally important. This chapter examines the health care system in Tatarstan, as well as health care education practices, problems and perspectives. Particular attention is given to

- the functioning of the health care system and the efficiency of its management;
- current approaches to public administration education;
- current approaches to health management and health policy education and training; and
- conclusions for further development and deeper involvement of public administration schools in the processes of preparing and retraining health managers and policy makers.

Education in health care administration in Tatarstan is provided only by higher medical institutions. Although not prohibited by law, no other institutions are in reality allowed to train and retrain managers for the health care system. This situation creates critical insufficiencies in the quality of health management and health policy in the country and provides opportunities for greater involvement by public administration schools in health management and policy education and training.

2. Country Profile

The Republic of Tatarstan is a sovereign republic of the Russian Federation. Tatarstan is a large industrial and cultural center with a population of more than five million. The republic consists of 43 large industrial regions. Its capital is Kazan, with a population of about two million. The city, historically founded both as a border between the East and the West and as a place where the two met, is situated on the bank of the Volga River in the central part of Russia.

The Republic of Tatarstan is one of the largest republics within the Russian Federation. Consequently, processes taking place within the Republic are a reflection the policies of the government of Russia. The structure of state power in Tatarstan is similar to that of Russia and includes a President and a Cabinet of Ministers as the executive branch, and a State Council as the legislative branch.

¹ Kazan State Technical University, Kazan, Republic of Tatarstan.

² Kazan State Medical University, Kazan, Republic of Tatarstan.

Executive power consists of the government administration and legislative power consists of a two-house Parliament.

There currently is a strong tendency to strengthen the state's vertical power through enhancing federal control over local government bodies. This is done, it is claimed, to improve the quality and efficiency of public administration (even though international experience often is quite different). Significant attention is paid to education in the field of public administration, which is why a great number of institutions now provide such education.

The Russian (and Tatarstan) education system does not fully correlate with the European system. The new (Bologna-based) European system includes three levels of education: pre-graduate (bachelor's degree), graduate (master's degree), and postgraduate (Ph. D. degree). In Russia, the bachelor's and master's degrees represent a single-stage education; after secondary school, a person enters a university, and then receives a diploma upon graduation. After that, he or she has the right to work as a specialist in his or her area of specialization. The Russian equivalent of the Ph. D. degree is *kandidat nauk*. Given that these differences create difficulties internationally for Russian students, Russia plans to adapt its system of higher education to the European system.

The Civil Service Law in the Republic of Tatarstan was adopted on 24 January 2002. This law regulates relations in the sphere of civil service and the position of civil servants in the Republic. According to this law, a civil servant in Tatarstan is a citizen of Russia who fulfills the duties according to his or her position and receives a salary that is paid from the budget of the Republic. There are five groups of civil servants:

- higher civil servants;
- basic civil servants;
- leading civil servants;
- senior civil servants; and
- junior civil servants.

Civil service positions are divided according to specializations, based upon the levels of professional education regarded as necessary for the specializations. To become a civil servant in the fifth group, for example, a person need not have the education provided by the Institute of Civil Service; it is enough to graduate from another higher education institution in the specialization area relating to the person's employment. After becoming a civil servant, a person has to complete education in the Institute of Civil Service; the duration and amount of this education is identified jointly by the administration and the Institute.

3. Health Care System

The health care system in Tatarstan involves the interaction of different ministries, departments and organizations. Appendix A provides a graphic illustration of the health care systems in Tatarstan. The main body is the Ministry of Public Health

of Tatarstan, founded in 1922. It is primarily responsible for shaping government policy in health care and oversees public health in the Republic. This ministry is directly subordinated to both the Ministry of Public Health of Russia and to the Cabinet of Ministers of Tatarstan.

The Ministry of Public Health of Tatarstan directs and coordinates work in the following areas:

- training medical personnel in secondary education areas;
- managing public health in the large cities;
- regulating the activities of local medical institutions;
- directly managing the largest medical institutions that provide highly specialized medical services of high quality; and
- overseeing the republic's health policy and the health of the population.

Prior to 1991, the health care system in Russia (and in Tatarstan) was financed through the federal budget. All managers had clear instructions about the distribution of financial resources. Thus, they did not need to make any important decisions; everything was decided by the government.

Since 1991, the health care system of Tatarstan and Russia has been administered in accord with the program of obligatory medical insurance (OMI). Medical insurance is a form of social protection of citizens' rights in the sphere of health care. There are two kinds of medical insurance: obligatory and voluntary. Obligatory medical insurance provides all citizens equal access to medical care and medications. Voluntary medical insurance provides citizens with supplementary medical services that are not included in the republic's program of obligatory medical insurance (e. g., plastic surgery, gestalt therapy).³

Obligatory medical insurance is administered according to the "Program of Government Guarantees for Providing Free-of-Charge Medical Help for Citizens of the Russian Federation," confirmed by the government of Russia and the Cabinet of Ministers of Tatarstan in 2000. According to the Tatarstan law "Medical Insurance of Citizens in the Republic of Tatarstan," citizens can count on receiving medical help and services at the level specified in the basic program of obligatory medical insurance. Within the framework of this basic program for the entire republic, city and regional administrations in Tatarstan organize territorial programs of obligatory medical insurance. These territorial programs cannot provide a lower level of benefits than those provided in the republic's basic program of obligatory medical insurance. In the obligatory medical insurance system, insurers for unemployed citizens are local administrations; insurers for working citizens are employers; and the insurer for individual workers and farmers is the state. Hospital funds are special organizations in the system of obligatory medical insurance. They work as insurance companies in this system.

³ Law of the Republic of Tatarstan, "Medical insurance of citizens in the Republic of Tatarstan," No. 1991-XII, 20. 10. 93.

Voluntary medical insurance is administered by other insurance companies that possess a state license for this kind of health care organization. The Cabinet of Ministers of Tatarstan, local administrations of cities and regions, and trade unions are responsible for protecting the citizens' rights in the system of medical insurance. Financial support of the republic's public health system also includes

- republic and local budgets;
- state and public organizations, as well as enterprises;
- citizens' personal means and charity payments;
- bank credits;
- income from securities; and
- other sources that are not restricted by law.

The financing of medical institutions has as its base the hospital funds in the Ministry of Finance of Tatarstan. Medical institutions first provide medical help to citizens according to the program of obligatory medical insurance. These institutions then send the bills for their services to the hospital funds, which are responsible for covering these bills. The hospital funds use the money from a social tax to pay the bills. Another responsibility of hospital funds is to ensure the rational use of financial resources in the system of obligatory medical insurance.⁴

Problems of the System: Finance And Management

Financing Problems

The transition to a new insurance-based system of financing produced a serious crisis in the health care system during the first few years the program was implemented. At the present time, the situation is not so difficult; however, the transition to the insurance payment principle is not yet totally complete. The system of medical insurance that exists today is, in certain aspects, not effective. For example, there is no clear definition of "free-of-charge" medical services; a list of medical services covered from public financing sources also does not exist. This leads to a situation in which the regions lack the financial resources to fully implement the program. Statistics show that the resources deficit in the program is about 30 to 40%. This reality leads to citizen distrust of government and its social institutions. Nevertheless, legislation relating to the financing of the health care system can help to improve the functioning of the system.

Too much attention in the health care system is given to inpatient medical care, which is much more expensive than outpatient medical help. In Russia, 60-70% of the finances to administer the health care system cover inpatient costs, compared to 30-35% in Western countries. Moreover, 75-80% of the doctors work in inpatient hospitals compared to 50% of doctors in Western countries. In addition, the number of hospital beds is very high (12 per 1,000 patients), and the length of hospital stays is very long – 17 days, compared to 8-13 days in Western countries. Every extra day of inpatient care is very expensive.

⁴ Decree of the Cabinet of Ministers of the Republic of Tatarstan, No. 108, 6. 03. 01.

Another problem is that 30% of the inpatient stays relate to so-called “social” patients. In other words, the hospitals fulfill not only medical functions but also social functions, trying to compensate for the lack of a social protection system. One reason for this development is that Tatarstan lacks hospices and gerontology and rehabilitation centers. Given all these factors, it is necessary that the government reconsider the role of the hospitals and the number of their stationery beds. This work also needs to be coordinated with the development of the social protection sector.

Another finance-related problem relates to medicines. An analysis of the current situation shows that expenditures on medical provisions are not effective for several reasons. Substantial resources are spent not on important drugs for treatment but on drugs that are not directly treatment oriented, because there is no control system in this area. This lack of government control is one of the reasons for the “hidden” pharmaceuticals market. Also, the Russian pharmaceuticals industry cannot provide citizens with the necessary volume of medicines, and Russian citizens must buy very expensive imported drugs. Consequently, it is critically important to pay attention to political decisions that are focused on developing a well-coordinated policy involving the changing health care system and the national pharmaceuticals industry.

A very important finance-related problem is the structure of expenditures within the health care system. The existing health care system is not oriented to encouraging the good health of citizens, but rather to treating medical problems. It is not popular to be healthy. As a result, the question of who is responsible for citizens’ health – the citizens themselves, employers, or the state – is still unanswered. In the obligatory medical insurance system, two links are most important – the prevention of disease and rehabilitation after illnesses. Although the level of expenditures in the health care system is relatively high, the health of citizens cannot be said to be satisfactory. This is due to the fact that the influence of the health care system on the health of citizens is only 10%; the other 90% is influenced by economic, biological, and social factors. Thus, health care system expenditures could be lowered if the country gave more attention to prevention and rehabilitation procedures and to the promotion of a healthy life, since people need motivation to want to remain healthy.

Possible solutions could be:

- redistribution of the cash flow in the system of obligatory medical insurance to direct much more resources to prevention and rehabilitation;
- introduction of different levels of insurance payments by employers that would depend on the sickness rate in an organization;
- introduction of a system of privileges for employees who do not get sick during a year;
- promotion of good health and a healthy lifestyle among the citizens; and
- reduction of socially dependent diseases.

The government of Russia has already begun to give more attention to the problems and concerns of the social welfare of Russian citizens and also to the development of public health. For example, the government has developed different special-purpose social programs that seek to improve the level and quality of life of its citizens, especially its socially dependent ones. These programs include "Social Support for Disabled People," "Preventing and Treating Socially Grounded Diseases," "Prophylactics and Treatment of Arterial Hypertension," and others that are included in the plan for the development of public health and medical science in 2000-2005. However, even though the government's attention to the problems of the social welfare and health of the population is rising every year, the current levels of financing and managing the health care system are not enough to cover the needs of the country.

An important related problem is that medical science also is suffering from a lack of adequate financing. Although some research institutes are trying to maintain their basic functions through grants from foreign investors, most scientific structures are in a difficult situation related to their poor reputation. Most medical research in Russia is not focused on the main problems of public health. It is likely that medical science and research activity need to be reoriented. At present, there is much potential for science and medicine that has no way to be realized. Medical science could make an essential contribution to the development of a reformed health care system by developing solutions to special and strategic problems. Government departments in the health care system at both the federal and republic levels should support medical research institutions and involve them more directly in the restructuring of the health care system.

Unfortunately, medical science is not connected with medical practice. That is why there is an urgent need to rationalize medical research in Russia so that it supports the objectives of the health care system as a whole. This could be done through audits and the specification of strategic plans for research that correspond to national public health management policies.

Management Failures

Most of the current problems in the health care system relate to its management. Management responsibility has been given to individuals who lack the necessary education and experience to manage personnel and operate in an environment of limited financial resources. The problems of management exist on every level.

On the federal and national levels, the health care system needs to be strategically oriented. It also needs the support of consultants in the field of management, as well as a clear division of rights and responsibilities between the departments of public health at the federal, republic, and local levels. The Ministry of Public Health of Russia must be the main body that focuses on policy and strategy, not on operational management. It must formulate a national policy that reflects the basic goals in health care and the means to achieve them. This kind of document has to be adopted by the government and is absolutely necessary for implementation of a

health care system with these basic goals. Political will is necessary for defining the health care goals and for taking the necessary planning and monitoring actions.

At the level of local medical institutions, the main management problem is managers' limited professional knowledge. In most cases, doctors manage the institutions. Currently, most institutions carry out their work passively, with decisions based on the experiences of prior years without consideration of the new conditions in the country. Many managers have great difficulties in reorganizing their work to take into account these contemporary conditions. Their lack of understanding about necessary economic knowledge and information about judicial matters, including medical law, causes these difficulties. As a result, medical personnel are suffering, and their interest in providing high-quality services is declining.

Compared to international standards, doctors in Russia have less authority, public attention, and social prestige. This is reflected in incomes that are only 66% of the average salary in Russia. Medical personnel should be motivated by moral values, but they must also have the support of a good reputation and salary. New, more favorable conditions create the possibility of managing hospitals like commercial organizations. Hospitals would benefit by having supplementary financial resources to obtain new diagnostic and medical equipment, raise the qualifications of the medical personnel, and motivate them to provide high quality medical help. The necessity for medical managers to have economic education is illustrated by the fact that the few hospitals managed by specialists with both medical and economic education have higher quality services and also employees with much higher salaries.

In conclusion, it is clear that to improve the management of the health care system at all levels, professional managers and economists that have experience in making decisions and solving problems are needed. Recent policy of this type is limited, however; there are no legislative requirements for appointments to the top health manager positions (except to be a doctor). In reality, doctors with work experience and an economic education have advantages. It is obligatory that, after they become chief doctors, they attend two-month courses that advance their qualifications in their specializations. Attestation that takes place every five years and lasts for one month is also obligatory. In addition, managers in the Ministry of Public Health in Tatarstan must attend one-month courses at the Institute of Civil Service once every three to five years.

4. Overview of Public Administration Education Practices

In the process of transition to a market economy, Russia has faced the difficult problem of forming a new economic structure that would correspond to the new conditions of life. Attempts to reform the economy by simply applying international experience, without taking into consideration specific Russian features, has not worked. The resulting crisis has affected the entire country. Thus, the country is now giving a great deal of attention to education in public administration and management. A few years ago the word "manager" was new and hard to understand;

now, though, economic and/or management education is included in almost every higher education institution in the country.

In the Republic of Tatarstan, education in public administration is available in the five-year degree programs of most departments of economics in most higher education institutions. About 20 higher education institutions now provide economic education in Tatarstan. Some of them are state institutions, and others are commercial. The leading ones include Kazan State University and the Kazan State Financial and Economic Institute. One higher education institution, Kazan State Technological University, deals directly with public administration.

The specific institution that delivers education in public administration is the Institute of Civil Service, which is supported by the President of the Republic of Tatarstan. Given the different European Union and Russian educational systems, it is difficult to provide an EU equivalent for the Institute of Civil Service program; however, it is comparable to a graduate program, conducted in accord with the all-Russian standard of public management education. The Institute of Civil Service was founded in 2001, building on the Republic's Center of Advancing Qualification for Civil Servants, which has existed since 1996. It is a rather new institution and the program is constructed according to the all-Russian standard of education in public management. There are no health care management courses at the Institute of Civil Service.

Today, only specialists with higher medical education are appointed to the top management positions in hospitals. Thus, although there are a great variety of educational possibilities in Tatarstan in economics and management, it is possible to get an education in public health management only in Kazan State Medical University and Kazan State Medical Academy.

5. Overview of Current Education Practices in Health Care Administration, Management and Policy

The history of public health development and the training of medical personnel through higher education in Tatarstan began in 1814 with the opening of the Emperor's Kazan University department. It was a great event for Russia. Currently, training and retraining of medical personnel for the health care system of the Republic of Tatarstan take place in one of the oldest higher education institutions in Russia, Kazan State Medical University (KSMU), and also in Kazan State Medical Academy (KSMA). KSMU and KSMA conduct training and retraining of medical personnel according to the plan defined by the Ministry of Public Health of the Russian Federation.

Kazan State Medical University, together with the Moscow and St. Petersburg surgical-medical academies, founded higher medical education in the territory of modern Russia. KSMU's departments are the following: medical, prophylactic medicine, pediatric, dental, pharmaceutical, and graduate nursing. It has a sub-department of public health administration, where all students have one to three semesters of classes.

The public health administration sub-department was established in 1985. Forty-three postgraduate residents (professional post-graduate training – clinical residencies) and six postgraduate interns (advanced training in primary specializations – medical internships) have graduated. The courses cover subjects such as medical statistics and informatics, medical law, basics of medical insurance, and organization of medical help. After finishing the postgraduate course of study, students have to take qualification examinations. The questions for the exams are prepared by the sub-department of public health administration, according to the program of the course of study. The program of the course of study is prepared on the basis of a letter of recommendation from the Ministry of Public Health of Russia and can be changed.

The program of education in KSMU also includes a one-semester course on the theory of economics. During such a short period of time, students become acquainted with the basic elements of the theory of economics, but they do not have enough time to study the subject of economics in detail. Moreover, the program does not include subjects such as management. The KSMU program is outlined in Appendix B.

The other higher education institution in Tatarstan providing education in the area of public health administration is Kazan State Medical Academy (KSMA). This institution offers postgraduate education and provides an opportunity for medical personnel to advance their qualifications in the department of economics and public health management. The KSMA program is outlined in Appendix C.

There is no effective system of health policy education or training in the Republic of Tatarstan.

6. Conclusions

At the present time, there is a great lack of educational programs in health management administration in Tatarstan. It is impossible to receive a full university education in this area (e. g., a master's degree) because only certain courses are available. One cannot obtain a postgraduate education in this field at Kazan State Medical University and Kazan State Medical Academy at the level of *kandidat nauk*. No systematic health policy education and training exists.

Existing programs in public health management are unable to educate and train good managers to take responsibility and solve the different problems they face in the present economic conditions. Clearly, there is no optimum health management program in Tatarstan. Existing education and training tracks do not satisfy the needs of managers, given the current economic situation in the country. It also is necessary to bring health management education and public administration education closer together. However, public administration is a new branch of science in Tatarstan, so it is a bit early to speak about real cooperation between these two branches. The present short-term objective should be to make existing programs

in health care management better by attracting public administration specialists to the programs.

