Experiences of Finnish cooperation in the health and social sectors in the Republic of Karelia (north-western Russian Federation)
A case study

Ali Arsalo
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EUROPEAN HEALTH21 TARGET 1
SOLIDARITY FOR HEALTH IN THE EUROPEAN REGION
By the year 2020, the present gap in health status between Member States of the European Region should be reduced by at least one third
(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

EUROPEAN HEALTH21 TARGET 14
MULTISECTORAL RESPONSIBILITY FOR HEALTH
By the year 2020, all sectors should have recognized and accepted their responsibility for health
(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

EUROPEAN HEALTH21 TARGET 18
DEVELOPING HUMAN RESOURCES FOR HEALTH
By the year 2010, all Member States should have ensured that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health
(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

Keywords
INTERNATIONAL COOPERATION
HEALTH PLANNING
HEALTH POLICY
PRIMARY HEALTH CARE
SOCIAL SECURITY
FINLAND
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THE POLICY LEARNING CURVE SERIES

Through its Policy Learning Curve Series, WHO's European Centre for Health Policy (ECHP) provides timely information on health policy developments in European countries.

As far as possible, these developments are described by those who were active participants in the process. This will allow readers to gain insight into the policy environment in which they took place, the motivation behind such processes, and the experiences of some of the major stakeholders.

We believe that, in this way, policy-makers and students of policy development across Europe will have easy access to emerging developments, or thoughtful analyses of past events that have shaped policies for health. By sharing this experience, we trust that the capacity to assess what might work or not work in other countries or regions will be strengthened.

The aim is to go beyond the rather narrow circle of people who read scientific articles on policy development, to reach those who actually take the decisions to make policy happen. Authors have therefore been requested to present up-to-date information on and insight into health policy development processes based on available evidence and experience, without the formal demands of a scientific article, but to provide core references to potential further reading.

These papers and further information on the work of the ECHP can be found on our web site (http://www.who.dk/hs/ECHP/index.htm).

Dr Anna Ritsatakis
Head, European Centre for Health Policy
FOREWORD

This article is a case study on some aspects of Finnish–Karelian collaboration in the health and social sectors between the authorities of the Republic of Karelia and the Finnish National Research and Development Centre for Welfare and Health (STAKES).

The article is based on essential project documents and related studies as well as on personal interviews with Finnish and Karelian experts involved in the collaboration.

Finally, a few conclusions are presented reflecting some of the most essential developmental aspects that became obvious and also some problems related to the process.

While the authors are responsible for the content of the study, we wish to thank all those experts and friends who gave their time in contributing to the completion of this article.
Experiences of Finnish co-operation in the health and social sector in the Republic of Karelia (north-western Russia)

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Ali Arsalo and Sanna Vesikansa

1. Introduction

1.1 A meeting point of East and West

Many readers will be unfamiliar with the area with which we are concerned. “Karelia” can mean different things, depending on the perspective from which it is viewed. Geographically, it can be understood as a large region extending from the eastern shores of the Baltic Sea to the White Sea in the north, the first known inhabitants of which were various Finno-Ugric tribes. At the beginning of the second millennium, these territories were partly penetrated by the Slavs.

Political authority over parts of this large territory has changed with time. At different times it has been part of both Sweden and Russia. Nowadays, in the Finnish language, the name “Karelia” is used to refer to provinces of present-day Finland that border the Russian Federation. In this document, however, we are concerned with the present-day Republic of Karelia, which in 1991 succeeded the Autonomic Soviet Socialist Republic of Karelia established in 1923. A part of this territory was once in Finland until it was lost to the USSR as a result of the Second World War, at which time the majority of its Finnish population moved to present-day Finland.

The new republic was granted special status, with considerable autonomy compared with the more common administrative unit in Russia, the oblast. The Republic of Karelia has its own constitution and legislature in accordance with the authority designated to it in the Constitution of the Russian Federation. Nevertheless, such autonomous republics are in some respects dependent on federal government legislation and allocation of resources.

