

## Guest Editorial

# Lessons from health financing reform in central and eastern Europe and the former Soviet Union

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Policy makers in the so-called *transition countries*,<sup>1</sup> as in all countries, face the challenge of improving the performance of their health systems. These countries share a unique historical experience – the period and collapse of communist rule – and all embarked on an unprecedented social, political and economic transition that began at the end of the 1980s. Despite this shared history, differences emerged (or became more apparent) in the early years of transition. Most obviously, there are large economic differences between the countries, with the richest country, Slovenia, having an estimated purchasing power parity-adjusted per capita gross national income in 2008 of \$26,910 compared with that of \$1860 in the poorest, Tajikistan (World Bank, 2009) (Table 1). The transition created particular challenges and opportunities for their health systems, in general, and for health financing systems, in particular. And indeed, most of the countries introduced either comprehensive or piecemeal reforms in a number of areas, including the introduction of compulsory health insurance (CHI) funds, changes in provider payment methods and changes in benefit packages and user charges.

A recently completed edited volume (Kutzin *et al.*, 2010) reviewed the experience of transition countries with two decades of health financing reform and synthesised lessons learnt to date, some of which may resonate for countries

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1 These include the 27 countries that were formerly part of the Union of Soviet Socialist Republics (USSR) or the 'Eastern Bloc' of former Communist countries of central Europe. Collectively, we refer to these countries as being from central Europe, eastern Europe, the Caucasus and central Asia (CE/EECCA).

**Table 1.** Key health financing indicators by country income group, 2006

Country income group <sup>a</sup>	Bottom third	Middle third	Top third
GDP per capita in international dollars	3922	9540	17,911
Government health spending as % of GDP	2.41	4.51	5.17
Private health spending as % of total health spending	57.26	30.62	22.41
Total government spending as % of GDP (the fiscal context)	30.59	38.38	41.04
Government health spending as % of government spending (the priority given to health)	7.71	11.74	12.58
Real public spending on health in 1995 relative to 1990 (%)	48%	93%	107%

<sup>a</sup> The 27 countries analysed in the book were ranked by per capita GDP in international dollars in 2006. The countries were divided into three equal size groups with nine members each. Group averages are not weighted for population size. The bottom third includes Tajikistan, Kyrgyzstan, Uzbekistan, Moldova, Georgia, Armenia, Albania, Azerbaijan and Ukraine. The middle third includes Bosnia and Herzegovina, Macedonia, Montenegro, Serbia, Belarus, Kazakhstan, Bulgaria, Romania and Russia (estimates of real public spending on health 1990–1995 missing data for Bosnia and Herzegovina, Serbia and Montenegro). The top third includes Croatia, Poland, Latvia, Lithuania, Hungary, Slovakia, Estonia, the Czech Republic and Slovenia.

elsewhere. The review focused on contrasting reform design and implementation experiences in countries considered to be more successful early reformers and innovators with countries considered to be lagging. A number of factors were taken into account in defining success and failure. More successful reformers were those that (a) set clear policy objectives and demonstrated measurable progress towards these; (b) implemented a successful transition to a more coherent system design explicitly aligned with those objectives; and/or (c) implemented a realistic strategy in especially challenging contexts which constrained the extent of progress that could be attained. On the basis of these criteria, a number of countries emerged as more successful reformers, among them were the Czech Republic, Estonia, Kyrgyzstan, Moldova and Slovenia. These countries represent both the higher and the lower end of the social-economic development spectrum and implemented different reforms; but several important commonalities emerged (Table 2).

Twenty years of reforms have yielded numerous opportunities for learning and the volume cited above discusses many of the lessons and pitfalls. Here, we highlight five key lessons. Successful reformers:

- not only identified clear policy objectives, but also prioritised them in a logical manner and sequenced reform steps accordingly;
- did not attempt to implement ‘models’ developed elsewhere; rather, they understood financing arrangements in functional terms and used this to address problems of fragmentation and mis-alignment, paying particular attention to pooling arrangements;
- paid attention to the sequencing of reform steps; strengthening purchasing mechanisms to drive change seemed to be an effective starting point;

**Table 2.** Summary of reform directions in successfully reforming countries

Revenue collection	Diversified revenue base from general tax with limited co-payment for medicines to a combination of revenue sources including general tax, payroll tax and co-payments.
Pooling	Addressed previously fragmented arrangements by progressively centralising the pooling of funds.
Purchasing	Moved away from input-based line-item payment mechanisms linked to capacity-based norms (staff, infrastructure) towards more strategic purchasing on the basis of population and activity-based payments and, occasionally, targeted bonus payments, whereas concurrently extending greater financial management autonomy to contracted providers.
Benefit package design	Replaced implicit entitlements with explicit coverage rules and reduced mandates that had become unfunded during the transition period.