Another problem is that receiving an education in health management is not a high priority for graduates. This is related to the fact that, following graduation, they will not immediately become top managers of medical institutions because of their young age. As a result, graduates usually choose a medical specialty for their postgraduate education; then, after a few years of medical practice, they can apply for top management positions.

Recommendation

In the future, to improve public health management and policy education and training in the Republic of Tatarstan, medical departments and academies should be much more active in training professional managers, economists, and policy makers in the field of public health administration, as well as in promoting much closer cooperation with public administration institutions.

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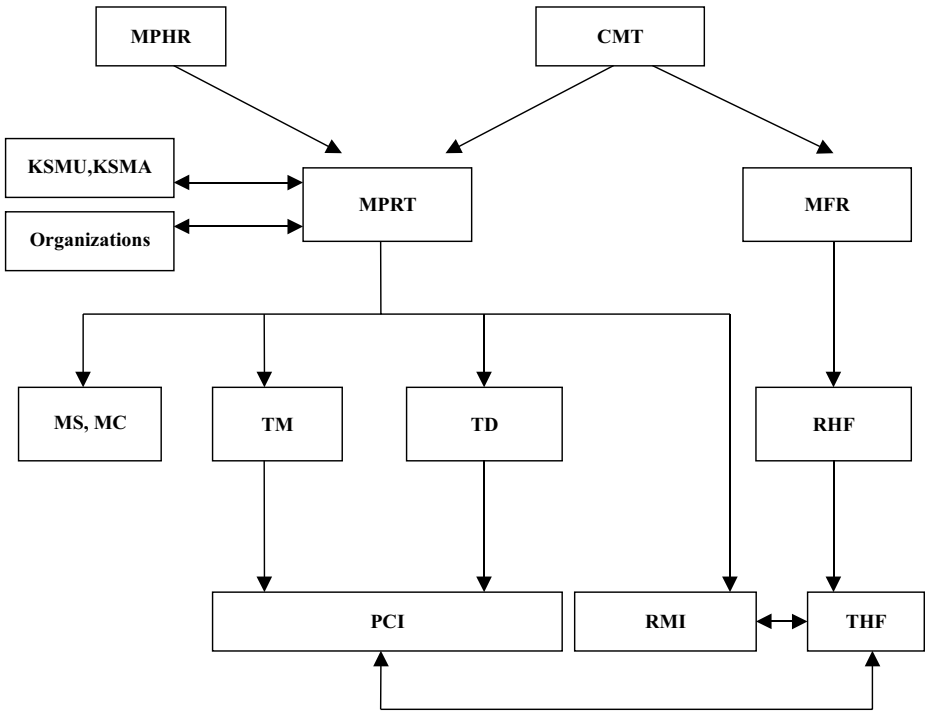
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Appendix A.

Health Care System in Tatarstan



Appendix B.

Residency Program in Kazan State Medical University (Sub-department of Public Health Administration)

Nearly 500 students graduate from Kazan State Medical University every year. One of the postgraduate education opportunities is the residency program. This program lasts for two years.

1st year

1. Organizational principles of public health administration (36 academic hours (h))
2. System of public health administration (74 h)
3. Social insurance and provisions for citizens (90 h)
4. Basics of public health administration and its connection with medicine (150 h)
5. Training and retraining of medical personnel (36 h)
6. Basics of public health administration and management (72 h)
7. Ethics and deontology
8. Medical law (electives 72 h)
9. Information technologies (144 h)
10. Management psychology (36 h)

2nd year

1. Theoretical and organizational basics of health care administration
 - Medical insurance management (144 h)
 - Traditional medicine and its connection with official medicine (150 h)
 - Financial, economic and planning aspects of public health administration (144 h)
 - Basics of labor legislation
 - Information technologies on public health administration (electives 30 h)
 - Psychology of management (electives 36 h)
2. Public health
 - Basic types of documents in medicine (electives 72 h)
 - Disability – public health criteria
 - Medical and social aspects of demographic processes
 - Individual and group estimations of physical growth and development
 - Hygienic education
 - Health propaganda (72 h)
3. Organization of medical and prophylactic help to citizens
 - Organization of medical and prophylactic help to citizens
 - Organization of stationary (inpatient) help to separate groups of citizens (144 h)
 - Organization of medical help to different groups of population (144 h)
 - Organization of sanatorium services (144 h)

- Quality management (72 h)
- Practice (electives 36 h)

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Appendix C.

Internship Program in Kazan State Medical Academy

(Department of Economics and Public Health Management)

1. Organization of public health management in contemporary social and economic conditions.
2. Social hygiene and public health administration.
3. Information technologies in public health management.
4. Protection of the health of an economically active population.

The internship program lasts for one year. The department of economics and public health management conducts this program. Usually, one or two interns graduate from the department every year.

Kazan State Medical Academy actively collaborates with Kazan State Medical University and the Ministry of Public Health of Tatarstan. The Kazan State Medical Academy plays a very important role in the Republic of Tatarstan.

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Public Health Management and Policy Education and Training: Ukraine

*Svitlana Khadzbyradeva and Natalya Kolisnichenko*¹

1. Introduction

While Ukraine has undergone significant changes since 1991, its health care system has been little transformed. Consequently, the country continues to have significant needs in terms of both reforming its health care system and in the training of those who manage it. The requirements for educating public health managers in Ukraine are defined by the need of the Ukrainian state to solve a complex set of problems associated with demands to improve the health conditions of the country's population. These training needs are further complicated by the emergence of efforts to improve the health system through the introduction of new management technologies (financial, personnel, economic, planning, etc.), as well as the introduction of new approaches to health care financing. Consequently, it is necessary for Ukraine to adopt training programs for public health (PH) managers which are compatible with the growing requirements of contemporary policy and management practice.

In addition, the greater independence and higher responsibility of regional public health agencies requires an increase in the efficiency of their management and the utilization of new scientific methods and approaches. Consequently, the administrative reform of the health system underway in Ukraine presupposes the solution of many different tasks including such strategic ones as:

- the necessity to reform public health education;
- the development of a general strategy for improving public health management;
- the reforming of public health management training and education standards;
- the improvement of specialist training for the public service, especially in the health sector;
- the reforming of short-term in-service training in the health sector.

As Ukraine further integrates into the world community, it needs to improve the training of managers in many different areas. They have to be experts capable of reacting to change quickly and in an adequate way, to think globally, implement innovations effectively and to improve constantly their professional skills. To reform the training of public health managers, it is necessary to create the appropriate (both in qualitative and quantitative aspects) efficient and flexible system of education in accordance with the basic requirements of public administration.

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There are several factors that must be taken into account in any effort to improve the system of training for public health (PH) administrators. First, the role and tasks of the government in the health sector are dramatically changing due to administrative reform. Second, the reform of the public health system requires improvement of public health managers training. Third, the improvement of public health managers training is still in the process of developing.

Changes in health management education in Ukraine are taking place within an environment in which management education more generally is changing very rapidly. This process is developing in accordance with such tendencies as an enhancing of the level of management education programs, a growing orientation to world standards of management education and the strengthening of existing training programs in all of the CEE countries. As a result, the implementation of any suggested scheme of reformation of the management mechanism of the PH system must reflect the reality of changing administrative, corporate and economic relations. It should encourage the following beneficial consequences: a more transparent system of control; enhanced manageability and effectiveness of public administration performance; and increased responsibility, along with more rights and opportunities in decision-making.

2. Country Profile

The territory which now makes up Ukraine has been occupied from the third millennium B. C. Kyivan Rus, which lasted from 900 AD to 1200 AD, was a conglomerate of principalities, with the core located in present day Ukraine. The society of Kyivan Rus was highly sophisticated for its time, its economy flourished and it developed extensive foreign relations with the rest of Europe. Galician-Volhynian principality was the primary inheritor of the Kyivan Rus legacy. In 1569, when Poland and Lithuania united into the Polish-Lithuanian Commonwealth, Ukraine was exposed to the practice of the Magdeburg City Law which established a tradition of autonomous local government in Ukraine.

On January 22, 1918, an independent Ukrainian Republic was proclaimed in Kyiv which included the Right and Left Bank areas of the Dnipro. On November 1st, after the collapse of the Austro-Hungarian monarchy, the Western Ukrainian Republic was proclaimed in Lviv. It formally merged with the Ukrainian National Republic in Kyiv on January 22, 1919. But due to war with the Russian Bolsheviks and the Poles, Ukrainian independence was short-lived. The Ukrainians themselves were not capable of uniting behind a single leader or policy of independence.

In April 1945, after World War II, the Western Ukraine was incorporated into the Ukrainian Soviet Socialist Republic. A dissident movement in the 1960s had as its goal achieving greater civil liberties and national rights.

On July 16, 1990 after the breakup of the USSR, Ukraine issued a proclamation of sovereignty. This was followed, on the heels of the failed Communist coup in August 1991, by a proclamation of independence by the Ukrainian Parliament. On

December 1, 1991, in an all-Ukrainian referendum, the proclamation was confirmed and Leonid Kravchuk was elected as president. Since the dissolution of the Soviet Union, Ukraine has had to quickly reform its political and administrative structures (26, P. 265-279). The reform of personnel and/or civil service structures was of particular importance as they provided the basis for the administrative infrastructure of public management reform efforts.

New public management reforms favored decentralization, efficiency and the use of private sector methods to solve public sector problems (10, P. 25-42). Ukrainian government operations, and society in general, are still very influenced from the Soviet era, where important public policy decisions were made in Moscow and their implementation took place according to rote plan. With no developed notion of federalism or local autonomy, there are strong pressures for the centralization of decision making which mitigates individual initiative in reforming administrative structures or ameliorating public problems and concerns. This lack of autonomy can and does lead to a dissociation of local level officials from the most critical problems of public policy.

Though Ukraine has had brief historical flirtations with democracy (especially in the 18th and 19th centuries), there is no firm base of Ukrainian democratic traditions upon which to rely (23). Thus, for example, Ukrainian public service policy remains highly centralized since the country operates as a unitary state. According to the Ukrainian Civil Service Law, the Supreme Council (Rada) of Ukraine determines national policy in the sphere of civil service. Much legislation has been aimed at reforming the civil service system and how it functions. Indeed, 139 of the 160 (87%) legislative documents forming the basis of Ukrainian government operations specifically address public management or civil service issues. Among them, for instance, are documents directed towards avoiding the duplication of similar functions performed by different bodies of the executive branch. Nevertheless, the structure of power, fixed by Ukraine's Constitution, is causing the duplication of functions between presidential and governmental structures. There is a duplication of functions between separate ministries and between different bodies within ministries. For instance, the Ministry of Public Health partly duplicates the work of the Ministry of Labour and Social Policy regarding the attestation of executives and engineers employed within the labour safety and working place (labour conditions) attestation system.

Public management reform efforts have taken place in the context of a continuing national economic crisis characterized by high inflation, low productivity and high unemployment. Nevertheless, Ukrainian public management must be improved because of the general lack of formal training and education in public management and administration of public employees; insufficient funding for personnel salaries and budgeted agency activities; under-utilization of technological advances such as computerization; lack of the concept of a national identity; the continuing economic crisis; ongoing power struggles at higher management levels; slow implementation of new laws; continuing conflict between the executive and legislative branches;

conflicting laws; pervasive corruption; a punitive taxation system; and the lack of trust among different groups in society.

In addition to these obstacles, legislative acts adopted by the central government have been controversial and imperfect. They have created additional instructions, disoriented local governments and hindered effective planning. For example, the current system of personnel management does not clearly define employee responsibilities, provides inadequate rewards and does not encourage accountability and professionalism among its members. At the same time, on the positive side, there can be observed some progress in decentralization and more freedom in planning.

The positive but slow trend toward professionalization of the public service could be expedited by the strengthening of regional centers for public administration continuing education, establishing new training programs and further development of formalized university-based public administration programs. Strong legislative support is needed to effect these changes, not only through increased funding for public administration education, but for the stabilization and enhancement of public sector pay systems and the increased computerization of public management activities.

To improve the management of personnel/civil service systems in Ukraine, various measures have been proposed including: changing senior managers in favor of personnel with more professional training, a formal system of job rotation, better definition of the duties and responsibilities of personnel and their respective departments, eliminating special protections for higher level administrators, increasing protections for rank-and-file employees, improved selection procedures, and favoring younger workers over those indoctrinated by past administrative practices.

The Ukrainian civil service appears to be on a slow but positive path toward professionalization. During 1995-1997, significant progress was made on improving the public servants training system. In 1995, the President of Ukraine adopted the Decree on Personnel Support of Public Service with a chapter on Training, Re-training and Raising the Level of Public Servants which included arrangements concerning the realization of this program. Also in 1995, in order to help train civil servants, and according to a Presidential Decree, the Ukrainian Academy of Public Administration and its four branches were created.

With support from the main department of the Civil Service, a new degree Master of Public Administration (MPA) has been established and curriculum was developed. Such Institutions as Kyiv National Economy University, Kharkiv State Economic University, East Ukraine State University (Luhansk), Ternopil Academy of National Economy, Donetsk State Technical University, Dnipropetrovsk State Technical University, Dnipropetrovsk State University, Ivano-Frankivsk State Technical University of Oil and Gas, and Odessa Law Academy offered public service oriented MPA degrees, which were similar to UAPA MPA Program. In 1996, the government initiated the foundation of regional in-service centers for public officials.

At the beginning of 1997, the government of Ukraine approved the Regulation on Training, Re-training and Raising the Level of Public Servants.

Recent Initiatives on Perfection of the Quality of Public Management

This past year on the legislative level, a number of laws were adopted which were directed at improving the quality of public administration (PA) (18, 19, 20, 3, 4, 5). This legislation shaped the main directions for PA system development, including the improvement of the context for PH managers' education, training and re-training. The legislation also established guidelines for implementing a new system of training for managers and it formalized a government commitment to the provision of an adequate system of PA administrators' preparation.

In addition, on the institutional level, according to the needs of administrative reform, it was approved to reform the system of public servants training, which will provide for the formation of an effective, efficient and flexible system for executive and local bodies personnel training (in both quantitative and qualitative fashion). The important directions of this activity are: improving of teaching strategy, reform of training content, reforming managers personnel training, improving of public servants training, reforming of the short-term training system and personnel training reform.

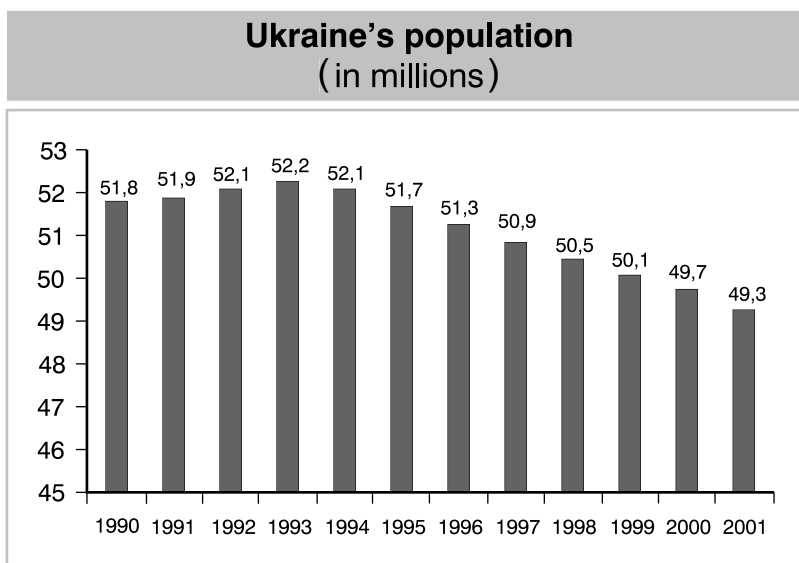
3. Health Care System in Ukraine

Current Situation of the Health Care System in Ukraine

Indicators of health and the quality of life. Public health is directly reflected in such indicators as average life-span, the dynamics of the natural increase or decrease of the population and the mortality rate among children, youths and able-bodied people. Ukraine's situation is characterized, first and foremost, by the presence of demographic tendencies akin to a crisis: the population is decreasing, while mortality among the able-bodied age cohort is increasing, and average life expectancy is decreasing. These facts point to the unsatisfactory state of public health and the spread of social stress in society.

In 1991-2000 according to data presented by the Ukrainian Centre for Economic and Political Studies (24), Ukraine's population fell from 51.9 to 49.3 million people, or by 2.6 million. In particular, in 2000, 385,100 people were born, while 758,100 died. Table 1 presents the negative demographic dynamics in Ukraine.

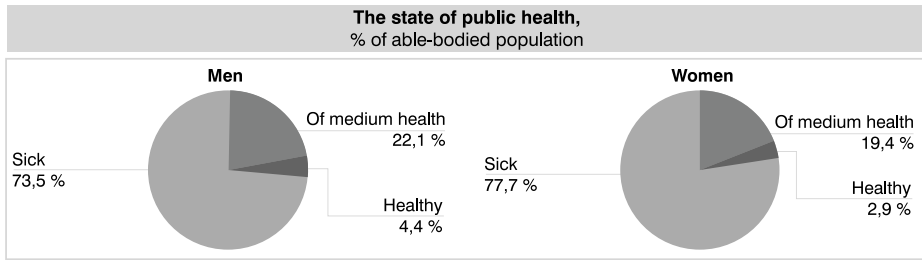
Table 1.



There are some positive tendencies in demographic processes: the reduction of infant mortality, which, after peaking in 1997 (14.7 per 1000 newborn babies), went back down to the level of 1990 - 12.8. Nevertheless, if the present tendencies persist, according to various estimates, demographic decline will continue at a still higher pace and, over the next ten years, the country's population may decrease by five to six million people. For instance, according to the forecast of the UN Population Department, the tendency to the depopulation of Ukraine will be aggravated due to the degressive standard of living, poor health, stress and lack of confidence in the future and the aftermath of the Chernobyl disaster. In 2010, it is estimated that Ukraine's population will decline from 49 to 44 million people (25, P. 8).

Every year, up to 70 million cases of illness are registered in the country, every second Ukrainian may be considered seriously ill (6, P. 13). Diseases of social origin, such as tuberculosis and HIV/AIDS, are especially spread. According to the Ukrainian Institute of Public Health, only 4.4% of Ukrainian males and 2.9% of females are in good health and are in the so-called safe zone; the health of 22.1% of males and 19.4% of females may be called average; while 73.5% of males and 77.7% of females have one or another degree of a disease (15, P. 33).