This reference to its history helps to give some understanding of the special characteristics of the Republic of Karelia, where eastern and western cultures meet. It is an area that shares many experiences with its neighbours, but there are also some differences – for example in the influence of the traditions of the Orthodox church in Russia and of the Lutheran church that dominated in Finland.
As neighbours, Finland and the Republic of Karelia have long cooperated on an unofficial level. During the Soviet era, the Russian authorities regularly visited Finland and vice versa. About 12% of the inhabitants of the Republic of Karelia are of Finno-Ugric ethnic origin, and the 17,000 Russians living permanently in Finland make up the largest group of foreigners in the country.

Because of this common history and close cultural values, the Republic of Karelia has a special status in Finnish society. This is reflected in Finnish foreign policy, which emphasizes Karelia as one of the priority areas for international collaboration.

The 700-km-long border between Finland and the Republic of Karelia and Leningrad oblast is also the border that underlines the differences between the European Union and the Russian Federation. The difference in living standards on the two sides of the border is one of the widest in the world.

1.2 The Republic of Karelia

The Republic of Karelia is situated in the north-western corner of the Russian Federation, stretching to Murmansk in the north and to about 150 km from St Petersburg in the south. The inhabitants of the Republic account for only 0.5% of the population of the Russian Federation. From the centre of the Russian Federation, Karelia may appear to be a distant, remote and peripheral part of the country, but it can also be seen as an important area bordering the European Union.

The total territory of the Republic is 180,000 km² with a population of 776,400. The capital, with some 280,000 inhabitants, is Petrozavodsk on the shores of Lake Onega. The majority of the population (74%) live in cities and towns, mainly in the south of the Republic. Massive depopulation of the countryside took place after the Second World War, particularly in areas that used to be part of Finland, since many inhabitants of Finnish origin moved to Finland.

The Republic of Karelia is divided into 19 municipalities (rayons). A new federal law on local self-government in the Russian Federation was introduced in 1995, but the process of devolution is still incomplete. One of the most difficult obstacles to devolution is the fact that municipalities do not yet have sufficient financial independence.

More than 49% of the area of the Republic is covered with forest, and the major contributors to the economy are timber and wood processing (pulp and paper), although the metals and heavy engineering industries, mining and electricity are also important. Half of the population is employed in industry and construction.

Life expectancy at birth in 1996 was 64.3 years (58.1 years for men and 71.3 years for women) (Table 1). Both figures were declining slightly at the beginning of the last decade (1).
Table 1. Life expectancy at birth in the Republic of Karelia, 1989–1996

<table>
<thead>
<tr>
<th>Year</th>
<th>Average</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989−1990</td>
<td>69.3</td>
<td>63.8</td>
<td>74.2</td>
</tr>
<tr>
<td>1990−1991</td>
<td>68.4</td>
<td>62.1</td>
<td>73.8</td>
</tr>
<tr>
<td>1992</td>
<td>65.7</td>
<td>59.7</td>
<td>72.0</td>
</tr>
<tr>
<td>1993</td>
<td>63.0</td>
<td>56.2</td>
<td>70.8</td>
</tr>
<tr>
<td>1994</td>
<td>61.3</td>
<td>55.0</td>
<td>69.0</td>
</tr>
<tr>
<td>1995</td>
<td>61.2</td>
<td>54.7</td>
<td>69.2</td>
</tr>
<tr>
<td>1996</td>
<td>64.3</td>
<td>58.1</td>
<td>71.3</td>
</tr>
</tbody>
</table>

Source: Skog (1).

Although health status deteriorated in the first half of the 1990s, it began to improve towards the end of the decade (1). The birth rate and population growth declined throughout the 1990s (Table 2).

Table 2. Birth, mortality and infant mortality rates, 1990, 1996 and 1997

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>1996</th>
<th>1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births per 1000 population</td>
<td>13.2</td>
<td>8.3</td>
<td>8.0</td>
</tr>
<tr>
<td>Deaths per 1000 population</td>
<td>10.0</td>
<td>14.3</td>
<td>13.2</td>
</tr>
<tr>
<td>Infant mortality per 1000 live births</td>
<td>14.0</td>
<td>13.2</td>
<td>13.3</td>
</tr>
<tr>
<td>Population growth</td>
<td>+ 3.2</td>
<td>– 6.0</td>
<td>– 5.2</td>
</tr>
</tbody>
</table>

Source: Skog (1).

During the Soviet period, the administrative system was highly centralized, including health and social policy development and the service delivery system. The health services were based on polyclinics and hospitals, and “western” style social services and general practice were practically nonexistent. The health service ideology was based on the curative services provided by specialist physicians, while the potential of nurses was underused.