- treated definition of the benefit package as a policy instrument rather than as an accounting exercise;
- accompanied implementation with analysis, reporting, learning and adaptation.

### Getting the objectives right and in the right order

Health system reform begins from a precise understanding of the roots of performance problems. At the end of the Communist era in the countries of central/eastern Europe and the former Union of Soviet Socialist Republics (USSR), health financing systems were characterised by high degrees of fragmentation between health sub-systems (systems organised at each level of public administration, such as district, province etc.) and vertical integration of financing and provision. Purchasing (the allocation of pooled resources to providers) was not 'strategic' but implemented simply on the basis of input-driven norms, with very limited flexibility to reallocate at provider level. The norms created incentives for capacity expansion and low productivity, whereas the fragmentation magnified the incentive problems, inhibited population-based planning and reduced the scope for redistribution of public funds.

Despite this, the pre-transition health systems had achieved universal coverage at what appeared to be a sustainable cost. However, changes in the wider economic and fiscal context that occurred with the transition undermined the ability of systems to sustain effective universal coverage. In a technical sense, there were two major contextual shifts. The first was the fiscal shock that greatly reduced the ability of governments to spend (Cheasty, 1996); consequently, health budgets declined in most countries of the region. The second was integration into the world economy, leading to a change in relative input prices, particularly for medicines and energy.<sup>2</sup> Governments in the region, therefore,

2 The impact on the price of imported medicines occurred quickly. Most governments did not allow energy prices to rise immediately; these began to rise in the mid-1990s as countries liberalised prices for public utilities.

had less money and faced higher prices, although the severity of the change varied greatly across countries.

The inefficient organisational arrangements and incentives inherited from the past had consequences for health system objectives such as financial protection, equity and transparency. By 2000 in Kyrgyzstan and Moldova, for example, over 20% of total public spending on 'health' actually went to pay for the utility costs of buildings (Kutzin *et al.*, 2009). Moldova and Kyrgyzstan were among the most severely affected countries in terms of the magnitude of the fiscal shock, so the presence of structural inefficiencies was especially visible. But they were not alone in experiencing this unprecedented contraction in the size of the state; the problem of inefficient infrastructure absorbing an increasing share of a decreasing government budget was a problem across the region.<sup>3</sup> The more governments had to spend to provide energy (heat, electricity etc.) for an extensive and poorly maintained physical infrastructure, the less money they had to pay for inputs such as medicines, medical and non-medical supplies and salary top-ups.

As a result of the inefficiently large service delivery infrastructure, patients had to buy their own medicines and other treatment inputs, leading to higher out-of-pocket costs than would have been the case in a more streamlined system. This was in contrast to the pre-transition period when health care had been free of charge (except for small co-payments for medicines and some informal payments) and levels of financial protection had been high. Patient out-of-pocket payments soared during the 1990s, with estimates<sup>4</sup> for 2000 at or above 50% of total health spending in seven of the countries, over 60% in five and over 70% in three (WHO, 2009). Although inequities had existed during the Communist era, they were greatly exacerbated by the new context because the need to pay out of pocket presents a greater obstacle to service use for poorer persons and a greater financial burden for them should they choose to pay. Hence, the health system's structural problems led to and still have distributional consequences: the poor suffer more from inefficiencies.

The inefficiency problem also spilled over into a transparency problem because payments to health facilities were for inputs that were meant to have been provided without charges (i.e. informal payments). The countries that experienced a greater fiscal shock and greater decline in public funding for

<sup>3</sup> In 1989, general government revenues in the USSR were about 41% of GDP, according to the IMF (Cheasty, 1996). By 1995, this had fallen to an unweighted average of 25% for the 15 countries of the former Soviet Union. This average masks a range spanning from 5% in Georgia to 44% in Belarus. The countries of the Caucasus and central Asia were most affected, while the westernmost CIS countries, the Baltics and Russia took a less severe hit. In Kyrgyzstan, revenues had fallen to 15% of GDP in 1995, while in Moldova the corresponding figure was 20%. Of course, the level of GDP had also fallen considerably in these countries.