Table 2.



Accessibility of health service. Against the background of an unfavourable epidemiological situation, the state of the healthcare system is steadily deteriorating: the number of medical establishments is decreasing, budget funding has been cut to an unacceptably low level; and the movement towards paid medical services greatly limits its accessibility to the vast majority of people. The healthcare system requires priority attention on the part of the state, given the unsatisfactory public health situation and the tendency to its deterioration.

According to WHO standards, the state of domestic medicine in Ukraine is critical. By the indicator of per capita expenditures on healthcare, Ukraine occupies 111th place among 191 countries of the world and eighth place among post-soviet countries of the CIS and Baltic States; by the level of attainment of healthcare targets - 60th place. In Ukraine, per capita healthcare expenditures are not only insufficient but show a steady tendency to decline significantly: in 1997, they were \$47.3 per capita; in 1998, they were \$32.2; in 2000, they were only \$13. For comparison: in Great Britain, per capita healthcare expenditures are \$700 and in the U. S., \$3,750. Of that, the share of state expenditures is: in the US, 42%; in Canada, 74%; in Germany, 78%; and in Great Britain, 86%.

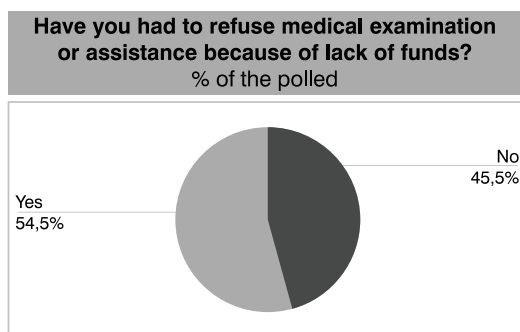
By the share of GDP channeled for healthcare, Ukraine lags behind not only developed countries (where expenditures on public health are close to 8% of the GDP), but also countries with average and even low incomes, where the indicator is equal to 4% of the GDP. In 2000 (as was mentioned in speech by the Minister of Public Health of Ukraine at the Verkhovna Rada of Ukraine Session on November 2000), Ukraine spent only 2.7% of GDP for this purpose. For comparison: in Great Britain, 5.9% of the GDP is spent on public health; in Poland, 6.2%; in Japan, 8.3%; in Germany, 9.0%; and in the U. S., 14%. According to the WHO standards, expenditures on public health cannot be less than 5% of the GDP, otherwise the health system becomes not only ineffective but unmanageable. As a result, in Ukraine, experts assess that the need of the population for medical services is satisfied at the level of a mere 30% of minimal requirements. None of the national programmes in the field of healthcare is being implemented in full.

The unsatisfactory state of health services is seen in the results of a public poll which found that the overwhelming majority of the population (80.7%) believes

that the right of people to healthcare is not being guaranteed in Ukraine; only 11.3% of those polled expressed the opposite opinion. At the same time, 72.4% of respondents are not sure if their children living in Ukraine will be able to rely on quality medical services, while only 11.7% of those polled gave optimistic answers (15, P. 14).

The growth in the volume of paid medical services, and their comparatively exorbitant price, serve to further reduce access to health services for the vast majority of the population. Approximately 10% of Ukrainian citizens are entirely denied medical assistance. There were cases when people died because they could not get medical assistance. In course of the sociological survey conducted by Ukrainian Centre for Economic and Political Studies (15), 54.4% of those polled reported that they had to forgo medical examination or assistance because of lack of funds (Table 3).

Table 3.



The quality of medical assistance to the population constantly deteriorates due to the permanent reduction in the number of medical establishments and personnel. Reductions in funds are also applied to various sectors of the healthcare system, which are critical, given the present situation in Ukraine.

In general, the state of Ukraine's healthcare system proves that the Government cannot adequately guarantee its citizens the right to medical assistance. Limitation of access to health services poses a real threat to human health and life, and provokes a constant fear of falling ill, since for many, this presently means total impoverishment or even the impossibility of treatment.

To further complicate the situation, the access of Ukrainian citizens to medical care is becoming more and more limited as a result of the transition to paid medicine in the country and the insufficient financing of the public sector from the budget. This leads to the reduction of the network of medical establishments and shortage of medicines for the sick whom the state is obliged to provide with free medicines. Restriction of access to medical services is creating a real threat to public health, endangering the health of future generations and bearing witness

that the state cannot fully guarantee the citizens' right to medical care, which is in fact a violation of the human right to life.

Health Care Provision

Restructuring of health care provision. The main factor underlying the demographic crisis and deterioration of public health is the sharp decline in the standard of living of the overwhelming majority of Ukrainian citizens. Shrinking budgetary resources and unclear responsibilities have led to major deterioration in social service delivery (7). In Soviet times, large state enterprises were responsible for the provision of many social facilities, including kindergartens, schools, hospitals, sports and social welfare facilities. With the onset of reforms, many of these functions were passed on to local governments that lacked the necessary resources. In some cases, communities have simply curtailed the provision of such services. In others, providers of health care and education exploit the relatively stable demand and charge "informal fees" for access to these services (27). A survey carried out under the Khrakiv/Lviv/Donetsk anticorruption initiative showed the highest level of perceived corruption was in medical services (27, Attachment 1, P. 4).

The Ukrainian health care sector had a long established tradition of good medical provision and was amongst the best in the USSR. A health care reform plan was promoted in 2000, but throughout the transition period there has been a lack of an overall national strategy for co-ordinated restructuring. As a result, the main recent features of the health care system have involved attempts to preserve pre-existing standards and facilities in the face of a dramatically worsening economic situation. For example, GDP in Ukraine was cut in half during the first five years of the 1990s, while health expenditure as a proportion of GDP remained unchanged. Health care expenditure in 1998 amounted to 3.5 per cent of GDP, less than half the EU average and below that of Czech Republic and Lithuania. The number of physicians per 100,000 is 229 compared to an average of 343.4 for the WHO European Region.

Recent developments. For the last twelve years, the public health policy strategy of reform in Ukraine has focused on achieving the aim of providing economic effectiveness and quality medical care, with the preservation of its accessibility for all population. The basic focus of this reform has been the change of the health protection financing system by dint of a gradual transition from a one-source budgetary system to a multi-channel financing one.

The national budget for health care is to be directed towards the financing of socially important medical, sanitary and health programs, including immunization, money grants for medicines to preferential population categories, extraordinary arrangements regarding epidemics, subsidizing of certain territories with the aim to make health care conditions of the population equal and to stabilize the financial possibilities etc., as it is proclaimed in article 49 of Constitution. The rest of the costs should be provided by private funds.

In the sphere of health, in line with reforms elsewhere in Eastern Europe, the Government program proposes to strengthen primary health care on the basis of family medical practice, to develop a system of health insurance, and to create the conditions for private medical practice. A key feature of the current situation in Ukraine is the low level of remuneration for doctors and other health care staff. In regions outside the capital, nonpayment of wages remains a huge problem. In many cases, trade unions work closely with hospital management but many problems remain: low morale and poor working conditions, lack of equipment, unsatisfactory health and safety for employees, and irregular pay and imposed administrative leave for personnel.

The initial results of the World Bank reform plans for Ukraine were seen as “encouraging”, particularly in the area of privatization and legal reforms, such as bankruptcy procedures. Very soon, however, the Government began to display a lack of sustained commitment to the reform agenda. This, coupled with growing paralysis in decision-making in the legislature and the rising encroachment of the patrimonial state and the oligarchs, has increased the power of vested interests over the State. This “crony capitalism” makes a rational strategy of reform difficult to implement, since more often that creates new space for insider corruption. Today, Ukraine ranks among the highest performers in activities such as business harassment and corruption (27, P. 6).

4. Health Care Management System in Ukraine

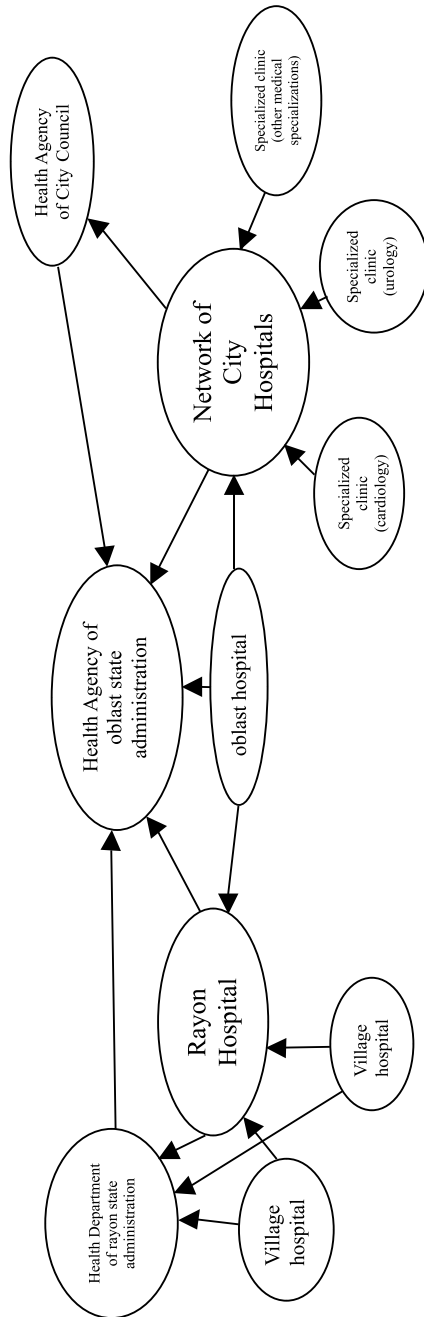
During the communist time in Ukraine there was a centralized health protection system, which possessed the signs of a totalitarian regime of state authority, had a highly developed administrative and bureaucratic nature and was not receptive to dynamic changes. Non-governmental structures of prophylactic and general health protection services did not function and the financing of the health system was provided overwhelmingly through the state budget. Such important mechanisms as medical insurance and private medical practice were not used. These historic conditions have created the gradual alienation of the health protection systems from the basic tasks of health services for citizens and have become obstacles for reforming the existing conditions of the current transitional period in Ukraine.

Currently, there are three basic hierarchical levels of health management in Ukraine: base (community), regional (oblast) and national which are closely associated with one another. The base level covers rural and urban administrative regions. In the rural administrative regions (rayons) a chief doctor of general practice leads the territorial unit. At the same time, he/she is the chief doctor of the central rayon hospital, he/she leads the functions in health care system performed by the rayon administration and oversees the administrative sub-system of the rayon central hospital.

In urban areas, the management of health care is somewhat different. Here, health agencies exist within the system of town or city authorities and they are led by a department head. Under the Department head is a group of administrators

composed of the main specialists (such as physicians, surgeons, pediatricists, etc.). This management system exists within the administrative structures of town or city hospitals.

Diagram 1:
Urban and Rural Health Networks



At the oblast level, there exists an oblast health agency whose head reports both to the Governor of the oblast (who is appointed by the Prime Minister, on behalf of the President) and to a lesser extent to the national ministry of health. Rayon and city hospital administrators have some reporting responsibilities to these oblast agencies and to the national ministry, although the principal source of funding for local health facilities now comes from local rayon and municipal authorities. In fact, current administrative and reporting responsibilities are in a considerable state of flux with new decentralization initiatives conflicting with traditions of high centralization.

Concerning the state (national ministry) administration it should be mentioned that it has such functions in health care as: the managing and prognosing of development in health establishments network; organization of medical care; control over the sanitary environment, observation of regulations in sanitary protection, realization of arrangements on prevention of infectious diseases; control over the privileges given to mothers and children, improvement of life conditions for those families having many children; control over labor protection regulations, accident prevention, sanitation and ecological demands for enterprises, organizations and institutions.

It is at the base level that the primary and secondary care branches of the public health system are concentrated. 90% of out-patient clinics and 80% of in-patient care are concentrated here. Thus, the results of the whole system depend on quality and effectiveness in the managerial sphere of this level. Most administrative activity at the base level is directed towards the development of specialized types of medical care.

Health system management at the base level has many problems:

- to begin with, it is not engaged in addressing social health problems, because of the absence of suitable information and obligations;
- second, it is not engaged in addressing the economic problems of medical care because of absence of proper specialists, and limited knowledge, etc.;
- third, it remains highly reliant upon the administrative-command method as its basic management method.

The realization of improved management of health organizations and the health system under new market conditions is impossible without the radical change of administrative activity at the base level. First, it requires public health system democratization. The issues of organization and assignment of qualitative and effective medical care must become one of the functions of locally governed agencies, which consolidate medical establishments. Medical establishments, like enterprises, must get the right to solve their own problems independently within the framework of existing legislation. They must be able to form their own organizational structure, establish the grounds for the economic principles of their activity and develop qualitative medical services in accordance with peoples need.

Today, the health system must function in an environment which is considerably changed. This is illustrated by the example of the Law on Local Government in Ukraine (12) that specified the authority and responsibility of the executive bodies of local government for services provided to citizens of territories in social sphere. It has defined the principle of local medical establishments (which are communal property) being funded from local budgets.

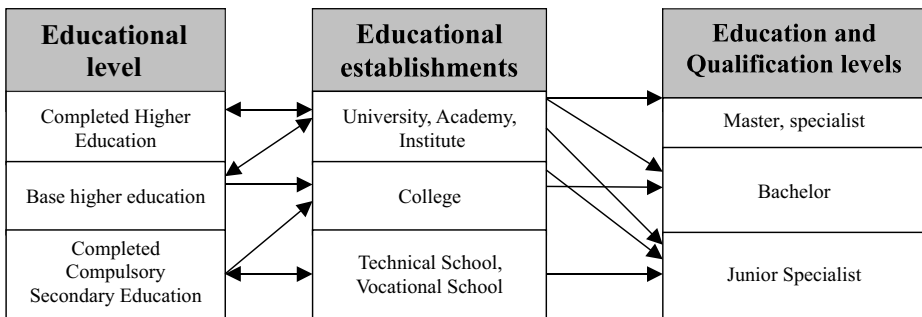
5. Public Administration/Management Education in Ukraine

Higher Education in Ukraine

Higher education constitutes an integral part of the system of education of Ukraine as provided for by the Law of Ukraine “On Higher Education” (13). It ensures the fundamental scientific, professional and practical training for the following educational and qualification degrees:

- **junior specialist** – provided by technical and vocational schools and other higher educational institutions of the first level of accreditation;
- **bachelor** – the basic higher education degree provided by colleges and other higher educational institutions of the second level of accreditation;
- **specialist (5 years), master (1-1,5 years)** – provided by higher educational institutions of the third and fourth levels of accreditation.

Diagram 2. The System of Higher Education in Ukraine



Requirements as to the contents, scope and level of educational and professional training in Ukraine are determined by the State Standards of Education. A state standard of education is developed for each area of training for various educational-qualification levels.

Government regulatory authorities and local authorities perform the management of education. The government regulatory authorities in the area of higher education include:

- The Ministry of Education and Science of Ukraine;
- Central authorities of the executive power of Ukraine, to which educational institutions are subordinated;

- The Supreme Certification Commission of Ukraine;
- The State Accreditation Commission.

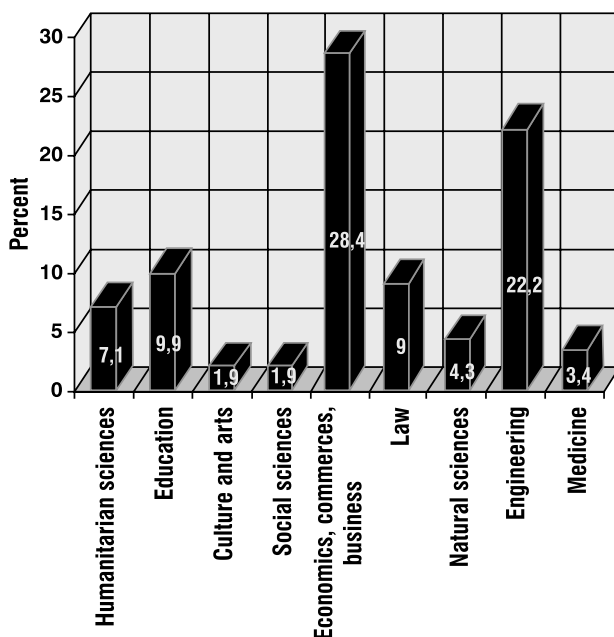
The Ministry of Education and Science of Ukraine is the central body of the government executive power performing management in the area of education. The Supreme Certification Commission of Ukraine organizes and conducts the certification of scientific and scientific-pedagogical personnel, manages the awarding of scientific ranks and the awarding of the academic degree of senior staff scientist.

In accordance with the results of the accreditation of higher educational institutions, the Ministry of Education and Science of Ukraine, together with ministries and departments, to which educational institutions are subordinated:

- determine the correspondence of educational services to the state standards of a certain educational-qualification level in particular areas, and establish the right to issue a document of education pursuant to the state standard;
- determines the level of accreditation of an educational institution;
- informs the community regarding the quality of educational and scientific activities carried out by higher educational institutions.

The attraction of health related occupations in comparison to other areas is presented in Table 4.

Table 4. Student Enrollment by Areas of Training



There are many skills which are needed to address new techniques and strategies pertinent to the development and enhancement of public health (PH) management and administration in the PH system. The PH administrator has a broad range of diverse responsibilities due to the nature of his/her job. The senior officer acts particularly at the executive level and is responsible for strategic planning. The regional administrator is obliged to follow the budget process and initiate the creation of new programs for PH development. Establishment managers must provide leadership to diverse departments providing external health services. Besides they must possess the ability for internal and external communication.