Thus despite the newly established autonomy of the Republic, when the Finnish–Karelian bilateral cooperation in the health and social sector was initiated, the Karelian system was still in practice centrally planned and led; integration at service delivery level between different ministries was almost totally lacking, and western-style comprehensive primary health care was nonexistent. There was little experience of policy development or strategic planning. Although the local authorities had a deep understanding of existing problems and clearly identified the basic needs of the population, they did not have the capacity or authority to make or implement decisions without the approval of the Republic authorities, who were still influenced by the old mentality.
The lack of a general primary health care concept was evident when, in 1995, during a large conference in Helsinki to confirm collaboration, the Finnish term for primary health care was translated as "first aid" by interpreters. The uncovering of this mistake and the ensuing explanation by a Finnish–Russian specialist eventually helped to put the whole process on the right track.

Furthermore, the Finnish collaborators came from an administrative system that had been moving strongly towards decentralization. The final step of decentralizing decision-making to the individual municipalities in Finland had taken place in the early 1990s. These were the kinds of basic conceptual and administrative difference that formed the framework on which the Finnish and Karelian experts and colleagues started their collaboration.

2. The background to cooperation

2.1 Finnish–Karelian bilateral cooperation

As mentioned, relations across the border between Finland and the Republic of Karelia had existed for decades. By the end of 1980s these had become much closer as the Lutheran Church of Finland, the Finnish Red Cross and other nongovernmental organizations took a more active and visible role in Karelia.

On the Finnish side, the idea of working together in the health and social sectors arose at the national level in the autumn of 1993. Then, in the spring of 1994, the Finnish Ministry of Social Affairs and Health decided to take the initiative and the National Research and Development Centre for Welfare and Health (STAKES) began planning a project proposal. Funding was provided by the Ministry of Social Affairs and Health and later by the Ministry for Foreign Affairs.

Planning was started in cooperation with the Karelian authorities in October 1994, and in March 1995 a long-term comprehensive programme was defined (2) whose three main development objectives were to support and strengthen:

- health promotion and social support activities determined by the Karelian authorities;
- institutional development and capacity-building; and
- project coordination.

In the initial phase, the Karelian authorities were to be supported in the following priority areas:

1. the development of primary health care by:
   - improving the quality and accountability of services,
   - strengthening mother and child care;
   - improving the effectiveness of health promotion in schools;
   - supporting prevention of cardiovascular diseases;
2. the development of types of social security by:
   - assisting in reforming the financing system of the social and health care schemes;
   - improving services offered for the disabled, especially children and young people;

3. capacity-building through training and advising social services and health professionals and government officials;

4. the development of managerial and planning capacity by:
   - improving competence among service providers and authorities at different levels of administration;
   - developing an effective yet simple social and health information system to facilitate planning and management; and

5. the coordination of various international social and health projects to improve their effectiveness.

The Finnish bilateral project was the first broad international project in the health and social sectors in Karelia. It was also the first opportunity for Karelian policy-makers, planners and other personnel in the health and social sectors to speak with foreigners about the development needs of their system.

2.2 The Tacis project

Inspired by the progress of the bilateral project, in 1994 Karelian counterparts started discussions with the European Union through its programme for Technical Assistance for the Commonwealth of Independent States (the Tacis Programme¹), with the aim of launching a Tacis project for the health and social sectors in Karelia. During the planning phase, one of the issues discussed was how such a large international project would affect the operation of the already existing Finnish-Karelian bilateral project. In the event, it was agreed that the bilateral project should continue and be redesigned to work in parallel with the Tacis project, concentrating on two fields: mother and child health, and services for people with disabilities.

The Tacis project was started in February 1997 by an international consortium lead by STAKES. Other members of the consortium were the Netherlands School of Public Health and NHS Overseas Enterprises from the United Kingdom.