<sup>4</sup> This is likely to be an underestimate of the number of severely affected countries and even of levels of out-of-pocket spending, given the small number of systematic household surveys during that period that focused on deeper analysis of such payments.

health also experienced a greater problem with the rise of informal payments. Although in central Europe informal payment was mostly reported for medical personnel, informal payments in the former Soviet Union were equally widespread for medicines and supplies. The following examples illustrate the scale of informal payment and its variation across the region. Hungary has only experienced informal payments for medical personnel. Nevertheless, the level of payment at least doubled in real terms between 1992 and 2006, whereas the salaries of medical personnel remained below 80% of average national salary levels. In Russia, informal payments mostly include payments for medical personnel, with a small share for medicines and supplies, but despite efforts, informal payments rose from affecting 5.4% of patients in 2001 to 17.3% in 2008 for outpatient care and from 7.1% to 22.8% for inpatient care. In contrast, surveys of hospitalised patients conducted before major reforms in Kyrgyzstan (2000) and Tajikistan (2007) showed that most patients paid informally both to medical personnel and for medicines and supplies.

Informal payments create problems of transparency in terms of patient entitlements and responsibilities. The root cause of this transparency problem, however, lies not in corrupt practices, but rather in the mismatch between expected/promised benefits and available resources. This in turn is largely caused by the structural inefficiencies that became visible with the massive decline in public funds during the transition period (Gaal *et al.*, 2010). While the specific nature of this efficiency problem is perhaps unique to the post-transition countries, a more general message may be that where systems are 'wasting' a substantial amount of the public resources provided to them, it will be difficult to make much progress to improve financial protection, equity and transparency.

Countries needed to tackle major structural inefficiencies in the health service delivery system (and the fragmentation and incentive problems at their root) early in the reform process to enable progress in other areas. Those countries we consider successful addressed structural inefficiencies as a priority issue and underwent significant delivery system downsizing. For example, Estonia reduced the number of hospitals from 115 to 67 between 1993 and 2001 (Atun *et al.*, 2005) and Kyrgyzstan reduced the number of hospital buildings by 47% and floor space by 40% between 2001 and 2004 (MOH, 2008). The lesson is not that efficiency is inherently more important as a policy objective than equity. It is simply that the old health systems were 'broken' and had to be fixed before (or at least concurrently with) trying to address other policy objectives.

### **Understanding systems in terms of functions, addressing fragmentation and mis-alignment and paying attention to pooling**

A cursory look at the reform experience of these countries might see it as a shift from Beveridge to Bismarck. In fact, the experience suggests that this is both an outdated and inadequate way to think about health financing. For example, as

the system inherited from the USSR was funded from general revenues, pooling was highly fragmented: each of the administrative levels (e.g. republican/national, oblast/state, rayon/district, city etc.) funded their own facilities, often covering overlapping populations. Effective reform required both addressing this fragmentation and changing the incentive environment; simply changing from a 'tax-funded system' to a 'social health insurance system' was not sufficient. Although most transition countries introduced new CHI funds, only a few made real progress in using these as instruments to resolve fragmentation and stimulate real change in their systems. The impact of the new CHI funds was dramatically different in countries that saw and acted beyond the labels, such as Kyrgyzstan and Moldova, from others such as Albania or TFYR Macedonia where the funds did little to stimulate change or even worsened fragmentation and made the incentive environment less coherent.

In Kyrgyzstan, for example, the change included (1) replacing the fragmented budgetary structure with a single pool of funds, first at the oblast/regional level and later at the national level; (2) creating a split between the purchaser and the providers, ending both the 'ownership' of the providers by the purchaser and the hierarchical budgetary relationship; (3) shifting from input-based budgets to output-based payment; (4) giving providers autonomy over internal resource allocation decisions, so that they could respond to the new incentives; and (5) changing the way budgets were 'created' for public sector facilities so that public sector financial management rules would not penalise infrastructure downsizing by continuing to link the size of the budget to the number of beds. These measures led to substantial downsizing of the infrastructure (reducing fixed costs and re-directing public funds to variable inputs), greater geographical equity in public spending on health per capita and greater interpersonal equity in finance and the use of health services (as measured in a series of household surveys conducted in 2001, 2004 and 2007).