The analysis of surveys of PH managers conducted in different regions of Ukraine (Ternopil region – western Ukraine; Cherkassy region – central Ukraine; and Odessa region – southern Ukraine) serves to indicate skills needed for future implementation as part of the training in PH education programs. A sociological survey conducted by Ternopil State Medical Academy, Khmelnytsk Oblast, included 70 respondents, aged 26-68 (14, P. 49-51). The survey identified the following main characteristics for health system leaders according to their importance:

1. Competence (professionalism) – 55 (6%)
2. Honesty, fairness – 20 (4.8%)
3. Humaneness – 12 (3.9%)
4. Communicability – 6 (2.8%)
5. Self-organization – 16 (4.4%)
6. Charisma (leadership) – 6 (2.8%)

Judging from the answers to the question “What do you consider to be the main requirement for the health manager?”, the ideal PH manager is to be a professional, expert in the health area, honest and fair and a disciplined worker. He/she is to be confident of the future but able to organize activity in existing conditions of health area financing.

The Odessa Regional Institute of Public Administration in 1998 administered a questionnaire to 111 administrators and managers of Odessa Oblast clinics (11). More than half of those surveyed had not had any preparation in health organization and management before assuming their current positions. In 1999, nearly 30% of PH managers did not have any preparation. Only 14.9% of respondents evaluated their activity in the post of Chief Doctors as effective; 41.1% judged their performance as satisfactory; 24.3% considered themselves to be well prepared for health management. At the same time, 31.5% of the respondents assessed the level of their preparation as satisfactory. 75.2% of those surveyed expressed a desire to have training in a health administration program.

As for their involvement in administrative activity, respondents identified the following:

- Health quality management – 61.3%;
- Fundraising – 50.4%;
- Medical establishments activity evaluation – 48.6%;

- Marketing – 47.8%;
- Budget and taxation – 43.2%;
- Accreditation and licensing – 43.2%.

Such issues as personnel management, audit techniques and time management were also areas of concern.

The investigations of Cherkassy Institute of Management (Appendix) testify that professional activity of health manager presupposes the possession of such knowledge and skills as (2, P. 17-22):

- knowledge of modern, theoretical and clinical medicine;
- skills to give urgent (pre-doctoral) medical help;
- skills to organize and accomplish the general care of patients;
- knowledge of principles of health system organization, understanding of development and reform of the health system during the transition towards market-oriented relations and the introduction of the medical insurance system;
- knowledge of structure and peculiarities of clinics (medical establishments) functioning as both state and non-state organizations;
- skills to organize the activity of different services, divisions, medical establishments;
- knowledge of medical care technologies;
- knowledge of principles of financing, planning, audit, control and analyses of clinics economic activity;
- skills to organize medical care and to give medical services;
- special knowledge in health system management;
- special knowledge in health system marketing;
- knowledge of ethics and legislative aspects in health management;
- skills to realize the general functions of management by means of accomplishing administrative and operational procedures of work;
- readiness to make operational decisions within their competence;
- functional and informational preparation of draft decisions;
- operational management of initial (linear) clinical divisions (main activity);
- personnel management (technical servants and junior specialists);
- organization of prophylaxis.

The results received from the research carried out demonstrate that:

1. The majority of those who occupy the administrative positions in health system do not have special training;
2. Among the line managers there are many of those who did not have any training in health organization and management;
3. The absence of special training has negative results on management effectiveness;
4. The content and quality of the existing systems of special training in health organization do not satisfy the need of health establishments' administration.

To study the practical skills of public servants with a focus on health management, we developed and conducted a research study. The methodology of the research consisted of questionnaires which were specially developed for specific tasks and participants. 436 PH managers, 2028 workers of PH institutions and 3873 patients of medically-sanitary establishments took part in the study. A research methodology was formed according to three series of tasks.

The aim of the first series of questions was to identify the dominant strategies in contemporary PH management and to study the difficulties appearing in PH management. The aim of the second series was to assess the level of health services management skills possessed by PH managers. The methodology of this series included a set of items, which gave a possibility to the PH manager to demonstrate the level of his/her administrative competence in marketing and management. The purpose of the third series of questions was to analyze the attitude of clients and patients (consumers of medical services) concerning the quality of services provided by medical establishments and to define the main reasons for the difficulties which prevent the provision of high-quality medical service in Ukraine.

It is not possible to present here a detailed description of the work done but some aspects that are very important in developing contemporary PH management are presented. PH administrators and managers were asked to rank the necessary practical skills of PH workers (to choose the three most important). The results were:

- **83.7%** - to establish and support the system of good relationships with others (to create and to support the system of interpersonal relations); to be a leader, to manage personnel, to manage all complications and problems appearing in manager's activity together with authority and responsibility;
- **81.4%** - to prevent conflicts, and if they happen, to act as the arbitrator between the two sides in conflict, to regulate the troubles (as the result of psychological stress);
- **79.1%** - to possess skills of PH strategic management, making administrative decision in conditions of crises;
- **68.9%** - to work out information and on this base to build the system of communication in organization, to obtain reliable information and evaluate it effectively;
- **64.3%** - to make non-typical administrative decisions such as the skill to specify problems and make decisions in conditions when alternative variants of actions, information and aims are vague and/or doubtful;
- **60.2%** - to distribute effectively resources in the organization – skills to choose the most necessary alternative and to most effectively find an optimum variant in a short period of time and with a lack of resources;
- **51.7%** - self-examination ability – the skill to value objectively his/her managerial position and role in the organization; and the ability to see how to influence the organization;

- 46.4% - to demonstrate entrepreneurial ability – skill to meet justified risk and introduce innovations into organization;
- 45.9% - ability to insure the quality of medical services delivered by medical establishment and institutions;
- 39.8% - to manage effectively the processes of selection, professional estimation of medical personnel of different qualification level, and also their career;

The level of practical skills which PH managers felt they possessed is represented in Table 5.

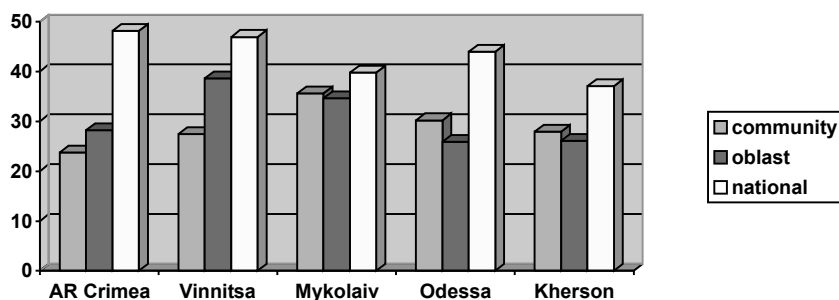
Table 5. The Level of Practical Skills Possessed by PH Managers

<i>High</i>	<i>Sufficient</i>	<i>Middle</i>	<i>Low</i>
2%	27%	56%	15%

As the table demonstrates, a high level of practical skills are possessed by only 2% of PH managers; sufficient - 27%; middle - 56%; and, low level, 15% of respondents. The analysis of the information that was received shows that not all PH managers pay enough attention to personnel management activity and they indicate that they were not taught to do this. The majority of the respondents do not demonstrate steadiness in stress condition, when it is necessary to solve problems quickly. Six percent of the respondents have a high level of creating conflicts.

We present here as well the thought of public officials in health management concerning the influence of the three levels of management on health policy in Ukraine: base (community), regional (oblast) and national (Graph 1).

Graph 1. Influence of Three Hierarchical Management Levels on Health Policy in Ukraine



These items allow us to conclude that it is necessary to provide courses so that PH managers can more effectively respond to the requirements of the transformation from the former system of organization, administration and economics in the system of health care to one that is able to function in conditions of democratization and market relations. PH personnel management needs immediate improvement

and the taking into account of the contemporary demands and specific character of medical organizations. This is especially important in crisis conditions, which are the current conditions of the transformation from state to insurance-funded medicine in Ukraine healthcare formation and development.

PA Education Practices in the Area of Health Care Administration, Management and Policy

Ukraine has existed only 11 years as an independent state (since August 24, 1991). However, in this short period, considerable changes in the training and teaching system for public servants have taken place. With regard to health education, medical universities provide education for doctors in general practice, with a medical specialization in the last year of their study. In 1994, the system was changed to be more similar to North American practice as a means of improving the quality of health education. Because of such changes, the Health Ministry has been required to develop new textbooks, curricula, quality assurance, methodology for quality improvement and other new programs.

In 1993, the government acted to increase the number of those who enter medical higher educational establishments by up to 500 people per year. The goal was to reach the norm of 34 doctors per 10,000 people. Also, at the same time, a decision on closing some health education establishments was approved (especially in Western oblasts of Ukraine where the number of doctors exceeded the need for them).

The legislative base for the higher education standards implementation (13, 7, 16, 17, 21, 22), particularly article 11 of the Law of Ukraine on Higher Education, provides that the system of health education standards consists of three components:

- National general higher education standards,
- Health branch higher education standards,
- Standards of the higher educational institutions (HEIs).

The Law provides that the higher education standards will be the basis for quality assessment and professional training as well as for the quality of the HEIs educational activity.

In Ukraine, health specialists are trained in fields such as “Medicine” and “Pharmacy” in those institutions which receive state validation to educate health experts. Statutory educational and professional programs of training, re-training and qualification improvement for specialists with basic and/or complete higher education are developed by the Health Ministry of Ukraine and approved by the Ministry of Education and Science of Ukraine. These educational-professional programs establish: terms of study; ratio of academic hours delivered according to program; content of training (modules, their informational amount and level of mastery according to the requirements of the educational and qualification characteristics); forms of control and state attestation.

The professional education program for health specialists includes both core and optional courses. The time of delivery among different parts and cycles of training, as well as the type and amount of academic hours, are specified by branch component of higher education standards (in accordance with educational-professional programs). The initial analysis of public health servants training (education) programs suggests that purposeful preparation for administration exists in seven higher medical schools and the Ukrainian Academy of Public Administration (faculties of public administration (PA) with the specialization “PA in the health sphere” have been opened in Kyiv, Odessa and Lviv) (Appendix 4). The core modules of the UAPA programs are the same as in the specialty of “public administration”, but optional modules consist of “State Policy and Strategy in PH”, “Theory and Practice of PH Management”, “Public Administration of Citizens Health”, “Strategic Planning and Management in PH Establishments”, “PH Economy”, “PH Financing”, “Healthy Way of Life Formation” (Appendix 1).

At other institutions, the core disciplines included in programs (Economics and Finance; Law and Legislative Process; Policy Sciences; Public Administration and Management; Social and Humanitarian Policy; Informational Technologies) focus upon general knowledge about the social, political and economic environment and present the basis for the health system’s functioning. There is a set of separate subjects included into the course of health professionalisation. They are: Theory and Practice of Health Organization and Administration; Public Policy and Health Strategy; Social and Individual Health; Health Economics; Health System Financing; Marketing in the Health System; Legislature On Health; Theory and Practice of Contemporary Health Statistics; Personnel Management in Medical Establishments; Medical Aspects of Social and Demography Policy; Health Quality Management; Medical Insurance; Strategic Planning and Health Management.

The bachelor in health management area studies all special disciplines. That is why he/she can work in other areas of economy being occupied with marketing, audit, inter-economy, educational, scientific professional activity.

The specialist in health management must be able to solve a set of specific problems connected with health establishments’ organization, medical care and with organization of prophylaxis and sanitary-epidemic measures. He/she is to know the structure and organization of different divisions in state and non-state health establishments organization; to be able to solve the issues of operational and perspective planning, provide the analysis of medical, prevention and sanitary-epidemic, resort establishments, entrepreneurial and commercial enterprises in the area of health care; be able to solve audit, accounting, personnel issues and to provide technical and medical equipment supply; to organize technical service; to be able to organize medical food supply of patients; be able to supply sanitary and anti-epidemic conditions, labor security and fire security requirements in clinics.

The specialist in medical service management is to have proper theoretical and practical preparation to be able to work in clinics as well as educational and scientific institutions, enterprises of medical and micro-biological industry, in administrative

bodies on different levels. He/she is to be able to prepare documents, use office equipment; speak foreign languages; to be trained in biology and theoretical medicine, to follow professional ethics and deontology; to be well-oriented in legislation and utilize knowledge in everyday practice; to know the basis of rehabilitation, sanitary and epidemic service and pharmacy service; to be able to make economic ties; to supply the requirements of labor security; to organize marketing research and supply and efficient commercial activity; to provide operational control over the quality of medical services; to provide analysis and evaluation of medical firms activity and their efficiency in conditions of competition.

The specialist of “management of organization”, with the qualification “health management” having proper experience can adapt to such directions of professional activity as: organization and administration; administration and economics; information and analyses. Supporting areas are: marketing; audit and control; inter-economics; education; scientific research.

Twenty-two of the higher educational establishments which train PH professionals (Appendix 4) teach economic subjects to students of medicine (Economic Theory, Management, Marketing etc.) but only seven of them (including the Ukrainian Academy of Public Administration) give special bachelor, specialist and master programs oriented to managers (administrators) as well as to economists and marketing experts.

6. Conclusion

The reform of the Ukrainian health system, coupled with the development of more effective management (by strengthening PH managers education and training), is a part of a general movement toward an improved system of public health. Increasing managerial autonomy and reducing bureaucratic control encourages more innovative practices and increases the responsibility of PH managers.

Change strategies involve the gradual moving of emphasis from in-patient medical care towards out-patient care; from narrowly-qualified specialists towards doctors of a more general profile; from tertiary-level help towards the primary level; and from not effectively functioning specialized health establishments towards investments in new health programs. New legislative and normative acts are developed with the purpose of encouraging the shift of medical care from in-patient (ambulatory-polyclinics) help towards out-patient (stationary) centers which are less intensive and require fewer resources -- such as general out-patient centers of practitioners and family doctors, polyclinics, or centers located in the neighborhoods of patients. Such tendencies simultaneously affect the system of PH workers' education by encouraging the improvement of doctors' general qualifications.

In Ukraine, where the responsibility for health establishments has been decentralized to local public authorities, the self-governing model is still at the initial stage of its development. As a first step to operating efficiently and improving hospital performance in a decentralized structure, PH managers should possess

new management knowledge and techniques: e. g. business process tools, client/patient-oriented performance, quality improvement techniques etc. Second, it is necessary to support new knowledge delivery to facilitate better decision-making in clinical, financial and other managerial areas of PH.

Third, to manage PH policy implementation it is necessary to possess a range of skills that will enable one to assess the environment or circumstances in which policy operates and to understand and influence the environment in favor of reform. Another set of skills involves the technical ability to manage policy implementation. That means the ability to set objectives according to the economic, social, and political environment; and to use such mechanisms as laws and financial tools to deliver responsibility. The implementation of PH policy requires a greater degree of knowledge and skills among PH managers – those who can make reform in health sphere feasible. One solution is to train the cadres who will be given responsibility for implementing reforms.

Today, for Ukraine, it is necessary to prepare new cadres for the health management system. The content of the study programs (curriculum) for preparation of health managers must include the study of general, functional and branch components. The general component provides the improving and renewal of the students' knowledge in the sphere of scientific and theoretical basis of such phenomenon as health system management, problems of health system formation and its development as science. The content of the functional component provides the acquiring of additional knowledge and skills according to the professional demands which all health managers are obliged to possess. The level of acquired knowledge and students' skills is to be appropriate for execution of functional obligations according to the qualification demands of the specialty "public administration in health sphere". The content of the branch component provides for the acquiring of practical skills in decision-making for the professional activity of future health managers. The content of this system of education creates the preconditions for theoretical and practical training of the administrative skills in health sphere by students as the method to improve their professional competence.

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Appendix 1.

Academic Programs in Health Management in Ukraine

National Pharmacy Academy of Ukraine

a) Speciality “Marketing”

Term of full-time study:

- Bachelor of economics - 4 years;
- specialist - 5 years.

Work: The modern level of the students training, effectively united the newest economical education and mastering the progressive practical experience of pharmacies and pharmaceutical manufacturers functioning, allows graduates to realize their knowledge and skills at the enterprises of chemical-pharmaceutical, medical-biological and cosmetic branches of Ukraine; in the sphere of pharmaceutical business and pharmacy enterprises; in bodies of customs control and state fiscal inspections; in advertising agencies; in dilling and broking companies.

