citizens should demand health care in line with the rest of Europe's.

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The road to reform

Look to the neighbours

The political transition in central and eastern Europe has not spared the region's health systems. Almost everywhere governments have abandoned the Soviet model of health care.[1] Initially, this model achieved much at first in ensuring universal access to health services and tackling common infectious diseases. Yet, by the 1970s, the cracks were appearing, and now many people in the region are dying from causes that should be preventable with timely and effective health care.[2]

Health systems in the region have had to respond to a variety of economic and political pressures as well as to the populations' longstanding healthcare problems. Many services were of low quality and were characterised by poorly motivated health professionals, poor responsiveness to citizens' needs, and outdated clinical practices.[1]

Although the range and depth of challenges has varied between countries, some are common to many of them. One of the greatest challenges has been the quest for sustainable financing. Most countries in the region were quick to reject the former model of financing from general government revenues, owing to general mistrust in governments and to the desire to follow what were perceived as superior models used in neighbouring countries.[3] Some form of social health insurance, based on contributions from individuals according to their earnings, seemed to offer a solution.[4]

Not so easy

Implementing systems of social insurance for health care has proved, however, to be much more complex than expected. In countries with large informal economies, high unemployment, and severe macroeconomic constraints—many have not yet reached the levels of gross domestic product (GDP) they had before political transition—the revenue base has been very small. The high costs of social insurance have fallen on those in employment, increasing labour costs and further encouraging working informally without paying tax or insurance.[5] In many countries, governments have had to make large scale transfers into health care from general revenues, and in some the move towards social health insurance has been reversed.

The continuing shortage of funds in many of the countries in this region has encouraged the persistent and widespread use of informal or "under the table" payments.[5] This hampers equitable access to health care,[6] creates many perverse incentives for doctors, and acts as a serious obstacle to implementing reform.[7] There have been, however, some encouraging experiences with regulating or formalising these fees as co-payments into local funds used by doctors and hospitals to improve services.[8] There have also been considerable improvements in purchasing practices, with some countries adopting effective contracting strategies and more than half moving from a system based on fee for service to performance related capitation in primary care and global budgets for hospital care.[9]

But these incentives have been effective only in those countries that have brought in concomitant reform of healthcare provision. The model of care based on inadequately and narrowly trained doctors in primary care, whose main roles were controlling absence from work due to sickness and acting as signposts to an extensive but poorly equipped hospital sector, has become obsolete. A new and more effective model of primary care based on family practitioners is taking root in many countries, in particular in central Europe. A paper on Russia by Rese et al in this week's *BMJ* shows,[10] however, that much remains to be done in some parts of the region.

In addition, several countries have restructured the hospital sector to reduce the oversupply of beds and increase efficiency. The number of beds remains much higher than that in western European

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countries, however. Moreover, when restructuring has revolved around hospital closures alone the expected savings have not materialised because hospitals in this region are often the main providers of social care and have not been replaced by more cost effective services.

Reform of the old public health system "Sanepid" is still a major challenge. There have been some advances in strengthening health promotion. But working across sectoral boundaries is difficult, owing to, among several reasons, an overmedicalised culture, weak ministries of health, and powerful lobbies, such as tobacco groups, that oppose legislation on improving public health.

Almost everywhere in the region reformed health systems need to focus on providing high quality, evidence based care. Although much has already been done in some countries, important challenges remain in many parts of the former Soviet Union, where the legacy and strong ideology of Soviet science[11] has persisted and where ineffective treatments are still widely used.

Improvements in the quality of care have been linked to better planning of human resources to balance skill mix, train staff, strengthen professional standards, and provide better incentives. Motivating and retaining staff is now an imperative; lowly paid health professionals in central and eastern Europe can now move abroad to work, and those from the new member states of the European Union are being welcomed by their western neighbours who face severe shortages of healthcare staff.[12]

Perhaps the biggest obstacle in implementing reforms has been the absence of effective stewardship by governments. Too often, policy makers have lacked an overall perspective of health systems, focusing their efforts on only partial initiatives. Nor have they exercised effective leadership or established appropriate regulatory infrastructures. In addition, limited technical capacity and lack of appropriate information systems have hindered the introduction of often very complex reforms.

Most importantly, governments have often lacked the political will to reform health care. The political honeymoon during the first years of transition was short lived and the instability caused by frequent changes of government in many countries has been a major cause for the failure of such reforms.[1]

The challenges that faced health systems in this region in 1990, when political transition began, must have seemed insurmountable. Yet some countries have transformed their health systems relatively successfully. The challenge now is to ensure that those who are still struggling with reform can benefit from the experiences of those who have been more successful.

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Supply and regulation of medicines

Costs of prescribing are rising, and patients may pay the price

Since the collapse of communist governments the pharmaceutical sector has changed considerably. Previously, the healthcare systems organised the manufacture and supply of drugs centrally and often suffered shortages or surpluses. They rarely developed new drugs or used foreign medicines. The state supplied all medicines either free of charge or for minimal fees paid by patients. After 1990 the healthcare sector was liberalised, the governments' manufacturing and distribution networks for drugs became private industries, and markets opened to Western imports. More recently governments have reintroduced regulation into the drugs market, partly in an attempt to restrain rises in expenditure, and partly in response to joining the European Union (EU).

The pharmaceutical market in central and eastern Europe is relatively small, comprising around 8% of the value of the EU-15 market (based on the previous 15 member states rather than the current 25). It has

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