Both the Kyrgyz and the Moldova reforms show how it was possible for low (or low to middle) income countries to transform their health financing system even as the main source of public funds remained general revenues, with their new health insurance payroll tax playing a relatively minor role in absolute financial terms, although it was an important implementation step enabling the creation of the new pooling/purchasing agency (Kutzin *et al.*, 2009). Conversely, in Albania the introduction (in 1995) and evolution of its Health Insurance Institute (HII) over the next decade was not co-ordinated with other arrangements for pooling public funds and purchasing health services. For example, for primary care the HII paid for physician salaries and drugs, the Ministry of Health allocated budgets for other personnel and operating costs and local governments provided budgets for equipment and facility maintenance. This fragmentation in pooling created problems for purchasing, with no single agency able to create a coherent incentive environment to promote efficiency and quality (Couffinhal and Evetovits, 2004).

Like most central European countries, the Czech Republic re-introduced social health insurance shortly after the 1989 'velvet revolution' as a return to the type of system it had had before World War II. In 1992, it approved legislation to enable multiple insurers to compete for enrollees. To ensure universal coverage, the government financed contributions on behalf of the non-working population. The system experienced many problems during the 1990s, but by the end of the decade the market had stabilised with nine health insurance funds. One fund covered 60% of the population; the others were organised around large employers or sectors, and therefore tended to serve a younger and healthier population than the large fund. This was recognised as early as the mid-1990s, leading to the introduction of risk adjustment. Initially, however, only the revenues of the state-subsidised population and 60% of the revenues of contributing members were subject to risk adjustment, and the methods used were crude. As a result, incentives for cream skimming by insurers remained. The problem was largely addressed by a 2003 law that made all health insurance revenues subject to risk adjustment and improved the sophistication of the adjustment mechanism so that insurers no longer had much to gain from investing in risk selection (Hroboň *et al.*, 2005). In doing so, the Czech reforms effectively reduced fragmentation within a system of competing insurers.

The Russian Federation's experience with insurance competition has been very different. The reform originally intended to replace the inherited Soviet budgetary system with a single CHI system in each of the country's 88 territories, and then to have insurers compete for enrollees within each territory. Implementation was uneven, however, as in most regions local governments did not re-direct all of their health revenues to the CHI system, but instead continued to finance their health care facilities directly. Beyond this, there is great variation in the sophistication of risk adjustment methods used in the different territories. The sequence and pace of the transition from the old to the new system of health financing were never established by Russian legislation and implementation of CHI has been poorly controlled by federal authorities and has largely depended on regional authorities' attitudes (Sheiman, 1997; Shishkin, 1999). Competition among insurers exists, but only to a limited extent and in forms that do not create strong incentives for improving the accessibility and quality of services. Thus, after 15 years of reform, the Russian health financing system combines old and new forms of pool fragmentation and overlap (Shishkin, 2006).

Although the countries we consider relatively successful reformers started their process with the creation of new funding arrangements, so too did many countries that were less successful. Simply establishing a health insurance fund is far from a sufficient condition for progress, and the evidence further suggests that both single payer and multi-payer systems can succeed or fail depending on how they are implemented. What appears to matter most is whether the reforms explicitly address and resolve pre-existing forms of fragmentation and avoid creating new forms. It has also been important to avoid making the mistake



commonly made by many low and middle income countries elsewhere in the world: establishing an entirely separate system for the insured population and then hoping that economic growth will lead to growing formalisation of the economy and increase the contributing share of the population. In much of the developing world, this approach has worsened fragmentation and inequity, with health financing arrangements exacerbating existing socio-economic inequalities because the contributing population tends to be better off and also more able to create pressure for expanded benefits, rather than pushing for greater population coverage (Londoño and Frenk, 1997).

### **Successful implementation depends on appropriate sequencing of reforms; strengthening the purchasing function to drive change seems to be an effective starting point**

The first lesson (getting the objectives right) implies that addressing the roots of structural inefficiency is the first priority for action. This means reducing fragmentation and eliminating incentives for expanding capacity, which in turn requires aligning reform instruments to achieve these aims. Conceptually, there are many approaches to reducing fragmentation in financing and changing the incentive environment. The reform experience suggests, however, that there are important differences between what is conceptually possible and what is practically (or politically) feasible. Reducing fragmentation in pooling and changing provider payment incentives have been critical pre-requisites for progress. Although a new revenue collection mechanism is not conceptually necessary to make such changes (as demonstrated by the experience of England, Finland, Sweden and others, for example), most transition countries could not initially implement reforms within the constraints of their public financial management systems.