1st year of study

	Subject	Hours/credits
1 semester		
1	Social-political History of Ukraine	54/1,0
2	Culture of Ukrainian Language	81/1,5
3	Law Study	54/1,0
4	Foreign Language of Professional Communication	81/1,5
5	Physical Training	54/1,0
6	Ecology Fundamentals	54/1,0
7	Political Economy	81/1,5
8	Higher Mathematics	135/2,5
9	Theory of Probability and Mathematical Statistics	81/1,5
10	Introduction to Speciality	54/1,0
11	Chemical and Physical Production Fundamentals	81/1,5
12	Latin	54/1,0

2 semester		
1	Culturology Fundamentals	54/1,0
2	Law Study	81/1,5
3	Foreign Language of Professional Communication	54/1,0
4	Physical Training	54/1,0
5	Microeconomics	81/1,5
6	Informatics and Computer Technics	108/2,0
7	Political Economy	81/1,5
8	Higher Mathematics	135/2,5
9	Theory of Probability and Mathematical Statistics	54/1,0
10	Chemical and Physical Production Fundamentals	81/1,5
11	Latin	54/1,0
12	Biology and Physiology with Anatomy Fundamentals	108/2,0

2nd year of study

	Subject	Hours/credits
3 semester		
1	Philosophy Fundamentals (Philisophy, Ethics)	81/1,5
2	Foreign Language of Professional Communication	81/1,5
3	Physical training	54/1,0
4	Microeconomics	81/1,5
5	Productive Forces Placing	81/1,5
6	Informatics and Computer Technics	108/2,0
7	Statistics	162/3,0
8	Management	162/3,0
9	Chemical and Physical Production Fundamentals	54/1,0
10	Pathological Physiology	54/1,0
11	Business Fundamentals	54/1,0

PART II

4 semester		
1	Philosophy Fundamentals	81/1,5
2	Life Security	54/1,0
3	Physical Training	54/1,0
4	Microeconomics	81/1,5
5	History of Economics	54/1,0
6	Informatics and Computer Technics	81/1,5
7	Marketing	162/3,0
8	Economy of Enterprises	108/2,0
9	Technics and Technology of Field	81/1,5
10	Pharmacology	81/1,5
11	Foreign Language of Professional Communication	81/1,5
Practical Training		
1	Technical-economical	108/2,0

3rd year of study

	Subject	Hours/credits
5 semester		
1	Politology fundamentals	54/1,0
2	Religion study	54/1,0
3	Physical training	54/1,0
4	Macroeconomics	81/1,5
5	History of economic studies	54/1,0
6	Mathematical programming	54/1,0
7	Accounting	81/1,5
8	Economics of enterprise	108/2,0
9	Finance	135/2,5
10	Infrastructure of goods market	108/2,0

11	Technics and technology of branch	81/1,5
12	Organization of pharmaceutical branch	108/2,0
13	Pharmacology	54/1,0
14	Foreign language of professional communication	81/1,5
6 semester		
1	Politology fundamentals	54/1,0
2	Physical training	54/1,0
3	Economical history	54/1,0
4	Investing	108/2,0
5	Mathematical programming	81/1,5
6	Finance	135/2,5
7	International economics	108/2,0
8	Accounting	81/1,5
9	Production organization	135/2,5
9	Economical mechanism of pharmacies functioning	54/1,0

4th year of study

	Subject	Hours/credits
7 semester		
1	Sociology	81/1,5
2	Infrastructure of goods market	162/3,0
3	Psychology	81/1,5
4	Econometry	81/1,5
5	Accounting	81/1,5
6	Labour economics	108/2,0
7	Internal economical mechanism of enterprises	135/2,5
8	Commodity research	108/2,0
9	Marketing goods policy	108/2,0

PART II

10	Economical mechanism of pharmacies functioning	108/2,0
11	Marketing management	54/1,0
12	Industrial pharmacy	81/1,5
8 semester		
1	Logistics	54/1,0
2	State economical regulation	81/1,5
3	Economical legislation (legal regulation)	81/1,5
4	Economical analysis	81/1,5
5	Ensurance	81/1,5
6	Economics and organization of innovative activity	81/1,5
7	International marketing	108/2,0
8	Industrial marketing	81/1,5
9	Marketing policy of communications	81/1,5
10	Marketing price policy	54/1,0
11	Principles of labour protection	54/1,0
Manufacturing practice		
1	Technical-economical (on marketing)	108/2,0

5th year of study

	Subject	Hours/credits
9 semester		
1	Labour protection in branch	27/0,5
2	Strategic marketing	162/3,0
3	Civil defence	54/1,0
4	Advertising management	108/2,0
5	Commodity innovative policy	135/2,5
6	Manufacturing logistics	54/1,0
7	Pharmacoeconomics	81/1,5

8	Commercial activity of intermediary organizations	81/1,5
9	Innovatics and protection of intellectual property	27/0,5
10	Marketing in pharmacy	135/2,5
Manufacturing practice		
1	Pre-diploma	432/8,0

State attestation:

- Diploma thesis defence;
- State exams.

b) Speciality “Management of Enterprises”**Period of full-time study:**

- Bachelor of Economics - 4 years;
- specialist - 5 years.

Work: The modern level of the students training, effectively united the newest economical education and mastering the progressive practical experience of pharmacies and pharmaceutical manufacturers functioning, allows graduates to realize their knowledge and skills at the enterprises of chemical-pharmaceutical, medical-biological and cosmetic branches of Ukraine; in the sphere of pharmaceutical business and pharmacy enterprises; in bodies of customs control and state fiscal inspections; in advertising agencies; in dilling and broking companies.

1st year of study

	Subject	Hours/credits
1 semester		
1	Social-political History of Ukraine	54/1,0
2	Culture of Ukrainian Language	81/1,5
3	Law Study	54/1,0
4	Foreign Language of Professional Communication	108/2,0
5	Physical Training	54/1,0
6	Ecology Fundamentals	54/1,0
7	Political Economy	81/1,5
8	Higher Mathematics	135/2,5
9	Theory of probability and mathematical statistics	108/2,0

PART II

10	Introduction to Speciality	54/1,0
11	Chemical and Physical Fundamentals of Industry	81/1,5
12	Latin	54/1,0
2 semester		
1	Culturology Fundamentals	54/1,0
2	Law Study	54/1,0
3	Foreign Language of Professional Communication	54/1,0
4	Physical Training	54/1,0
5	Microeconomics	81/1,5
6	Informatics and Computer Technics	108/2,0
7	Political Economy	81/1,5
8	Higher Mathematics	135/2,5
9	Theory of probability and mathematical statistics	4/1,0
10	Chemical and Physical Fundamentals of Industry	108/2,0
11	Latin	54/1,0
12	Biology and Physiology with Anatomy Fundamentals	108/2,0

2nd year of study

	Subject	Hours/credits
3 semester		
1	Foreign Language of Professional Communication	54/1,0
2	Physical Training	54/1,0
3	Microeconomics	81/1,5
4	Productive Forces Placing	81/1,5
5	Informatics and Computer Technics	108/2,0
6	Statistics	162/3,0
7	Management	162/3,0
8	Chemical and Physical Fundamentals of Industry	54/1,0

9	Pathological Physiology	54/1,0
10	Business Fundamentals	81/1,5
11	Philosophy Fundamentals	81/1,5
4 semester		
1	Philosophy Fundamentals	81/1,5
2	Labour Protection	54/1,0
3	Physical Training	54/1,0
4	Microeconomics	81/1,5
5	History of Economical Studies	54/1,0
6	Informatics and Computer Technics	81/1,5
7	Marketing	162/3,0
8	Economics of Enterprises	108/2,0
9	Technics and Technology of Field	81/1,5
10	Pharmacology	81/1,5
11	Foreign Language of Professional Communication	54/1,0
Practical Training		
1	Technical-economical	108/2,0

3rd year of study

	Subject	Hours/credits
5 semester		
1	Politology Fundamentals	54/1,0
2	Religion	54/1,0
3	Physical Training	54/1,0
4	Macroeconomics	81/1,5
5	History of Economical Study	54/1,0
6	Mathematical Programming	54/1,0
7	Economy of Enterprises	108/2,0

PART II

8	Finance	35/2,5
9	Technic and Technology of the Field	81/1,5
10	Organization of Pharmaceutical Field	108/2,0
11	Pharmacology	54/1,0
12	Foreign Language of Professional Communication	54/1,0
6 semester		
1	Politology Fundamentals	54/1,0
2	Physical Training	54/1,0
3	Economical History	54/1,0
4	Investing	108/2,0
5	Mathematical Programming	54/1,0
6	Finance	135/2,5
7	Accounting	81/1,5
8	Economical Risk and Methods of its Estimations	108/2,0
9	Internal economical mechanism of intermediary organisations functioning	108/2,0
10	International Economy	108/2,0
Practical Training		
1	Technological Practice	54/1,0

4th year of study

	Subject	Hours/credits
7 semester		
1	Sociology	54/1,0
2	Psychology	54/1,0
3	Econometry	108/2,0
4	Accounting	162/3,0
5	Labour Economy	108/2,0
6	Internal economical mechanism of enterprise	135/2,5

7	Informational Systems and Technologies of Enterprises	81/1,5
8	Economical Risk	108/2,0
9	Planning of Enterprises Activity	54/1,0
10	Commodity research	81/1,5
11	Industry Organization	81/1,5
12	Economical mechanism of pharmacies functioning	81/1,5
8 semester		
1	Psychology	54/1,0
2	Technology of Perfumery and Cosmetic Preparations	135/2,5
3	Special Preparing	108/2,0
4	Aromology	81/1,5
5	Clinical Pharmacy	135/2,5
6	Pharmaceutical and Cosmetical Chemistry	81/1,5
7	Organization and Economy in Pharmacy and Perfumery-Cosmetical Field	108/2,0
8	Management and Marketing in Pharmacy and Perfumery-cosmetical Field	81/1,5
9	Pharmaceutical and perfumery-cosmetic commodity research	81/1,5
Practical Training		
1	on Ready-made Medicines	54/1,0
Manufacturing practice		
1	on Organization and Economy in the Field	54/1,0

5th year of study

	Subject	Hours/credits
9 semester		
1	Biopharmacy	81/1,5
2	Technology of Perfumery and Cosmetical Preparators	162/3,0
3	Clinical Cosmetology	81/1,5
4	Management and Marketing in Pharmacy	81/1,5

PART II

5	Pharmaceutical and Cosmetical Chemistry	81/1,5
6	Plastic Surgery Fundamentals	81/1,5
7	Pharmaceutical and Perfumery-Cosmetical Commodity Research	54/1,0
8	Innovatics and Intellectual Property Protection	27/0,5
9	Quality Management	54/1,0
10	Labour Protection in the Field	27/0,5
10 semester		
1	Law and Ethical Aspects in Perfumery-Cosmetical Field	81/1,5
2	Equipment of Perfumery-Cosmetical Manufacturing	81/1,5
3	Clinical Cosmetology	54/1,0
4	Pharmaceutical and Cosmetical Chemistry	135/2,5
5	Clinical Study of Medical Cosmetic Substances	81/1,5
6	Apparatus Cosmetology	108/2,0
7	Financing activity of enterprises in branch	54/1,0
8	Quality management	54/1,0
9	Computer technologies in cosmetic preparations research	54/1,0
Manufacturing practice		
1	on apparatus and clinical cosmetology	108/2,0
2	on management and marketing in branch	108/2,0
3	standardization , quality control and certification of perfumery-cosmetic preparations	108/2,0

State attestation:

- diploma thesis defence;
- state examinations.

c) Speciality “Management of Organizations”

Period of study:

- full-time for bachelor of management - 4 years.

Work: enterprises of chemical-pharmaceutical, medical-biological and cosmetic branches; sphere of private pharmaceutical business and pharmacies; educational

and scientific-research institutions of pharmaceutical profile; consulting centres, dilling companies; advertising organisations.

1st year of study

	Subject	Hours/credits
1 semester		
1	Philosophy Fundamentals (Philosophy)	54/1,0
2	Ukrainian Language Culture	54/1,0
3	Law Study	54/1,0
4	Foreign Language of Professional Communication	81/1,5
5	Physical Training	54/1,0
6	Social-political History of Ukraine	54/1,0
7	Higher Mathematics	108/2,0
8	Theory of Probability and Mathematical Statistics	54/1,0
9	Economical Theory	54/1,0
10	Chemical and Physical Fundamentals of Industry	108/2,0
11	Business Fundamentals	54/1,0
12	Placing of productive forces and regionalistics	54/1,0
13	Introduction to Speciality	54/1,0
2 semester		
1	Philosophy Fundamentals (Philosophy)	54/1,0
2	Foreign Language of Professional Communication	81/1,5
3	Physical Training	54/1,0
4	Higher Mathematics	108/2,0
5	Theory of Probability and Mathematical Statistics	81/1,5
6	Economical Theory	54/1,0
7	Macroeconomics	81/1,5
8	Informatics and Computer Technics	108/2,0
9	Biology and Physiology with Anatomy Fundamentals	54/1,0

PART II

10	Chemical and Physical Fundamentals of Industry	108/2,0
11	Business Fundamentals	54/1,0
12	Placing of productive forces and regionalistics	08/2,0
Practical Training		
1	Computer	108/2,0

2nd year of study

	Subject	Hours/credits
3 semester		
1	Foreign Language of Professional Communication	54/1,0
2	Physical Training	54/1,0
3	Macroeconomics	81/1,5
4	Informatics and Computer Technics	108/2,0
5	Logics	54/1,0
6	Psychology and Pedagogics Fundamentals	81/1,5
7	Mathematical Programming	54/1,0
8	Statistics	135/2,5
9	Technology Systems	81/1,5
10	Management Fundamentals	108/2,0
11	Pathological Physiology	54/1,0
12	Money and Credit	108/2,0
4 semester		
1	Physical Training	54/1,0
2	Life Safety	54/1,0
3	Mathematical Programming	81/1,5
4	Microeconomics	54/1,0
5	Computer and TV Communications	108/2,0
6	Economics of Enterprises	81/1,5

7	Finances	54/1,0
8	Management Fundamentals	108/2,0
9	Operational Management	108/2,0
10	Pharmacology	108/2,0
11	Technics and Technology of Pharmaceutical Field	81/1,5
12	Foreign Language of Professional Communication	54/1,0
Practical Training		
1	Organizational-economical	108/2,0

3rd year of study

	Subject	Hours/credits
5 semester		
1	Physical Training	54/1,0
2	Economy of Enterprises	81/1,5
3	Finances	54/1,0
4	Operational Management	108/2,0
5	Microeconomics	54/1,0
6	Pharmacology	108/2,0
7	Technics and Technology of Pharmaceutical Field	81/1,5
8	Foreign Language of Professional Communication	54/1,0
9	Religion	54/1,0
10	Operations Investigation	81/1,5
11	Ecology Fundamentals	54/1,0
12	Manager Work Organization	54/1,0
13	Sociology	54/1,0
6 semester		
1	Physical Training	54/1,0
2	Foreign Language of Professional Communication	54/1,0

PART II

3	Culturology Fundamentals	54/1,0
4	Sociology	27/0,5
5	Econometry	81/1,5
6	Finance of Enterprises	81/1,5
7	Accounting	108/2,0
8	Marketing	81/1,5
9	Organization of Pharmaceutical Field	135/2,5
10	Hygiene and Industrial Sanitation of Pharmaceutical Enterprises	108/2,0
11	Insurance Management	108/2,0
12	Taxation Management	108/2,0
Practical Training		
1	Technological Practice	108/2,0

4th year of study

	Subject	Hours/credits
7 semester		
1	Audit	81/1,5
2	International Economical Affairs	108/2,0
3	Business Law	108/2,0
4	Marketing	54/1,0
5	Informational systems in management	54/1,0
6	Fundamentals of labour protection	54/1,0
7	Latin	216/4,0
8	Pharmaceutical commodity research	216/4,0
9	Management in pharmacy	216/4,0
10	Marketing management	54/1,0
11	International marketing	54/1,0
12	Economics state regulation	81/1,5

8 semester		
1	Ethics and aesthetics	54/1,0
2	Politology principles	54/1,0
3	Theory of economical analysis	81/1,5
4	Logistics	81/1,5
5	Controlling	81/1,5
6	Personnel management	108/2,0
7	Fundamentals of external economics activity	108/2,0
8	Labour law	54/1,0
9	Marketing in pharmacy	81/1,5
10	Marketing management	54/1,0
11	International marketing	54/1,0
Manufacturing practice		
1	Management	162/3,0

State attestation:

- complex state examination.

Ukrainian Academy of Public Administration, Office of the President of Ukraine*Part-time program*

Curriculum 2003-2006 years of study

Specialty - 8.150000 "public administration"

Qualification "master of public administration"

Term of study - 30 months

PART II

		Sessions				
		Lectures	Practical	Total	Self-learning	Total number of study hours according to Plan (credits)
1	2	5	7	9	11	3
	Normative part	330	454	784	1106	1890
	Public Administration	108	96	204	282	486
1	Theory and History of Public Administration	26	20	46	62	108
2	Organizational and Legal Basis of Public Administration	26	20	46	62	108
3	Strategic Planning	14	8	22	32	54
4	National Security of Ukraine	8	14	22	32	54
5	World and European Integration	8	14	22	32	54
6	Personnel Policy and Civic Service	26	20	46	62	108
	Legislative and Normative Activity	42	24	66	96	162
7	Theory of State and Law	14	8	22	32	54
8	Constitution Law	14	8	22	32	54
9	Administrative Law	14	8	22	32	54
	Political Institutions and Processes	24	20	44	64	108
10	Conceptual Basis of Political Sciences: Theory and History	12	10	22	32	54
11	Public Policy: Analysis and Mechanisms of Implementation	12	10	22	32	54
	Economic Policy	52	36	88	128	216
12	Contemporary Economy: Theory and Problems of its Implementation	14	8	22	32	54
13	Economy Analysis of Public Policy	12	10	22	32	54
14	State Finances and Budget Process	12	10	22	32	54
15	Statistical Methods of Policy Analysis	14	8	22	32	54
	Social and Humanitarian Policy	34	12	46	62	108

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16	Social and Humanitarian Development Management	34	12	46	62	108
	Regional Management and Local Government	30	16	46	62	108
17	Territorial Organization of Power in Ukraine	30	16	46	62	108
	Information Policy and Information Technology	18	50	68	94	162
18	Information Policy in Ukraine	10	12	22	32	54
19	Information Technology	8	38	46	62	108
20	Logic, Methodology and Methods of Scientific Research	10	12	22	32	54
21	Ethics of Public Service	12	10	22	32	54
22	Ukrainian Business Language in Public Administration		22	22	32	54
23	Foreign Languages in Professional Activity		156	156	222	378
10 Speci alizat ion	Public Health management	70	84	154	224	378
9.1	Public Policy and Strategy in Health Sphere	12	10	22	32	54
9.2	Theory and Practice of Public health Management	10	12	22	32	54
9.3	Public Health Public Administartion	12	10	22	32	54
9.4	Strategic Planning and Medical Establishments Management	8	14	22	32	54
9.5	Health Care Economy	8	14	22	32	54
9.6	Health Care Financing	12	10	22	32	54
9.7	Formation of Healthy Way of Life	8	14	22	32	54

Appendix 2.

The Kharkiv Medical Academy of Post-graduate Education

The Kharkiv Medical Academy of Postgraduate Education is one of the oldest educational establishments of Ukraine. The Academy has the IV-th certification level. In 2000, the Academy (KhMAPE) obtained a license in the speciality 7.050201 “Organization Management” (specialization “Management in Health Services”) – second higher education

Appendix 3.

Cherkassy Institute of Management (Department of Health Care Management, School of Business Management)

Students at Cherkassy Institute of Management receive two levels of education leading to the bachelor degree and the specialist degree in health care management. The department has day and correspondence education. It trains specialists for managing economic institutions, epidemiological-sanitary services, medical institutions, medical research institutes, medical colleges, insurance companies.

The curriculum consists of eight blocks: humanities; fundamental subjects; theoretical and clinical medicine; health services; management and marketing; economics and finance; law; practical training.