¹ The Tacis Programme is a European Union initiative that provides grants for know-how to foster the development of market economies and democratic societies in the newly independent states and Mongolia.
Building on the information partially gathered through the bilateral project, the inception report for the Tacis project defined the principal problems of social and health care provision in the Republic as follows (3):

- the absence of a strategic policy for the development of social and health care services;
- a declining financial base and the absence of a clear strategy for the deployment of financial resources between primary and institutional care, or between social and health services;
- an imbalance in the development of institutional and noninstitutional forms of care, and between health and social care;
- the absence of any “gatekeeping” function to control access to costly institutional care;
- a lack of effective legislation to facilitate reform, in particular the transition to a stronger primary health care sector;
- a skilled workforce (particularly in the health sector) but no agreed mechanism for relating human resource planning and management to the priorities of reform;
- low prestige and motivation among many professions in the health and social sectors;
- at both republic and district levels, the absence of a comprehensive approach to the planning and management of the provision of health and social care;
- parallel and inadequate systems of management information;
- a lack of practical trials of alternatives to institutional health and social care;
- a population poorly informed on the need for and consequences of reform;
- poor representation skills among key decision-makers; and
- insufficient collaboration between republic ministries and local authorities.

The Tacis project had seven components, some of which had previously been covered by the bilateral project (3):

1. assistance in the design of basic health and social policies and in facilitating their ownership by society;
2. development of a legislative framework for improving service provision;
3. reform of organizational structures and organizations, with a focus on management and financing;
4. development of human resources, including curriculum development and training;
5. development of information systems;
6. promotion of the reforms among politicians, professionals and the general public; and
7. testing the reforms in practice at the rayon level, and getting feedback on successes and needs for change in the construction of a Republic-wide framework for decentralized health and social care.
The Finnish–Karelian bilateral project continued in parallel with and even after the completion of the two-year Tacis project (Fig. 1). New plans for 2001–2003 are currently being completed.

Fig. 1. Finnish–Karelian collaboration 1994–2000 led by STAKES

3. What was done and what happened

3.1 The beginning of bilateral cooperation

When cooperation with the Karelian authorities started on a bilateral basis in 1994, the following strategy was chosen (2):

- first, carrying out studies on which to base detailed project plans;
- promoting wide participation by having joint Finnish–Karelian expert groups in every component; and
- working mainly on a consultation basis, but also organizing seminars, training and study tours.

It was planned that the coordination of all the sub-projects, and the coordination of all actors from the health and social sectors in general, would be carried out by the Karelian authorities. At first, it was intended that the bilateral project would gather together different actors working in the field under a wide umbrella organization. In the event, the management structure and networks developed were much too heavy for the resources available, and the basis for cooperation had to be reduced.

Despite these problems, common to any development project, the chosen working strategy was considered to be largely successful. The combination of seminars, study tours and consultations offered a natural opportunity to discuss the substance of the reforms, to learn from each other and to agree on common concepts.

3.2 Introduction of the extensive Tacis development project

Compared with the bilateral cooperation, the Tacis project (Fig. 2) was initiated under very different circumstances in 1997. The basis for setting common goals had already been established and several studies had been carried out,
providing information that was unknown to both Finnish and Karelian parties at the time when the bilateral cooperation was started.

For the most part, the same experts were working in both the bilateral and the Tacis projects. It was considered important that the same experts continued all the way through the project from planning to implementation. Interest in working with Karelian counterparts was highest from experts in neighbouring eastern Finland.

**Fig. 2. Tacis project objectives and components**

The Tacis project established pilot projects to test new ways of organizing primary health care and social welfare services (Table 3). Different models were introduced in the districts of Kondopoga, Olonets and Sortavala as well as at the polyclinic of the Republic Diagnostic Centre and the Republic Centre of Social Assistance to the Family and Child in Petrozavodsk.
Table 3. Pilot projects under the Tacis programme