Most countries needed to start by establishing a new institution outside the Ministry of Health with off-budget status to break open the rigidities of the inherited system. In the more successful reforming countries, new roles and relationships between purchasers and providers took root and reached a point where there was no risk of reverting back to the old way of doing business. Following the establishment of a new purchasing entity (or entities), it was essential to create the conditions for it to be effective. Apart from many technical factors, one of the most critical conditions is time. Becoming a good purchaser means developing the skills and systems needed to make an effective shift from input- to output-based allocation. It also involves identifying constraints on the ability to implement active purchasing of services, such as public finance/budget formation rules and institutional or managerial constraints at provider level. Fundamentally, ensuring that purchasers have enough time to develop requires political commitment to work through the inevitable early problems.

Perhaps the most important role of the new CHI funds in the region has been to allow or even catalyse new approaches to pooling and purchasing, and thus to



create the preconditions for effective restructuring of infrastructure. Estonia, Kyrgyzstan and Lithuania explicitly aligned restructuring plans with purchasing methods. For example, the restructuring strategy approved in Lithuania in 2003 included a crucial role for the purchaser. First, the health insurance fund set up a restructuring programme to finance approved plans for change. Second, it modified the case-based hospital payment system to drive restructuring by increasing rates of pay for day surgery and creating a negative list of inpatient services to be excluded from reimbursement. Third, targets for hospitals to reduce excess capacity, lower admissions and develop day and outpatient services were incorporated into contracts. As a result, a number of inefficient hospital departments were closed, some hospitals in the capital city were merged, the number of day surgery cases has increased almost fivefold, the number of outpatient services has risen by 8% and the hospitalisation rate has fallen from 23.7 to 20.2 per 100 inhabitants. Although capacity remains at a level far above the European Union average, implementing these measures has significantly altered the attitudes of managers within the system and the potential to promote further restructuring through purchasing now rests on a solid foundation (Szende and Mogyorosi, 2004; Waters *et al.*, 2006; SPF, 2008). In contrast, countries that developed health facility master plans as stand alone reform instruments rarely achieved efficiency gains. The evidence suggests that having such a plan is a necessary, but not sufficient condition for restructuring. Where the plan was not backed by clear purchasing incentives, as in Romania, progress was limited (World Bank, 2004).

Although noting the importance of changing the incentive environment, with a strong purchaser at the core, experience suggests that this was far more effective for promoting efficiency and productivity than for driving quality improvement. It is widely accepted that the provider payment methods of the pre-transition health systems were tied to outdated clinical practices and did not provide clear incentives to promote quality of care. However, the evidence from these (and other) countries suggests that the scope for driving quality improvement through purchasing incentives alone is limited (Figueras *et al.*, 2005; Velasco-Garrido *et al.*, 2005; Maynard, 2008). Quality is inherently hard to measure in a systematic, real-time way that allows for purchasing decisions to be made regularly on this basis. So although purchasers should make use of quality standards, financial incentives need to be combined with changes in medical education and provider-level quality improvement processes.<sup>5</sup> There remains an important agenda for purchasing to promote efficiency in the organisation and delivery of services, but countries should avoid over-design of financial incentives for quality (or penalties for poor quality). At minimum, a reasonable aim for policy in many cases would simply be to eliminate incentives

<sup>5</sup> For example, some quality initiatives can be designed in parallel to financing/provider payment reforms, and converge over time, e.g. accreditation or the existence of internal quality improvement processes that eventually become a condition for contracting by the purchaser.

that promote poor or uncoordinated care, and replace them with neutral incentives. These lessons are particularly relevant for transition economies, in which provider payment reforms, which are relatively easy to implement, have been seen as a direct route to eliminate performance problems.

### **Treating the benefit package as a policy instrument rather than as an accounting exercise**

Many health systems face pressures to calculate the 'true' or 'real' cost of their benefit packages. This often involves recommendations to undertake large scale burden-of-disease, costing and cost-effectiveness studies. When combined with estimated levels of use and revenue projections, it is theoretically possible to determine a cost-effectiveness threshold for including or excluding services from the package, and therefore to 'buy' the most health for a given budget. In practice there are several problems with this approach. One of the main objectives of reform has been to reduce the fixed costs of maintaining the 'heavy' infrastructure of the pre-transition health systems. As 'cost' is, in economic terms, a function rather than simply a point estimate, the observed unit cost of service delivery in any one year reflects both capacity use and the existing inefficiencies in the structure of service delivery. To the extent that restructuring reforms succeed in reducing fixed costs, the same level of public revenue can buy more services than before reform. Similarly, the cost of increased levels of use will be less than the calculated unit cost if substantial excess capacity remains.<sup>6</sup> It is therefore essential to understand the cost and production functions of service delivery rather than merely having a single point estimate of unit costs. Worse, fixing unit costs and contracting on that basis may actually inhibit restructuring reforms, as the contractual price is likely to be overstated and will reduce incentives for further downsizing.