Besides general computer technologies, students learn computer technologies in medicine and management. Special classes in psychology ensure empathy to patients and their relatives. Alongside theoretical studies, students receive practical training in health care institutions. Curricula were developed for all major and minor subjects of the department. All course aids provide good materials for correspondence students in medical management, business-plan of medical institutions, ethics and legal aspects of management, medical statistics, diagnostic services and others. Graduates of the department are awarded state diplomas and European diplomas, which meet the requirements of international education standards. In 2000, the first bachelors in medical care management graduated from the Institute. They are the first specialists in the field in Ukraine. The curricula provides for shorter course of studies for those who have diplomas of junior specialists (medical nurse, junior registered medical nurse, junior obstetrician, junior dentist, junior pharmacologist). Since 1997, education by correspondence has been provided for those having the diplomas of junior specialists. It gave the possibility for the representatives of Eastern and Western regions of Ukraine, Russia and Baltic countries to receive education in health care management. In 2000, the programme for retraining in medical care field of those having diplomas of higher medical education was worked out and approved. Studying by correspondence during 2.5 years, doctors can receive the second state diploma of higher education.

Appendix 4.**Higher Educational Schools of Ukraine With Accreditation in Health-related Areas**

I-IV level of Accreditation

I-II level of Accreditation

#	Institution	Management in Public Health	level of Accreditation
The Autonomous Republic of Crimea			
	Crimea State Medical University named after S.Georgievsky (Simferopol City)		I-IV
	Kerch Medical School		I-II
	Medical School of Crimea State Medical University named after S.Georgievsky (Simferopol City)		I-II
	Crimea Medical College		I-II
	Sebastopol Medical School		I-II
	Yalta Medical School		I-II
Vinnitsa oblast			
	Vinnitsa State Medical university named after M.Pirogov		I-IV
	Bershadsk Medical School		I-II
	Gaysyn Medical School		I-II
	Mohiliv-Podilsk Medical School		I-II
	Pogrebyshchensk Medical School		I-II
Volyn' oblast			
	Kivertsivsk Medical School		I-II
	Kovel Branch of Lutsk Medical School		I-II
	Lutsk Medical School		I-II
Dnipropetrovsk oblast			
	Dnipropetrovsk State Medical Academy		I-IV
	Dniprodzerzhynsk Medical School		I-II
	Dnipropetrovsk Medical School #1		I-II
	Dnipropetrovsk Medical School #2		I-II
	Kryve Ozero Medical School		I-II
	Nikopolsk Medical School		I-II
	Pavlograd Medical School		I-II
Donetsk oblast			
	Donetsk State Academy of Administration		III-IV
	Donetsk State Medical University		III-IV

	Donetsk Institute of Administration		III-IV
	Donetsk Medical School		I-II
	Gorlivka Medical School		I-II
	Artemivsk Medical School		I-II
	Kostyantynivsk Medical School		I-II
	Makiivsk Medical School		I-II
	Mariupol Medical School		I-II
	Toresk Medical School		I-II
Zhytomyr oblast			
	Berdychivsk Medical School		I-II
	Zhytomyr Medical School		I-II
	Novograd-Volynske Medical School		I-II
Zakarpatska oblast			
	Berehivske Medical School		I-II
	Mizhgirsk Medical School		I-II
	Hustske Medical School		I-II
Zaporizhzhya oblast			
	Zaporizhzhya State Medical University		III-IV
	Berdiansk Medical School		I-II
	Zaporizhzhya Medical School		I-II
	Zaporizhzhya Medical School of the Dnipro Railway Road		I-II
	Melitopol Medical School		I-II
Ivano-Frankivsk oblast			
	Ivano-Frankivsk State Medical Academy		III-IV
	Ivano-Frankivsk Medical School		I-II
	Kolomyia Medical School		I-II
City of Kyiv			
	Kyiv Medical Academy in Post-graduate Education	Organization and Management of Health Care (certification)	III-IV
	European University (Finance, Information Systems, Management and Business)	Management of Health Care Organization (Bachelor, Specialist, Master)	III-IV
	Kyiv Bogomolets National Medical University		III-IV
	Kyiv Medical School #1		I-II
	Kyiv Medical School #2		I-II
	Kyiv Medical School #3		I-II
	Kyiv Medical School #4		I-II
Kyiv oblast			
	Bila Tserkva Medical School		I-II
	Makarivka Medical School		I-II

PART II

	Obukhiv Medical School		I-II
Kirovograd oblast			
	Kirovograd Medical School		I-II
	Oleksandriysk Medical School		I-II
Luhansk oblast			
	Luhansk State Medical University		III-IV
	Antratsyt Medical School		I-II
	Lysychansk Medical School, Kreminsk Branch		I-II
	Lysychansk State Medical School		I-II
	Luhansk Medical School		I-II
	Stakhanovsk Medical School, Pervomaysk Branch		I-II
	Sverdlovsk Medical School		I-II
	Starobilsk Medical School		I-II
	Stakhanovsk Medical School		I-II
Lviv oblast			
	Regional Academy of Personnel Management	Medical Management and Marketing; Pharmacy Management (Junior Specialist, Bachelor, Specialist)	III-IV
	Lviv State Medical University		III-IV
	Boryslav Medical School		I-II
	Lviv Medical School of Lviv railway Road		I-II
	Lviv Medical College		I-II
	Sambirsk Medical School		I-II
Mykolaiv oblast			
	Mykolaiv Medical School		I-II
	Pervomaysk Medical School		I-II
Odessa oblast			
	Odessa national Medical University		III-IV
	Bilgorod-Dnistrovsk Medical School		I-II
	Odessa Medical School		I-II
Poltav oblast			
	Ukrainian State Medical Dental Academy (Poltava)		III-IV
	Kremenchug Medical School		I-II
	Lokhvytske Medical School		I-II
	Lubensk Medical School		I-II
	Poltava Medical School		I-II
Rivne oblast			
	Dubnivske Medical School		I-II

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	Rivne Medical School, Kostopilsk Branch		I-II
	Rokytnivsk Medical School		I-II
	Rivne Medical College		I-II
Sumy oblast			
	Glukhivsk Medical School		I-II
	Konotop Medical School		I-II
	Lebedynsk Medical School		I-II
	Sumy Medical School		I-II
	Shostkynsk Medical School		I-II
Ternopil oblast			
	Ternopil Gorbachevsky State		III-IV
	Ternopil Gorbachevsky State Medical Academy		III-IV
	Kremenetsk Medical School		I-II
	Chortkivsk Medical School		I-II
Kharkiv oblast			
	Kharkiv Medical Academy in Post-graduate Education	Management and Economics of Health Care (Specialist)	III-IV
	National Pharmacy Academy of Ukraine (Kharkiv)	Economics of the Enterprise; Marketing; Management of Organizations (Bachelor, Specialist, Master)	III-IV
	Kharkiv State Medical University		III-IV
	Bogodukhiv Medical School		I-II
	Vovchansk Medical School		I-II
	Izyumsk Medical School		I-II
	Krasnograd Medical School		I-II
	Kup'yansk Medical School		I-II
	Kharkiv Medical School #1		I-II
	Kharkiv Medical School #2		I-II
	Kharkiv Medical School of South Railway Road		I-II
Kherson oblast			
	Beryslav Medical School		I-II
	Genychesk Medical School		I-II
	Kherson Medical School		I-II
Khmelnysk oblast			
	Kamyanets'k-Podilsk Medical School		I-II
	Khmelnysk Medical School		I-II
	Chemerovets'k Medical School		I-II
	Shepetivka Medical School		I-II
Cherkassy oblast			
	Cherkassy Institute of Business Administration	Management in medical services (Bachelor, Specialist)	III-IV

PART II

	Cherkassy Medical College, Vatutinsk Branch		I-II
	Uman' Medical School		I-II
	Cherkassy Medical College		I-II
Chernivtsi Oblast			
	Bukobyna State Medical Academy (Chernivtsi)		III-IV
	Vashkivets School, Bukobyna State Medical Academy		I-II
	Novoselytsk School, Bukobyna State Medical Academy		I-II
	Chernivtsi School, Bukobyna State Medical Academy		I-II
Chernihiv oblast			
	Nizhyn Medical School		I-II
	Novgorod-Siversk Medical School		I-II
	Prylutsk Medical School		I-II
	Chernihiv Medical School		I-II

PART III

Findings and Conclusions: Public Health Management and Policy Education and Training in Central and Eastern Europe

*Juraj Nemec*¹

1. The Role of The State in Health, Public Health, and Health Service Delivery

There is almost universal agreement that both health and health care cannot be the sole responsibility of the individual citizens of a country and that it is inevitable that the state should have a specific role in such matters. Most economic and socioeconomic arguments support state interventions, especially in terms of the allocative and redistributive roles of government (Stiglitz 1988).

In theory, a perfectly competitive market, with well-informed and rationally acting providers and consumers, is one structural means by which an optimal allocation of health care resources may be obtained. However, many obstacles prevent the achievement of allocative efficiency in a health care market.

Limited information on the side of the patient/consumer is one very important obstacle preventing health care from satisfying free market conditions. Free market conditions imply that the consumers of health services must possess or obtain information about the effectiveness of all available treatments and about the likely future effects of these available treatments on their health status. In reality, consumers have very little information concerning their needs, the level and form of treatment required, and the effectiveness of the treatment. They often must rely on the producers of health care for almost all information. In addition to information asymmetry and the complex nature of “good health care” (Feldstein 1993), another important factor limiting individual demand for health services in a free market is the limited or inability to pay for this service, which can be very expensive.

Further complicating the matter is the fact that each case in the health care system is potentially different from every other case. It is impossible to automatically assume that two different persons with the same diagnosis will have the same treatment with respect to methods, medicines, length of recovery, reactions, and so forth. Thus, the supply of health care represents a complicated sequence of adaptive responses to conditions of uncertainty – uncertainty concerning the best way to treat the patient from the time the illness occurs.

Health care is associated with several kinds of positive externalities, and its provision as a public good can prevent some negative externalities. Very important positive externalities result, for example, from preventive measures, vaccination and the support of technical developments. Consequently, there is a general view

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in developed Europe (see, for example, the European Charter of Social Rights) that everyone is eligible for basic health care services independent of his or her ability to pay.

Many market type mechanism elements were introduced into the health systems of the CEE and NIS countries in the late 20th century, and this trend is likely to continue. Indications of a more open health care market have been affirmed by recent actions of the European Court of Justice in the health sector, namely, judicial decisions about ensuring a competitive market. On the other hand, recent attempts to introduce new public management techniques and more market conditions into the system have confirmed that the capacity of developed health care systems for marketization is limited. It is also difficult to assess the real potential for such reforms in the health sector, because they have been introduced only partially or recently.

Introducing market type reforms into the health care systems in CEE and NIS countries is even more complicated because of several specific features of these countries' internal environment. Two of the most important barriers limiting marketization of health services delivery are

- “quality” of competition; and
- “quality” of democracy (that is, citizens' expectations versus political and bureaucratic failures).

Most potentially competitive markets in the CEE and NIS transitional countries are still not well developed, even in countries that already, according to EU evaluation, have achieved a “market economy.” The “quality” of the market and competition is still limited, at least to some extent, although the weaknesses differ among countries. Many partial markets are still characterized by monopolistic or oligopolistic structures and behavior. In market conditions close to those of a monopoly, private producers do not behave as suggested by standard theories of competitive markets; rather, they focus especially on possibilities of short-term large profits – and the impacts of such strategies are clearly visible, for example, in connection with the introduction of health insurance systems in CEE and NIS countries. Even in the most developed countries of the region, “state of law” conditions have not yet been achieved (e. g., in Slovakia, the standard length of a commercial court case is about two years). Under such circumstances, the use of market mechanisms in the public sector, and especially in health care, has to be evaluated very carefully.

Health reforms in CEE are very much (as everywhere) influenced by relations between the primary players within the democratic system of the country – citizens, politicians and bureaucrats. Real democracy limits the scope for action of both bureaucrats and politicians. However, in countries with a legacy of 40-70 years of Communist regimes, citizens/electorates are not able to protect themselves against malfunctioning political and bureaucratic power; most citizens still think that the state is there to help them, to protect them, and to serve the public

interest. In such conditions, politicians and bureaucrats dominate the processes of health care reforms, and development trends depend very much on their opinion about “best solutions.”

Especially in the most developed countries of the CEE region (Czech Republic, Hungary, Slovakia, Slovenia, Poland), the electorates are reluctant to support major changes in health systems and insist on maintaining the universal access principle. Thus, it should not be surprising that the promises of respective governments are high; for example, the Slovak Law on Health Care (277/1994) declares that:

“Everybody has the right to get health care, including medicines and medical aids. Health care is provided by state health establishments, municipal providers and other suppliers run by legal or physical entities, and is provided on the basis of current medical and scientific knowledge.”

When the introduction of market elements negatively influences the dogmas (not necessarily the realities) of universal access, then there is a high probability that the chances for marketization are severely limited.

2. Health Reforms

All CEE countries implemented large-scale health care reforms after 1989, trying to convert a “socialist” model of a health care system into a perceived “modern” one. The starting point was relatively similar, even though certain differences existed between countries.

The aim of the “old” systems was to provide a comprehensive system of health care for all members of society, free at the point of use. All decisions on health care were generally made on political or administrative grounds, and the only accountability was to the Communist party.

In spite of the promise of universal access as an important feature of “real socialism,” health care was not a high priority sector, at least during the process of building a Communist society. There was a trade-off, with current generations sacrificing some current well-being to build a sufficiently productive economy to allow future generations to give their health a higher priority.

Another reason for the low priority of health was a legacy of the Marxist-Leninist political economy. Drawing on Marx’s distinction between productive and unproductive labor, the official ideology placed health in the second and less prestigious ideological category. This reinforced its position as a non-key sector and identified its problems as less urgent for policy makers. It also accounted for the relatively low wages in the health sector and for its overwhelmingly female labor force.

The important feature of the planned economy was the supply-constrained nature of the system. Planned economies generally exhibited chronic and sometimes acute excess demand for goods and services. Thus, crudely, but only slightly inaccurately, whatever was produced could be sold. This had a damaging effect on

quality, raising the importance of quantity above quality in plans, and led to producers being insensitive to consumers' wishes. Neither demand nor supply influences necessarily affected the output plans of institutions, nor did they necessarily affect where exchanges occurred; it was the suppliers who dominated. There were no economic incentives to improve system performance, and in general excess demand prevailed. Some observers of the system felt that where excess supply existed, officials would order extra, unnecessary tests so that hospitals could present an impression of working at full capacity. There were no attempts to reduce excess supply or demand through either coordinated treatment scheduling or pooling the resources of the different sectors of the health care system.

The efficiency of the health care system was no better than that of the overall economy itself, and health systems in some countries (e. g., Russia) suffered from important crises. In other countries, like Czechoslovakia, major crises were avoided by effective planning; however, even in these countries there were grave and urgent problems that had not been addressed, including the effects of severe pollution; the neglect of mental health and disability facilities; and the very poor health record of the Roma population (Castle-Kanerova 1992).

Clearly, some of the problems existing in 1989 were a reflection of the fact that under Communism there was no direct consumer input into policy formation or resource disbursement processes. There were no pressure groups, and no public discussions about health policy.

The influence of the legacy of Communism and central planning, initially all pervasive, has now decreased. But it can still be seen in the relatively low priority accorded to health care in state budgets, in low pay among health workers, in the supply-constrained nature of many health services, and, most obviously, in the dominant role of the state, directly or indirectly, in determining supply, finances, incentives and new directions in the provision of health care.

Different Conditions, Different Reforms

The changes after 1989 differ among the CEE countries, depending very much on the specific conditions present at the start and during the processes. In countries profiled in this book that represent the most developed countries in Central Europe (that is, Czech Republic and Slovakia), the main principle of the health reforms was to maintain universal access and to increase efficiency and quality. The declaration of the Slovak government in 1992 is typical:

“Government activities in the field of health care shall be based on the urgent requirement to stop the impairment of the state of health of the population.... Based on the “health for all” principle, the essential element of our policy of public health is to afford health care to every citizen of our republic as required by his state of health, financially based on the principle of mandatory health insurance, with the state providing for this obligation in the case of economically inactive citizens. The insurance system will result in radical changes in the health

care financial field and in the physician-patient relationship.” (Government of the Slovak Republic 1992)

Even though the health care reforms in Central Europe were never able to achieve all their promising expectations (e. g., values like transparency, economy, democratization, humanization, and a higher standard of quality of care, as stated in the Czech reform documents), at least the changes did not decrease significantly the level of universality of access. The main problems of these reforms appeared to be cost-efficiency, the scope and scale of services delivered free at the point of delivery, and available resources.

Both in Slovakia and the Czech Republic the most significant current problems of the health care system are connected with finance. The inadequate financing of the system at the starting point of the reforms after 1989, and the declining economic performance of the country as the result of transition, represent objective factors that underlay the financial inadequacies of the health care system in each country. However, many significant subjective, erroneous reform designs, and their related implementation, are factors that are bringing both systems close to collapse today.

The health systems in Slovakia and in the Czech Republic suffer from large deficits that have increased from year to year; data from Slovakia presented in the chapter on that country provides a very good example. As also shown in the chapter on Slovakia, government health system deficits have largely been covered by private sector suppliers of medicines, goods and services to health establishments. The state that promises a level of services greater than what it has available resources to deliver misuses its powers by pushing the private sector to support the health sector on a systematic and long-term basis. Such behavior destroys the principles and functioning of the market, and thus is very dangerous for the economy and the society. [For example, in October 2003 pharmacies in Slovakia almost stopped buying drugs, and many of them temporarily closed; in some districts having more than 100,000 inhabitants, only one or two pharmacies remained open.]

Development trends in health care systems of other, less developed CEE countries are even more dramatic, especially concerning access. In Albania, for example, after the breakdown of state socialism, changes have occurred in the legal framework as well as in the governmental policy, ownership, production, financing and reimbursement of health care. The main reform issues were decentralization and the introduction of health insurance, but the primary problems are caused by a very low level of Albanian health care finances: budgetary spending on health care was only 3.1% of GDP in 2001, one of the lowest in the region, and this level of resources is unable to provide enough resources to cover health care needs.

