Activities for Quality of Care Improvement in the Countries of Central Eastern Europe

The six countries in the Central Eastern Europe—Poland, Hungary, Slovakia, The Czech Republic, Slovenia, and Croatia, have much in common. They are all predominantly Roman Catholic and, except Hungary, share Slavic heritage and languages. They were incorporated in the Austro-Hungarian Empire until 1918 (this applies only to a part of Western Poland, comprising 32% of its population), when they became independent or constituent part of independent states (former Czechoslovakia and Yugoslavia).

During World War II, they were occupied or dominated by Germany, and from 1945 to 1990 lived under socialist regimes. Their health care infrastructure was impressive in terms of hospital beds and health care professionals. For example, there were 9.64 beds per 1,000 population, compared to 6.88 in the European Union (EU) and 3.15 vs. 2.89 physicians per 1,000 population, respectively (1). However, in terms of life expectancy, morbidity, and mortality the health status of their populations compared less impressively (2-4). Except for a few centers of excellence, health care technology, patient satisfaction, effectiveness, and quality of health care were inadequate (5). Communist parties and socialist governments declared their quality of care the best in the world, presenting it as an undisputable fact. For political reasons, quality improvement programs were not feasible (6,7), but in former Yugoslavia (of which Croatia and Slovenia were constituent parts) educational activities for health professional were organized and some assessment studies conducted, mainly by the Department of Social Medicine at the Faculty of Medicine in Belgrade (8). Since the early 1990, these countries are independent parliamentary democracies.

Following political reform, Western help became available in many areas, including the health care sector. External financing and technical assistance, supported by national governments and professional associations, allowed the introduction of quality improvement activities. The start-up of such activities, as well as their course and extent, differed from country to country.

Poland

In 1992, 44 hospitals in Poland answered a 100-item questionnaire about the baseline situation in quality of care activities. This was part of the COMAC Project (Committee Medical d’Action Concer)te) of the European Union, conducted from 1990 to 1993 in 162 hospitals in 16 countries, studying strategies of quality of care in four areas of clinical activity (9). Thus, the concept of quality of care was introduced into the medical community, stimulating the establishment of the National Society for Quality Improvement in Health Care (1993) and of its Center for Quality Assessment in Krakow (1994). In mid 1994, quality of care programs were initiated in three hospitals, in close collaboration with the Vlams Institute for Quality in Belgium (10). In the late summer of 1994, 11 professionals, all members of the newly formed Society, became acquainted with the quality of care philosophy and management in US medical centers. This was within the “Polish-American Quality Network”, sponsored by the US Agency for International Development (USAID). The aim was to create a critical mass of professionals who would be able to disseminate the concept of quality of care, starting at the local level (hospitals) and collaborating on the national level with the Society and the Center in Krakow, which would provide educational and financial support. A half-year project with the Maryland University Research Corporation (sponsored by USAID) made it possible to train professionals in setting up and conducting the quality of care programs in hospitals (10). The Center has an ongoing collaboration, supported by USAID, with the Center for Quality of Care Education and Research at the Harvard School of Public Health (11). The First National Conference on Quality of Care held in 1995 attended by 200 participants (11), and the Second one in 1997 attended by 300 delegates, focused on external mechanisms for quality of care, including accreditation. The Joint Commission International, Chicago, is assisting the development of accreditation (12). Assisted by Harvard University and supported by USAID, the Center surveyed 2,000 patients from 19 outpatient clinics in Krakow on the accessibility of services, patient experiences, and quality of clinical care (13).

Hungary

In Hungary, a start-up for quality of care was the involvement of 17 hospitals in the COMAC Project. Further 20 hospitals joined in its continuation (from 1994 to 1997), the PECO Project (Les Pays d’Europe Centrale et Orientale). This was made possible due to the continuing support of the Dutch Government and the technical assistance of the Dutch Institute for Quality of Care Improvement in Utrecht, at the time known as Centraal Begeleidingsorgaan voor Intercollegiale Toetsing or CBO. In 1992, the Hungarian Society for
Quality in Health Care was set up, and its Institute for education, training, and assistance in quality of care in 1993. In 1998, the Society hosted the 15th International Conference of the International Society for Quality in Health Care. The Government declared its intention to address the quality issue as a factor of decisive importance and several Government resolutions dealing with quality of care were supported by the Hungarian Hospital Association and the Social and Health Insurance Fund. In 1995, a National Accreditation Council was set up by the Parliament. As required by the "Act 154 of Health Care" (1997), quality of care activities are increasingly present in the daily work of hospitals, mostly aiming at certification with ISO 9000. Under the aegis of the Society, a study including six countries was conducted on quality in Primary Health Care, with an adapted and translated PROSPER questionnaire, originally developed at Harvard (14,15). Also, with the assistance of USAID, three interrelated studies on patient satisfaction in hospitals were conducted (16), and improved surgical site infection surveillance was introduced in hospitals (17). Not much has happened in the field of accreditation. Although plans and committees were set up, accreditation is still non-existent (16).