<table>
<thead>
<tr>
<th>District</th>
<th>Institution</th>
<th>Model services developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kondopoga</td>
<td>Suna Ambulatory</td>
<td>General practice with social work attachment.</td>
</tr>
<tr>
<td>Kondopoga</td>
<td>Girvas District Hospital</td>
<td>General practice and nursing home.</td>
</tr>
<tr>
<td>Kondopoga</td>
<td>Centre for social services</td>
<td>Two multiprofessional home care teams and elderly persons drop-in centre.</td>
</tr>
<tr>
<td>Kondopoga</td>
<td>District hospital</td>
<td>Medicosocial Commission for individual care programmes for joint clients.</td>
</tr>
<tr>
<td>Kondopoga</td>
<td>District administration</td>
<td>Coordinating Council for Social and Health Care Collaboration.</td>
</tr>
<tr>
<td>Olonets</td>
<td>Centre for social services</td>
<td>16 area-based multiprofessional teams.</td>
</tr>
<tr>
<td>Olonets</td>
<td>Vocational school</td>
<td>40-week modular training course for basic social workers.</td>
</tr>
<tr>
<td>Olonets</td>
<td>Mikhailovskii Ambulatory</td>
<td>General practice with social work attachment.</td>
</tr>
<tr>
<td>Sortavala</td>
<td>Haapalampi Ambulatory</td>
<td>General practice, health promotion programme.</td>
</tr>
<tr>
<td>Sortavala</td>
<td>Centre for social services</td>
<td>Fully developed medicosocial centre with day care, social and medicosocial home care.</td>
</tr>
<tr>
<td>Sortavala</td>
<td>Kheluliya village</td>
<td>Nursing home converted from district hospital.</td>
</tr>
<tr>
<td>Sortavala</td>
<td>District administration</td>
<td>Integrated department of social and health care.</td>
</tr>
<tr>
<td>Petrozavodsk</td>
<td>Polyclinic of Republic Diagnostic Centre</td>
<td>Model group general practice team serving Drevlyanka district in Petrozavodsk.</td>
</tr>
<tr>
<td>Petrozavodsk</td>
<td>Republic Centre for Social Assistance to the Family and Child</td>
<td>Comprehensive social work service to families and children: crisis intervention, long-term social work, legal consultation, children’s drop-in. Telephone information line on social services in the city. Professional consultation to districts.</td>
</tr>
</tbody>
</table>

Source: STAKES (3).

The management team of the project realized that, for sustainability of output, it was important to find as wide support as possible. Structures such as District Managers’ Groups were created to encourage cross-district cooperation, and these are expected to remain in place after the project’s completion.

Nevertheless, the approach was time-consuming and required the allocation of appropriate resources by the project management. It also demanded heavy commitment of time by senior representatives of the ministry.

3.3 Implications of running the two projects – learning by doing

When the Tacis project started, it was decided that the bilateral project should continue its work on policy and planning development with a longer development perspective, and that it should coordinate components not included in the Tacis project. The most important of these were the development of maternal and child health care and new service models for disabled children. In addition to a newly established day rehabilitation centre for
disabled children in Medvejegorsk, a wide campaign on mental disabilities was launched by Karelian television.

New mother and child health care services were developed in the pilot clinics in Petrozavodsk. The main focus was to reinforce the independence of nurses and midwives in preventive health care. A model of integrated health and social services was tested at one clinic, where a social worker was introduced as a permanent member of a team. Both of these were considered successful pilot reforms. Client-oriented services were strengthened by producing information material.

When the Tacis project was launched, policy design was considered a precondition for the renewal of the system. However, feedback from the field was considered to be equally important for successful policy design, and this required pilot testing. From the beginning, this approach was seen as a two-way information flow: the overall project contributed from the top to the district level through, for example, policy design and legislative reform, but the bottom-up flow of information from the pilot schemes was considered equally important.

As the work got under way, certain aspects became clearer and called for corresponding adjustments. It was clear that the process of policy design at republic level was time-consuming, but that motivation in the local pilot districts was high. A radical decision was therefore made that further strengthened the role of the municipalities: republic-level policy initiatives within the project were shaped above all by the needs and experiences emerging from the pilot schemes. This was reflected in the bottom-up approach of policy-making and also in the large number of round-table meetings organized between senior ministry representatives and local district administrations. These were especially important during the establishment and evaluation of the pilot programmes and the dissemination of the results.

Although it had originally been intended to focus on organizational, management and financing reforms, it was realized that reform of the financing system would have required action at the federal level that could not be influenced by the project. The focus was therefore shifted to ensuring that the services system functioned more effectively. Expert groups that had been set up at the republic level continued their work, but their objectives were changed as they began to lead the work of the pilot schemes.