The sociopolitical and economic upheavals that followed the devastating 1988 earthquake, combined with the political collapse of the Soviet Union, created a catastrophic public health situation in Armenia. After the country gained independence, the government of Armenia did not have the finances required to sustain the

existing health care system, which was expensive, unmanageable, and inefficient. As a result, it has introduced radical health care system reforms that accepted the premise that health care can not be provided free of charge to everyone; the only health care services guaranteed are part of a health care package for the most vulnerable populations.

In Bulgaria, the first health reform measures abolished the public monopoly in the health care sector and the gradual development of a private initiative. This process, however, took place not as part of a systematic effort but as a contingency accompanying other processes. For instance, the private ownership of municipal hospitals was permitted by an act that regulated the administrative structure and mandates of self-governance, not by a dedicated health policy document. Private ownership of medical establishments was accompanied by the elimination of the ban on private medical, dental and pharmacist practices. Due to the lack of political leadership and commitment, the reforms in the health care sector were stalled for more than seven years at levels of quasi-market transformations, which produced many negative effects, including unequal access to health care, low quality of services, "under-the-table" payments, and low salaries in the sector. In fact, although most of the health care services were *de jure* free of charge, *de facto* the users in one form or another had to pay for them.

After declaring independence financially and organizationally, the weak Georgian state was not able to maintain its expensive, overstuffed and oversized health care system. It had no way to cover the costs. The deterioration of the system was farther aggravated by its improper administration. The main feature of the health care reform was privatization; legislation outlined the principles of privatization of health care institutions by allowing either the employees to buy shares or an auction of them. Institutions were given one of three choices: keeping inpatient profiles for 10 years; maintaining outpatient profiles for 10 years; or being privatized unconditionally. Health care reform has proven to be one of the most controversial reforms carried out in Georgia since independence. In fact, it has pitted doctors and patients against each other and resulted in discontent on both sides. It is already seven years since the launch of the health care reform, and, although the reform was undoubtedly necessary, it has not yet brought any relief to the Georgian population.

In Russia, one of the main changes was the introduction of a health insurance system (CHI). In spite of high expectations and promises, by the end of the 1990s it was evident that the introduction of the CHI had failed to bring about clear positive results, in particular an improvement in access to or the quality of medical services. On the contrary, the quality and scope of medical services provided, as well as the health status of the population, have continued to decline. Hospitals and polyclinics suffer from a lack of equipment and medication. People continue to experience the same problems of access to and quality of medical services provided, and many of the places where the services are provided need major renovations

and new equipment. In fact, in a number of hospitals, a patient has to provide medication, food and even bed linen for oneself.

The development of the CHI itself has also encountered serious problems. First, it is characterized by extreme irregularity, which has created, in particular, a grave problem in using insurance policies issued by a regional fund when it is necessary to get medical treatment outside that region. In addition, by 2000 only about 30% (or 8,210) of the health services institutions had joined the CHI system; these included 5,649 hospitals, 1,900 primary care/policlinics, and 661 dental clinics.

The structure of the Russian health care system itself has not improved, either. The notorious number of available beds, which became the target of the criticism of the Soviet model, has not substantially declined, and no significant changes for the better in primary health care have occurred. What has declined is the number of medical personnel, mainly due to the fact that wages and salaries in the health care system are still among the lowest in the country. As a result, many medical professionals have to occupy two positions simultaneously, which enables them to get two salaries but definitely leads to work overload and poor quality of medical treatment. Such a situation also leads to widespread “gratitude” payments to medical staff in Russia.

The main innovation in the reform of primary health care was the introduction of the general practitioner (GP). At present, this is proclaimed to be the major development in the organization of health care in Russia. However, despite the positive experiences with GPs in other countries its introduction in Russia is likely to bring about many problems, the solution of which will require considerable additional investments.

Developments in Tatarstan, an important republic in the Russian Federation, confirm the experiences in these other countries. The transition to a new insurance-based system of financing in Tatarstan caused a serious crisis in the health care system in its first few years of implementation. At present, the situation is not as tense as it was, but the transition to the insurance principle of payment is not yet fully completed. In particular, the system of medical insurance that exists today is not effective in many respects. There is no clear definition of “free of charge” medical services, and a list of medical services covered from public resources also does not exist. These and other considerations are leading to a situation in which all regions lack the financial means to realize the program. [The deficit in the program is 30-40% of the required resources.] This lack of resources, in turn, shakes citizens’ trust in their government and in the institutions of social stability and protection.

Introduction of Health Insurance Financing: Evaluation of Short-Term Outcomes

One interesting common issue among the health reforms in CEE countries has been the introduction of a health insurance financing system for health services to replace a general taxation-based model. This issue is closely related to the de-

cision a country makes about the optimal way in which to bring public finance into the system. The main forms of public financing of health care services are as follows:

- a general taxation-based model (responsible for the financing of a dominant part of health services, including in the United Kingdom and Nordic countries; used as the norm in former socialist regimes in CEE);
- a social insurance-based model (frequently called the “Bismarck model,” in which the state provides resources via the insurance market); and
- a program model in which public funds are provided for health care (a typical example is the United States, with Medicare, Medicaid, and several other programs serving to improve access to health care).

After 1989, all post-Communist countries profiled in this book decided to switch from a general taxation model of financing health care to a social insurance system. This change typically was supported by arguments about plurality, independence and competition, which were viewed as the main positive features of the new system (Lawson and Nemec 2003).

For these countries, the political economy rationale for this switch is a mixture of economic, administrative and political considerations. The economic arguments involve the costs of a public monopoly in the previous system, a system whose efficiency might have been improved by an internal market.

The administrative arguments for the change are that the new insurance companies would be separate from the main government administration, and that this separation would improve the quality of the administration.

The political considerations for proposing this switch are more complex. On the one hand, earmarking taxes for health and subcontracting their administration to apparently independent insurance funds would seem to have the advantage of distancing government from a contentious area of public policy. After all, the interest groups, excepting insurance companies, are relatively unconcerned where extra resources for health will come from. Neither local nor many central health care policy makers are concerned about such trade-offs. They will continue to push for increased expenditures regardless of the consequences for either taxation or expenditures on non-health items. Thus the switch to an earmarked insurance system would seem to have the advantage of reducing pressures on general budgets.

However, the insurance system is not necessarily the best (theoretical) alternative; it can lead to a lot of possible problems, even if introduced in an optimum way. For example, persons with a high probability of needing costly treatments will usually pay a very high premium that might exceed their ability to pay (Feldstein 1993). A typical problem is “creaming” or “cherry picking” (Cullis 1979) – insurance companies try to select “best risk” customers, who are usually healthy and wealthy people. Moreover, too high a level of health care expenditures per capita does not automatically improve the health status of inhabitants (UNDP 2003).

An insurance system should be based on competition, but the level of competition in health care is naturally limited.

Another problem is the possibility of excessive administrative costs, if there are many competing insurance companies but few economies of scale. Alternatively, the general economic welfare problems of oligopolies would exist if the market turned out to be dominated by a small number of large insurance companies.

Given the important pros and cons associated with a social health insurance system of financing health services, general health economics theory and experience from the history of health systems in the world illustrate both the positives and negatives of the insurance system. It is necessary to conclude that there is no single best solution; the decision must be based on a careful evaluation of local internal and external elements of the health system, similar to what is necessary in any other public sector reform approach (Coombes and Verheijen 1997).

The decisions of selected CEE countries to switch from the previous “socialist” taxation-based system to a “modern” insurance-based system of health care financing was mainly based on political arguments (to show a willingness to change). It is apparent from the country studies in this book that such decisions were not primarily based on careful evaluations of internal and external environments, nor on the pros and cons of an insurance system. Because of its controversial character and implementation failures, the new system has not brought the expected outcomes, at least in the short term.

The following paragraphs seek to show what happened. Because it is impossible to disaggregate outcomes and the impacts of just one reform measure (namely, the introduction of health insurance), this analysis looks at the reform outcomes as a whole, recognizing that changes in the financing system are just one factor causing the current problems.

It is difficult to assess the outcomes and the impact of any reform measure, especially in areas where non-financial costs and benefits dominate, as in health care. To cope with this challenge, several international organizations have introduced their own evaluation systems, focusing on different aspects and using different methods. In this chapter, the following four considerations are addressed:

- health status of inhabitants;
- access to care;
- clinical quality of care and satisfaction (clients` quality of care) with respect to the process and with respect to results (quality of care); and
- efficiency and economy of care.

Although a country’s health care financing system has only a small impact on the health status of its inhabitants (the potential of health care to influence health status is estimated between 10-20%), some links exist. The life expectancy data in Table 1 show distinctly different patterns with respect to the health status of inhabitants in CEE countries – in some countries of the region, the health status is improving, but in other countries, it is significantly declining. A lack of financial

resources, including financial resources for health, and citizens' lifestyle (with no resources to change or influence it) might be some of the most important factors underlying these life expectancy differences.

Table 1. Changes in Life Expectancy in CEE Countries: 1970-1975 to 1995-2000

<i>Country</i>	<i>Life expectancy: 1970-1975</i>	<i>Life expectancy: 1995-2000</i>	<i>Change (%)</i>
Slovenia	69.8	75.0	+ 7.4
Czech Republic	70.1	74.3	+ 6.0
Slovakia	70.0	72.8	+ 4.0
Poland	70.4	72.8	+ 3.4
Hungary	69.3	70.7	+ 2.0
Romania	69.2	69.8	+ 0.9
Lithuania	71.3	71.4	+ 0.1
Bulgaria	71.0	70.8	- 0.3
Latvia	70.1	69.6	- 0.7
Ukraine	70.1	68.1	- 2.9
Russia	69.7	66.1	- 5.2

Source: UNDP (2003).

The trends concerning access to health care services are similar in all CEE countries. Accessibility of services and equality of access are decreasing, but in different degrees. As noted earlier, access and equality are still the primary formal features of health systems in Central Europe (even though they have not been fully achieved – and are not achievable); however, they have largely disappeared from the health systems in less developed countries.

Inequalities are aggravated by the existence of an informal health economy. A typical example might be Ukraine. Formally, according to the contents of its health reform strategy, Ukraine has focused on achieving economic effectiveness and providing quality medical care, while at the same time preserving accessibility for its entire population. As the country profile on Ukraine notes, however, the government has been unable to maintain access by all citizens to medical care and treatment. Access is increasingly limited because of insufficient public financing of the health care system and the transition to a system of “paid medicine” in the country. These factors have reduced the network of medical institutions available to citizens and led to a shortage of (free) medicines for the sick, as well as a constant fear of ill health, inadequate treatment, and even total impoverishment.

Even in the most developed countries, public opinion polls have shown that 89% of Slovak respondents and 47% of Czech respondents expect to have to bribe hospital doctors to get treatment (Miller *et al.* 1998). Corruption in the Czech system may be less common both because of the higher levels of public expenditures on health, and because the more developed levels of private practice allow a more rapid legal response to any excess demands for state provided services.

The fact that wages/salaries in the health care system in Russia are still among the lowest in the country leads to widespread “gratitude” payments to medical

staff in Russia. The same is true in any country in which the health care system is underfinanced and where there exist no effective mechanisms to involve private resources in a legal way.

Concerning the quality of health care, actual data are more or less unavailable; nevertheless, many facts indicate that a real health care quality crisis exists in all CEE countries. In Russia, many medical professionals hold two positions simultaneously, which leads to poor quality medical treatment. In more developed CEE countries, quality is increasing in some respects, mainly because of significant quality improvements on the supply side, especially in the structure and quality of equipment available in health establishments and the structure of medicines available and used for treatment; but, simultaneously, quality is decreasing in other dimensions. The mistreatment of the Slovak President in 2000 (Zajac and Pazitny 2000) clearly showed basic weaknesses in daily delivery of care, although it has not been an impetus for changes.

National governments are unable to conduct systematic medical and organizational audits of health providers to learn how care is delivered by doctors and under what conditions it is delivered to patients. Patients are still very far from becoming the central focus of the system. Only some countries have prepared and published a "Patient Rights" document; queuing for an ambulance, without the opportunity for an exact appointment, is typical for a large proportion of providers, including private ones.

The insurance system was expected to bring important positive changes to health care, especially concerning increased efficiency in the delivery of services. Because of its controversial character and the reform implementation failures (described in the country studies in this book), however, such expectations have not been fulfilled. The short-term outcome resulting from the introduction of health insurance (and other market mechanisms) in health care has been increased costs (relative to the resources available), especially increased costs for drugs and hospital services. It might be argued that such rising costs were necessary due to prior underfinancing of the health care system and the opening of the system to the importation of expensive foreign drugs and equipment. Nevertheless, the growth was too fast, clearly showing that insurance systems did not serve to contain costs.

The data from the first reform phases in the Czech Republic and Slovakia (Tables 2 and 3) highlight this problem very well. [Health insurance was introduced in 1992 in the Czech Republic and in 1993 in Slovakia.]

Table 2. Total Health Expenditures in Czech Republic and Slovakia

	<i>Country</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>
Total health expenditures (bill. CZ/SK crowns, current prices)	CZ	39.5	45.7	73.0	88.9	100.9	115.8
	SK	17.5	19.1	17.8	21.6	31.8	38.2
Health expenditures/GDP (bill. CZ/SK crowns, current prices)	CZ	5.3	5.4	7.3	7.8	7.6	7.8
	SK	5.9	6.4	5.3	5.7	6.2	6.6

Source: Radicova, I. and M. Potucek (1997).

Table 3. Expenditures for Drugs in Czech Republic and Slovakia

	<i>Country</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>
Total drug expenditures (bill. CZ/SK crowns, current prices)	CZ	7.7	12.3	14.2	21.3	25.7	28.3
	SK	3.3	4.5	6.3	6.3	8.6	10.0
Drug expenditures/GDP (bill. CZ/SK crowns, current prices)	CZ	1.03	1.45	1.42	1.86	1.95	1.90
	SK	1.17	1.35	1.71	1.43	1.67	1.72
Expenditures for drugs/capita (CZ/SK crowns, current prices)	CZ	747	1192	1375	2061	2488	2744
	SK	618	853	1189	1174	1603	1861

Source: Radicova, I. and M. Potucek (1997).

In addition to the lack of financial resources to satisfy the real needs of health systems in CEE countries, dysfunctions of health insurance systems were also caused by the inappropriate behavior of the state, acting in contradictory ways. On the one hand, the state introduced health insurance and other market type mechanisms into the health care system and was willing to use the potential benefits of market-based regulation. But, on the other hand, the state also limited competition and independency by permanent interventions into the health insurance system, frequent rule changes, and many indirect mechanisms.

3. Health Managers

Today the importance of health management education and high-quality health managers is formally acknowledged in all CEE countries. For example, Russian health officials at different levels – from members of the State Dumas (Lower Chamber of the Russian Parliament) to the Minister of Health and heads of CHI funds – have stressed the need to improve the quality of management in the health system, because the organization and management of health care services provide a vital link in the efficient delivery of quality care. Such statements result from the increased recognition that competent management is essential in every organization and in programs at every level. Thus, changes in the organization and financing of health care have created a need for well-qualified people who can manage health services in the context of the new realities and who have received management training in cost containment, quality assurance and access to health care. Well-quali-

² The CEE country profiles to which reference is made in this chapter are the earlier chapters in this book. Quotations from these country profiles are taken from these CEE country-specific earlier chapters.

fied managers are necessary to overcome a shortage of professionals in the areas of health economics, health management and health policy who have knowledge and skills in research, policy and planning, and administration.

However, the reality differs greatly from the proclamations. In Bulgaria, for example, the social status of public health professionals has not changed significantly despite the changes in the public health field. Public health specialists have no clear identity as such. They are usually medical doctors with specialties in community medicine, occupational medicine and related areas that are viewed as peripheral in the medical field. The identity/image/status problem is accompanied by an inadequately funded career structure.

The Czech Republic country profile² describes the core dimension of the problem as follows:

“In the past, a typical hospital director was a physician with some postgraduate training and special attestation. Health care services were considered to be a field of ‘social consumption’; the system was heavily centralized, with each facility having limited autonomy. This naturally has a straightforward implication on the prevailing professional skills of managers. Since the only economic task was to stay within the budget, there was absolutely no evidence of cost of services, and managers had limited knowledge about actual output. Economic criteria played only a marginal role in decision making, especially with respect to investment, new equipment purchases, and the like.

“The reform brought an entirely new environment for health care providers. Some skills, including those essential for the successful management of independent health facilities (e. g., financial analysis and management, strategic management, managerial/business accounting, marketing, information systems management) were lacking. Essential skills in the field of public health policy and administration were missing, too, but this absence was less evident, and nobody was overly concerned except a few experienced academics.”

Health systems in essentially all CEE countries have scarcely responded to such requirements, however, and today’s characteristics of a “health manager” do not differ (in most cases) from those in the socialist period. For example, people who occupy managerial positions in the Russian health care system are almost always doctors. In fact, the health care system in Russia is managed by physicians. There is a very strong belief within the medical profession that only doctors can manage health services. This is reinforced by the fact that the Minister of Health and other senior health officials are all doctors. The dominant culture of health services has been static for years. Most doctors work in the public sector and are state employees and salaried. The salary of health administrators depends on the size of the institution; for hospitals of various types, size is measured in terms of the number of beds, while for polyclinics and other primary care health services, size is measured in terms of the number of doctor positions. With such a system, the quality of skills is of very limited importance.

The problem of the quality and background of health managers in CEE is highlighted also by a World Bank report on social policies in Slovakia (2001):

“Management structures of health establishments are traditionally dominated by professionals with medical education, with very different levels of management qualification. Because of this fact, effective use of basic management tools from areas like strategic management, management of change, financial and economic planning, and management of equipment is still a very rare case.”

The Armenian country profile stresses other important problem:

“One of the many problems still facing the health care sector is the absence of a serious program to train health facility managers. Many senior managers and administrators have received little or no training in the new techniques that can replace their old method of reporting financial revenues and expenditures.”

Today there are many posts in the health care sector that should be occupied by real health managers. In hospitals and polyclinics, the main managerial posts include:

- hospital director;
- hospital vice-directors, especially economic vice-director;
- senior nurse; and
- heads of departments and other units.