Slovakia

In Slovakia, quality of care has been on the agenda since 1994. Accreditation and licensing were chosen as the strategy for its attainment, and in 1991 the Slovak Association of Hospitals established a Working Group for Quality and Accreditation. The necessity of accreditation for health care institutions was stated in an Act brought by the Government and, in 1996, the Ministry of Health (MOH) formed an Accreditation Council. With the help of European Union’s PHARE Project, 15 accreditation surveyors were trained at King’s Fund in London in 1997, and at the Postgraduate Academy of Medicine in Bratislava in 1998. Manual for indicators for hospital accreditation was also supported from one of the King’s Fund. A set of guidelines was developed, intended to help hospital management prepare for accreditation (18). However, the country has not progressed with the implementation of the National Policy on Quality Care Development (agreed upon with the World Health Organization in 1996), nor did it progress with hospital accreditation. This may be due to frequent changes of the Government and Ministers of Health, as well as insufficient coordination and other priorities (19).

Czech Republic

In the Czech Republic, the Association of Hospitals was the initiator of quality of care activities and started to develop national standards for quality of care in cooperation with Ministry of Health (20). In collaboration with the Department of Medicine, Georgetown University in Washington D.C., and supported by USAID, it instituted an ongoing survey of patient satisfaction with medical and nursing services at one of the university hospitals in Prague (21). It was an innovative survey of patient satisfaction, focusing on developing and evaluating measures that elicit reports about specific care experiences that do not reflect amenities but quality of care (22). The Association also started collecting data necessary for measuring and improving quality of care in 40 hospitals (23).

Slovenia

In Slovenia, quality of care has been on the agenda since 1994. The tendency is to attain it through external peer review and relicensing of physicians, the mandate for both lying with the Medical Chamber. A sociologist conducted several smaller studies on satisfaction with health services in general. The postgraduate education of family physicians at the Faculty of Medicine in Ljubljana includes a course on basic principle, as well as practical training, in quality of care, and a book on Quality in General Practice has been produced (24). Patient satisfaction with family practice was found to be comparable to that in other European countries, but improvement in communication skills of physicians was necessary (25). In 1996, the draft on national policy on quality in health care was introduced at the WHO conference in Ljubljana (26).

Croatia

Croatia is the only Central Eastern European country in which quality of care has not been initiated. This is probably due to the 1991-1995 war, during which the entire health care system became geared to the needs of the war (27,28) and had to face its devastating consequences in the aftermath (29). Lately, however, some developments have been initiated. In summer 2001, the Faculty of Medicine in Split introduced an obligatory course on Basic Principles in Improvement of Medical Care in its postgraduate program, and its university hospital formed the nucleus of a unit for the promotion of quality of care. The Ministry of Health has formed a Working Group on Quality in Health Care and is preparing a National Conference in December 2001; the possibility of founding a national society for quality is being discussed within the Croatian Medical Association.

Conclusions

This short review is most probably incomplete, mainly because a multitude of reports related to quality of care has appeared in national languages and therefore could not be used. Nevertheless, it is possible to draw some deductions from this article.

First of all, external funding and technical assistance were pivotal in starting-up and developing quality of care activities, but so were also the commitment and support of national authorities, professional associations, and other organizations, as well as the political stability in the country.

Secondly, quality of care activities could be introduced in the Central Eastern European countries during the transition period of their health care systems (1990-1999). These activities have improved the quality and effectiveness of care in the areas in which they were implemented. It is too early to consider whether they have contributed to the cost contain-
past, physicians took for granted that professional ethics and self-surveillance could assure quality, whereas the efficiency issue was of no relevance. It was not conceivable that medical information might be used by non-physicians to measure and assess quality of care. Furthermore, medicine in Central and Eastern European countries was oriented towards Austria and Germany. Belief in authority and the power of department heads dominated university hospitals and influenced the health care system outside them. This belief may still play an important role in resisting the introduction of quality of care, including accreditation (33). Since quality of care must be strongly supported by the medical profession, the raised awareness and change in attitude are an important achievement.

Lastly, the introduction of quality of care has resulted in creating an educated body of health professionals, competent to produce quality of care tools, conduct quality of care activities, and train additional teams to continue to develop them further. This is very much needed. Countries of Central and Eastern Europe have to cope with increased expenditures for health care and have designed various policies for cost-containment. Both providers of medical care and the general public should be alert to any threat to its quality and be able, given the resources available, to deliver care of acceptable quality and reduce waste and redundancy in health care systems. This approach to quality of care raises enthusiasm among clinicians, managers, and policy makers alike (34).

It should also be mentioned that all Central Eastern European countries are interested in joining the European Union. In 1997, the Committee of Ministers of the Council of Europe issued extensive and detailed recommendations for quality of care systems to be developed in European Union countries. These recommendations required governments of the member states to establish systems for continuous improvement of the quality of care at all levels.

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