A more promising approach to benefit package design in the region has focused on defining coverage breadth (population), scope (benefits) and depth (proportion of cost) in broad terms. In terms of breadth, most countries opted for maintaining universality (with the exception of Moldova, now struggling to expand entitlements to the uninsured). Thus, the scope and depth of coverage became the real policy instrument with which countries have tried to match commitments to available resources. Early on, many countries excluded services with limited health impact such as spa treatment and cosmetic surgery, but most stalled at this point, finding it hard explicitly to limit entitlements further. The countries we highlighted as successful reformers all crossed this barrier by introducing clear rationing mechanisms (co-payments and/or waiting lists) as one instrument in a broader package of financing reforms to reduce fragmentation, improve purchasing and downsize excess infrastructure.

<sup>6</sup> Where there is excess capacity (e.g. low levels of inpatient bed occupancy), the marginal cost of increased use is less than the average cost that would be reflected in a unit costing exercise.

Explicit rationing as part of a broader reform effort has seemed more sustainable and less controversial in comparison to the introduction of co-payments as stand-alone instruments expected to bring about unrealistic reductions in informal payment, patient financial burden and inappropriate use (for example in Hungary, Georgia and Tajikistan). Kyrgyzstan introduced co-payments as part of a well-sequenced reform package and successfully reduced the overall financial burden on patients (Jakab, 2007). In contrast, Tajikistan introduced a similarly structured benefit package, but without the accompanying pooling, purchasing and restructuring reforms and did not experience any reduction in overall patient financial burden (Jakab *et al.*, 2008).

### **Winning (earning) confidence, learning and using evidence**

As health reform ‘observers’ and analysts, we have some bias in favour of accompanying implementation with analysis. But there is more to it than that. Mechanisms for public accountability have been essential to promote transparency and reassure the government and the public that resources are being used for the purpose intended. The annual report of the Estonian Health Insurance Fund (EHIF, 2009) is an outstanding example of this and in fact goes beyond financial transparency to include a series of performance indicators related to population satisfaction and awareness of rights, access to and quality of health services, the balance between resources and benefits and the quality of customer service. The Kyrgyz reform process has also produced good analysis on the implementation and effects of reforms (see, for example, MOH, 2008), which has played a role in bringing together the donor community around the reform agenda and creating conditions to increase public funding for the services purchased by the Kyrgyz health insurance fund.<sup>7</sup>

In addition, well-designed and timely analyses of the effects of reforms are essential to identify and make possible a response to the problems that inevitably arise in the implementation process and to demonstrate the impact of reform on key policy objectives. This in turn enables the political and financial support needed from the rest of the government (and the population) to transform health financing more fully. The countries we characterise as ‘successful’ are able to give concrete responses when asked how they used the money and with what effect, which has contributed greatly to keeping reforms on track and avoiding sudden shifts in direction. Unfortunately, the ability to provide an evidence-based response to these questions is more the exception than the rule.

<sup>7</sup> In 2009, the World Bank’s independent Internal Evaluation Group awarded two Kyrgyz health reform projects its ‘Good Practice Project Award’. The monitoring and evaluation (M&E) aspects drew particular merit, which is notable given the focus of the M&E on sector performance rather than, more narrowly, on project implementation.

## Conclusion

A review of two decades of health financing reform in transition countries shows that while the countries largely began at a common starting point, there have been many changes in country context and reform experience since 1990. This leads us to conclude that the label ‘transitional’ is no longer helpful in understanding the CE/EECCA countries. The review provides some success stories and lessons learnt, but also points to a large unfinished agenda. The countries we did not highlight as successful reformers continue to grapple with both design and implementation of a coherent and well performing health-financing system. In many cases, pre-transition performance problems have been exacerbated by half thought-out reforms that coexist with the remnants of the old system; moving forward will require creativity and political will. In these countries, the reform agenda remains to a greater or lesser degree similar to that outlined in this article. For those countries we highlighted as successful reformers, the reform agenda is slightly shifting away from major health financing and structural reforms (although much remains to be done to fine-tune the system) towards improving the content of clinical care to see improvements in health outcomes. We hope that lessons provided by synthesising the past 20 years of reform will provide useful guidance as countries continue to address their health system performance problems.

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