In smaller medical establishments, the situation is more complicated, especially in CEE countries, where group practices are not well-established.

A specific neglected group of health managers consists of health professionals employed at different levels of public administration and responsible for health care, health protection, and even health policy issues. For this group, specific health management skills should be combined with public administration and public policy skills, what is largely not done in CEE countries.

There are no reliable data on the educational background of CEE health managers. Nevertheless, isolated data clearly show that most managerial posts in health care systems in CEE countries are occupied by medical doctors, and that only some of these doctors have had any health management/administration education or training. Usually, only the post of economic director of the medical establishment is occupied by an economist or lawyer, or sometimes by a technician.

4. Compulsory Requirements for Health Management Positions

In certain CEE countries, health managers need to fulfill some obligatory criteria, especially when they serve in top positions as director or have the status of civil/public servants. [All civil service laws, relatively new in CEE, require appropriate education and continuous training for civil servants.] The standard ways of defining the requirements concerning the necessary level and type of education and training for these health managers are as follows:

- defining compulsory requirements by law or by decree;

- providing health managers with the status of civil/public servants; and
- defining requirements by centralized (defined by a ministry or other central body) or decentralized (defined by the institution, or a lower level of public administration) job descriptions.

The system in Georgia has a legal basis; according to new legislation, registration of a medical institution requires a license. The Ministry of Labor, Health and Social Protection issues such a license. One requirement for licensing is that the head doctor must have a certificate in public health management. To obtain a certificate, doctors have to pass an exam; this exam is in the form of test questions, with answer options. The questions cover 25 areas of public health management, such as public health, health law, health care reform, morbidity of the population, prevention of illnesses, health care management, licensing and certification, labor law, primary medical assistance, organization of out-patient and in-patient services, quality control, economics and financing of health care systems, financing of state programs, medical insurance, marketing, information systems in health care, biostatistics, organization of emergency service, and organization of dental service.

In Russia, the decree system is used; however, in this way the Ministry of Health misuses its authority to keep doctors in the leading positions in health management. For example, as described in its country profile, Russia issued a special decree (n337/1999) stipulating what medical qualifications managers should have in order to be appointed to administrative positions in health services:

Table 4. Medical Qualifications Required for Health Administration Positions in Russia

<i>Administrative/Management Position</i>	<i>Medical Qualification Required</i>
Chief doctor	Social hygiene and organization of health care* (or any clinical speciality)
Deputy chief doctor	Social hygiene and organization of health care* (or any clinical speciality)
Head of department	Clinical speciality of the department

*"Social hygiene and organization of health care" includes therapy, surgery, trauma and orthopaedics, endocrinology and physiotherapy.

In Armenia, as noted in its country profile, a system of centralized standards has recently been introduced:

"The need for good managers and good accountants for successful health care facility management has been identified, and the Ministry of Health is currently developing training and retraining requirements for the positions of accountants and managers of large health care facilities. People appointed to these positions will be required to successfully complete appropriate training and to demonstrate competencies in skills that will be defined by the Ministry."

Bulgaria has introduced special course requirements for managers in some employment areas (e. g., health management). In these areas, as noted in the Bulgar-

ian country profile,”all public managers and higher-ranking civil servants in such institutions must obtain adequate training to continue to hold their positions.”

Albania’s regulation of job descriptions for health management positions has not fostered quality in these positions, as described in its country profile:

“Job and role specifications are rather outdated, inflexible, poorly defined and evaluated, and not linked to organizational purpose or scale of activities. In most institutions, human resources performance objectives are not established; staff development and career management also are very limited and uncontrolled. Inadequate supervision and management control tools make management procedures and employment practices out-of-date. There is a severe shortage of trained supervisory and management professionals, which has resulted in the managerial infrastructure being developed less quickly than the health services. Moreover, the managerial infrastructure is not being developed to create a health services system in which attention is concentrated on effectiveness and quality.

The most common problems faced in the human resources processes are as follows:

- There are currently no mechanisms in place to manage the movement of staff into and through the health services and between the public and private sectors.
- There are variable approaches to the recruitment and appointment of staff, but recruitment in the absence of planned objectives is not matching needs and will lead to massive over-supply in certain areas.
- The training for many types of staff is not keeping pace with the need for increased skills in the health services as a whole, particularly when new objectives are considered.
- Staffing decisions are based on institutional staffing norms that are not related to the actual workload; this is leading to low levels of efficiency and underutilization of many current staff.”

On the other hand, in Slovakia there are no compulsory control requirements for health management positions in health care establishments. In theory, anybody with a university degree can be appointed to hospital director and other positions. Nevertheless, in Slovakia in 2003 all hospital directors were medical doctors.

Access of Non-medical Staff to Top Health Management Positions

In the CEE countries profiled in this book, the top managerial posts in the health systems are occupied mainly by medical professionals, of which only a few have received training in health management knowledge and skills. Lower-level managerial posts (e. g., posts in economic departments of hospitals) are not well-paid, and it is very difficult to serve effectively in these positions. Non-hospital (primary and specialized ambulatory care) doctors usually do not use group practices to achieve economies of scale; they also often “misuse” their time to carry out managerial activities, even though their time is more expensive than that of a hired manager.

Entry barriers for graduates of health management, administration or policy schools into management positions in health care systems are usually (with some exceptions, like Russia) created not by legal systems, but in informal ways. For example, the Bulgarian report stresses that most of the health managers in that country have medical backgrounds and form a closed circuit that is difficult to penetrate.

In Georgia, where the health care delivery system is almost entirely privatized, the situation is described in the country profile as follows:

“The head doctors of all clinics in Georgia and the heads of other medical facilities have a medical education. It is not a written law that health care managers must be doctors; there are no legal obstacles preventing public administrators from becoming head doctors. But none of the health care facilities have head doctors who lack a medical education. This practice is rationalized, first, by the large number of doctors for whom employment must be found and, second, by the fact that the big clinics have other managers (e. g., in finance management and in public relations) who do not usually have a medical education.”

Taken collectively, the country profiles in this book show clearly that the medical profession has maintained its dominant position in the management of health care systems in CEE countries and that the opportunities for new specialists prepared by non-medical schools to enter the system are very limited. Better paid posts are usually non-accessible; lower-level posts are poorly paid; the responsibilities of managers in such posts are very limited; and thus the opportunities to perform well are not very high. All of these factors make such positions unattractive for “new blood,” who look to other sectors of the economy for employment challenges and opportunities. The closing of the health management program in Masaryk University in Brno in the Czech Republic and the downsizing of the program in Banska Bystrica in Slovakia are two clear “mirrors” of the current situation. However, the situation might change very fast – for example, in Slovakia the system of soft budgetary limits for hospitals is currently being replaced by a very strong budgetary discipline, which will require that hospitals use management skills to survive.

5. Primary Approaches to Educate and Train Health Managers

The country studies showed that higher education and training programs in health management already exist in all CEE countries. The following main approaches were noted:

- health management programs delivered by medical schools;
- health management programs delivered by schools of public health; and
- health management programs delivered by schools of public administration/management (PA/PM).

Table 5 and Table 6 show that the approaches used to deliver health management programs and training (including public health programs with certain health management contents) differ significantly among CEE countries. The most fre-

quent approach is providing respective courses or programs within the framework of medical schools.

Table 5. Approaches to Educate Health Managers in Selected CEE Countries (academic degree programs)

<i>Country</i>	<i>Health managers are educated by</i>			
	<i>Medical schools</i>	<i>Schools of public health</i>	<i>PA/PM schools</i>	<i>Specialized HM schools</i>
Albania	yes	no	no	no
Armenia	yes	yes	no	yes
Bulgaria	yes	yes	yes	no
Czech Republic	yes	no	yes	yes*
Georgia	yes	no	no	no
Russia	yes	yes	yes	yes**
Slovakia	yes***	no	yes	no
Ukraine	yes	no	yes	yes

* *Business school with health management (HM) program.*

** *Many humanitarian and technical universities offer health management programs.*

*** *Faculty of Nursing and Social Work.*

Table 6. Approaches to Train/Retrain Health Managers in Selected CEE Countries (excluding business sector courses)

<i>Country</i>	<i>Health managers are trained/retrained by</i>				
	<i>Medical schools</i>	<i>Ministry training institute</i>	<i>PA/PM schools</i>	<i>Schools of public health</i>	<i>Specialized HM schools</i>
Albania	yes	Yes	no	no	no
Armenia	no (planned)	Yes	no	yes	no
Bulgaria	yes	Yes	no	yes	no
Czech Republic	yes	Yes	yes	yes	yes
Georgia	yes	Yes	no	no	no
Russia	yes	Yes	yes	yes	yes
Slovakia	no	No	yes	yes	no
Ukraine	yes	Yes	yes	no	yes

The data show that the structure and potential for quality in the respective programs is very heterogeneous. None of the programs focuses only on public health management as a separate field, probably because in smaller countries such an approach does not make sense and because of the dominant ownership structure in the system.

Two important problems are worth mentioning. One is the limited or even absolute lack of cooperation between institutions delivering health management education and training. For example, as the Armenian country profile indicates, this prevents “the development of a sound system of public health management and administration in Armenia. Only greater cooperation and exchange of ideas,

teaching methods and materials can contribute to a working system of health care administration and management.”

The second problem is standardization. Especially during the first phase after the abolition of the Communist regimes, in most countries the “freedom” that emerged in the university education sector, which led to a lack of coordination and a lack of effective accreditation processes, allowed many institutions to offer programs that were not of high quality. Some countries began to standardize the contents of health management education, but the efforts were not always effective. The systems were usually dominated by state accreditation of university programs, not by voluntary cooperation and peer review.

A typical example is Ukraine. According to the legislative base for higher education standards implementation, particularly article 11 of the Law of Ukraine on Higher Education, the system of health education standards consists of three components:

- state higher education standards;
- health branch higher education standards; and
- higher education standards of the higher education establishments (HEEs).

In Ukraine, the higher education standards are the basis for quality assessment and professional training as well as for the quality of HEE educational activity (independent of HEE types, levels of accreditation and forms of education). Health specialists are educated only in those institutions that receive state validation to educate health experts. Statutory educational and professional programs of education, retraining and qualification improvement of specialists with basic and complete higher education are developed by the Health Ministry of Ukraine and approved by the Ministry of Education and Science. These educational and professional programs establish the terms of study; the ratio of academic hours delivered according to program; the content of training (that is, modules, their informational amount and level of mastery according to the requirements of the educational and qualification characteristics); and the forms of control and state attestation.

Evaluation of Alternatives With Respect to CEE Conditions

In general, there are no non-negotiable arguments in favor of any existing education and training approach to prepare health managers; all approaches have their advantages and disadvantages. From general experience, both the adaptation of management sciences graduates to health sector conditions and the retraining of medical doctors to become effective health managers can be effective; the personality of the individual is more important than the general approach used. Health managers serve in many types of posts – from directors of large hospitals to positions in state administration and public health institutions, and there should not be one single approach to educate and train all health managers.

From a practical and short-term perspective, when (as in the CEE countries) the health management system is dominated by medical doctors, the dominant use of medical schools to educate and train health managers might be the simplest approach, since it has been shown to be effective in countries in which the health systems are in the early stages of transformation. This approach has significant risks associated with it, however, as illustrated by the Bulgarian country profile:

“The curriculum development approaches and teaching methods in the public health/health management degree programs are still heavily oriented toward theoretical and factual knowledge. Most of that tendency can be attributed to the legacy of the traditions in Bulgarian academic education, which is characterized by a minimal focus on skills acquisition and training. Most public health courses are not tailored to the needs of students but to teachers’ styles and theoretical paradigms. Another consequence of the structure of Bulgarian higher education is the isolation of medical education into separate medical science universities (Des Marchais *et al.* 1992). Hence the education provided by other universities and educational institutions is not sufficiently integrated into public health education.”

Programs delivered by non-medical schools might have a better chance to incorporate the modern style, methods and contents of teaching, especially because their graduates have to be highly competitive to get posts in a closed or semi-closed health management system.

Longer term (after the economic recovery of a country), it may be more appropriate to support the creation of a multi-dimensional higher education “market” for the preparation of health managers, where all types of schools would compete and cooperate simultaneously and the quality of the education and training would be guaranteed by effective accreditation processes.

Compared to university education, the issue of the most suitable training system for health managers seems to be simpler. Taking into account recent public management approaches, a mixed public-private-civil sector provider system should serve best. Smaller scale training programs would especially benefit from free competition for licenses to deliver health manager training; longer term, the use of competition for participation might be the best way to ensure training program scope and quality.

Role of PA/PM Schools in Education and Training of Health Managers

According to the CEE country reports, the role of public administration and management schools in educating and training health managers is very limited – and in smaller and less developed countries, almost non-existent. Even in the Czech Republic and Slovakia, where more programs of this type emerged in the early 1990s, their position in the system is not improving, but is being marginalized.

Such trends are not encouraging, especially because the public dimensions of health care remain one of the main principles of health care delivery in all CEE countries (at least in theory). Health managers in a public health care system also

should be aware of the politico-administrative consequences of the system. The situation is worsened by limited or no cooperation between PA/PM schools and medical schools, which inhibits the “production” of “complete” health managers having the necessary portfolio of knowledge. As the Czech country profile concludes:

“The current scope and scale of education and training activities for health managers and policy makers is much broader It is clear, however, that a dominant segment of current programs focuses mainly on managerial skills (and these programs are primarily offered to health care administrators and hospital managers), rather than on necessary public administration and public policy knowledge.”

Taking into the account the profile of a health manager, and especially a public health manager, there is no doubt that the role of public administration/management schools in the education and training of these persons should be increased. This does not necessarily mean that new programs should be created; rather, it suggests that there should be expanded cooperation, an exchange of curricula and teachers, or other initiatives that support more complex approaches to health management education and training in CEE countries. Taking into account existing natural, financial and other barriers, such developments should be supported by external resources.

6. Health Policy Education and Training

The country profiles in this book confirm an important negative fact – in most, essentially all, CEE countries, there exists no comprehensive university program in health policy, even though such programs would be crucial in helping a country develop the capacity to implement effective health reforms and health policies. Thus, health care reforms can be successful only in special cases, not in general. A consistent health policy does not exist in any of the profiled countries (although some positive changes might be visible soon in Slovakia). Health politics (i. e., lobby interests) and inconsistent health policies generally have been the basis for the preparation of reform documents and the development of reform implementation processes. The cost for this approach has already been substantial; billions of dollars have been invested in reforms that have brought no progress – just profits to particular interest groups.

The lack of capacity to create, realize and implement health policy and to understand its impact on reform outcomes is caused by several factors. First, higher education systems in all transitional countries are still developing, and policy analysis is a new discipline for the entire region, introduced only after 1989. Time is still needed to develop this area of study, even in the most developed CEE countries.

Second, the demand for independent policy analysis from the central government or any government level is still limited. Many politicians are “short-term rent-seekers.” Most important, health system actors – politicians, bureaucrats, doctors

and pharmaceutical firms (patients are still excluded) – would not benefit from a systematic, consistent and comprehensive long-term health policy. In such a situation, both the supply side and the demand side of the “market” fail to produce effective numbers and effective quality. Moreover, there are very few CEE health policy “think tanks,” and those that exist have limited impact on health policy and are only irregularly asked for their advice.

To conclude, the ability to design a public health policy and to implement it in a CEE country, both at the national level and at the local level, does not receive sufficient attention; much more must be done. As in the case of bringing public administration/management and health management education together, external resources and support likely will be necessary to develop this capacity to design and implement health policies.

7. Conclusions

Health care in developed countries represents a mix of public-private arrangements; many factors underlie this fact, including important economic (market failure) and social (equity and universal access) arguments. The potential to use certain market elements and mechanisms in health care exists, but they should first be carefully evaluated and only then implemented based on comprehensive *ex ante* analysis, taking into account specific local situations and conditions.

All CEE countries started to reform their health care systems after the fall of Communist regimes; the starting point was more or less the same. However, the “level of crisis” in the “old” systems differed. As a result, the health reform strategies in CEE countries have many similarities, but also important differences. All reforms are formally based on a willingness to maintain some level of equality and universality of access (even though outcomes differ significantly), and all countries introduced a health insurance-based system to finance health care expenditures to replace, or to add to, the former general taxation-based system. These efforts share a common result: they have had limited positive impacts. On the other hand, other strategies (e. g., those relating to the scale and scope of privatization) differ significantly.

Outcomes of health reforms differ between the EU accession countries and the other CEE countries examined in this book. The health status of inhabitants is increasing in the EU accession countries, for example, but generally decreasing in the NIS region. However, health care quality should not be the dominant consideration. Quality is increasing at least in part because of the availability of new technologies, equipment and drugs, but much less has been done with respect to “patients’ quality.” Access and equality are decreasing very significantly in the NIS countries. Finances are a neuralgic point of all systems; most systems lack the resources to deliver the necessary quality and scale of health care services. Yet attempts to increase the efficiency (technical efficiency) of providers and the effectiveness (allocative efficiency) of the system either have not been introduced or have failed.

Health systems in all CEE countries urgently need new, well-educated health managers and health policy makers. The education systems have not responded adequately to these needs, due to the dominance of the medical profession in health policy and health management, limited financial and human resources, ineffective state regulations, and other factors. In most countries, medical schools dominate the delivery of health management education and training; approaches to create a pluralistic “market” of providers to stimulate quality improvements are not well-developed. The lack of cooperation between actors worsens the situation even further – and health policy education is virtually non-existent.

Creation of new institutions needs substantial resources. For this reason, it might be more effective to find ways to bring existing actors closer together, especially in countries where the level of quality-based regulation of the higher education “market” (e. g., accreditation) is marginal. One such actor should be public administration/management schools, which can bring important inputs to the system of health manager education – inputs frequently not deliverable or taught by medical schools (e. g., public administration, public management, non-profit management and marketing, and public policy courses). To support this expanded involvement of public administration/management schools in the education and training of health managers and policy makers, selected (and sensitive) external support is likely to be of critical importance.

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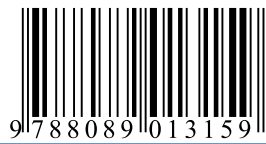
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