Certain aspects of the collaboration were seen to be increasingly important, particularly the use of study tours. An interactive participatory approach was followed in the organization of study tours. Groups were generally small (6–8 people) and, wherever possible, an effort was made to place in the same team participants who were likely to continue to work together following the study tours. This was felt to add greatly to the long-term impact of the study visits. It was quickly apparent that a well planned visit could have a dramatic effect on long-held attitudes. The study tour to Kotka in October 1998, for example, was very influential in accelerating the move towards collaborative working in the
social and health care sectors. This was because Kotka was one of first cities in Finland to integrate health and social services, and Karelian participants were impressed by a totally different way of organizing the system. A similar turning point was a study tour to the United Kingdom in May 1998, which radically changed the attitude of staff from the State University of Petrozavodsk towards the training of general practitioners. It was clear that when people see with their own eyes that things can be done differently, a rapid change in attitude is possible.

Dissemination of the project results was performed by a team of Karelian consultants who talked from direct and personal experience of the reforms that were under way. In this manner, dissemination became part of the reform process itself and had the effect of lifting the process to a higher gear. In the dissemination phase, the message of reform was taken to managers and specialist in every district of the Republic. The strategy of peer group consultation proved to be more effective than more traditional top-down approaches. It also established cross-district links between both professionals and decision-makers.

3.4 Some impacts of the collaboration

Looking back to 1995, when the first activities of the bilateral project were launched, and seeing them now from the perspective of the new millennium, it is apparent that the cooperation as a whole has led to a number of positive developments in the Karelian health and social sectors. Among these we can identify at least the following that we consider particularly important, some of which are real innovations.

- The participatory approach to working together has meant a real and profound change in many planning or working principles and attitudes. There is still much to be done, but it seems that the process has moved several steps forward.

- The idea and advantages of the project approach have become much more clear and familiar. This means that considerable capacity-building has taken place, enabling in the future the adoption of key principles of project work, both in other areas of international cooperation and with other partners.

- At strategic policy level, the government of the Republic has laid down a policy and legislative framework that reflects the advances made in the course of the project.

- Key policy-makers in the ministries and district administrations have been equipped with the necessary skills to for making basic economic analyses of social and health care costs, for human resource planning across the two sectors, and for the management of an integrated social and health care information system. Deeper understanding and capacity for
strategic planning by the ministries is essential if reform is to continue at republic level.

- A strategic plan for the Ministry of Health for the next five years gives support to the development of primary health care and general practice. This strategy was also supported by evidence from the pilot schemes in three districts, where working models of general practice, health promotion programmes, medicosocial service centres, multiprofessional teams and integrated social and health care management have been established. There is, nevertheless, much work to be done if the reforms that have been introduced are to be fully implemented.

- Enthusiasm and belief in the development opportunities has been growing in Karelia since the beginning of cooperation. This is most visible at the grass-root level, where workers and policy-makers have understood that they are able to change things themselves.

- Previously there was almost no cooperation between different sectors of the administration. Now changes can be seen in the way that the Karelian authorities act. A system of regular meetings between representatives of the different sectors is taking shape. Vertical contacts have also changed as the cooperation has facilitated dialogue between republic-level ministries and district administrations and within the districts themselves, which basically did not exist at the beginning of the 1990s.

- Integration of health and social sector work at the grass-roots level has given districts and the whole Republic the possibility of developing local solutions instead of following uniform, centrally controlled patterns. This is shown, for example, by the development of models in the pilot schemes that differ considerably from one pilot district to another, depending on local conditions and demographic factors. The authorities now have a variety of approaches to compare. Nevertheless, the adoption of different systems and approaches in different districts may create some risk of fragmentation.

- Extensive study tours have had an important impact in relation to self-perception, influencing ways of thinking and acting with colleagues and increasing contacts between different professional groups at grass-roots level. This change was partly achieved by shifting the focus of some of the study tours to new target groups. For example, as long as the project worked mostly with chief physicians, other health personnel did not believe that the project could bring any improvement in their work. However, after nurses went on a study tour to other countries and saw for themselves how things could be, a radical change in attitudes occurred. After such study tours, nurses were among the first to speak up for continuing reform.

Study tours also played a considerable role in raising the professional and personal self-esteem of personnel in the health and social sectors. The tours allowed them to discover that training in their own country was of a
high level, and that they were able to discuss professional matters on an equal footing with foreign colleagues and to analyse new approaches, benefits and disadvantages from the viewpoint of the Russian system. After their return, they trained others at their places of work and this teaching experience also contributed to an improvement in professional confidence.

- Human resource development in its widest sense has been accepted as a priority element of the reform programme, and certain human resource policies are now in place. A permanent training course for general practitioners is being introduced on the basis of the experimental programme completed in 1998. The draft legislation on general practice—the first of its kind in the Russian Federation as there is currently no federal legislation on the issue—provides this framework. The State University of Petrozavodsk, in a pioneer project for the entire country, has begun educating general practitioners. This education of general practitioners has for the first time introduced new types of health and social expert to the universities, creating the possibility of a whole new approach that could, in the long run, cut health care costs in the Republic.

- Nursing education and the training of trainers has been comprehensively revised in favour of enhanced nursing responsibility in an expanded primary health care sector.

- The Republic’s first ever accredited training course for basic social workers has been piloted and evaluated. A pool of teachers in social work has been trained to deliver the course in the future. Training for social workers and nurses is an example of how professional groups whose work has so far not been given much recognition can show that their work is significant and that their actions can generate new scientific results.

- An innovative medicosocial client record has been devised and tested in model establishments. The development of this recording system shows how modern information technology can be used to improve quality of care and make systems more effective.

- The value and impact of establishing pilot models has been shown to be significant. For example, the pilots show that rates of referral to hospital from general practice ambulatory services have declined by between 30% and 50%. In one district the cost of medicosocial care in the community has been demonstrated to be one-tenth of the cost of hospital care.

- The area affected by the project is quite wide, owing to the geographical spread of the various pilot schemes. Nevertheless, northern and eastern Karelia remained rather isolated from its impact owing to long distances and the poor accessibility of many towns in Karelia.
4. Subjective experiences, as seen by the Finnish counterparts

4.1 The working environment

The socioeconomic situation in Karelia has been turbulent over the past 5–6 years, owing to the far from stable economic conditions in the Russian Federation. This also had an effect on the implementation of the project. There were delays and alterations to the programme owing to the Republic elections in the spring of 1998. All the ministers changed, and for a period of 3–4 months there was uncertainty as to which of the personnel in the ministry would remain in place. However, the new government maintained the strong support for the development process, and the Republic’s approved strategy document on the development of health care over next decade is indicative of this support. Fortunately for the sustainability of the project, the majority of the staff continued in their previous positions.

The background of two years’ cooperation between STAKES and the Karelian ministries was extremely important in generating trust and was a major reason for the success of the Tacis project. On the other hand, conditions for implementing the bilateral project changed radically when the Tacis project began in Karelia in 1997. The introduction of a large international project influenced peoples’ attitudes, since the resources available under the Tacis project were considerable. For instance, the Tacis project was able to hire local staff, which was not possible to the same extent in the bilateral project.

Large projects with large resources are able to use different incentives, which may be more convincing and have a different influence and impact on people than those available to smaller projects. Thus in smaller projects with fewer material resources, the role of softer incentives, personal and institutional motivation, ideology and commitment must play a greater role. On the other hand, when working with people who are not used to the project approach, there must be careful preparation both for the planning of the project and for the hand-over, to avoid problems caused by unrealistic expectations from and after the termination of the project. During the implementation phase of the project it is already important to make it clear when the project will come to an end and that, when it does, this will also mean the end of the use of project resources.

As mentioned above, a number of projects are being implemented in the social and health sectors in the Republic of Karelia. One of the problems faced was that of achieving active communication and sharing of the results among the different actors. For example, one clinic might have been testing a particular model, the results of which could be valuable for other actors in the field. However, contacts with foreign consultants and experiences are sometimes thought to be owned by the pilot clinic, and there can be a reluctance to share. This leads to a situation of wasted resources and overlapping efforts. It is hoped to improve this situation in the future by allowing the Karelian Ministry for Foreign Affairs to coordinate the work.
Some of the components were seriously delayed because of problems due to economic transition. For example, it was almost two years before any activities took place in the pilot day centre for disabled children in Medvejegorsk. First there were difficulties in purchasing property. When the federal government gave permission for this purchase in the autumn of 1998, the Russian economy experienced a severe depression due to devaluation of the rouble. The result was that the municipality of Medvejegorsk could not afford to renovate the building.

4.2 Cultural aspects

A lack of common concepts was one of the main problems, especially at the beginning of the collaboration. This is admitted by those on both sides of the border. In the beginning it was extremely difficult for people to understand each other in terms the concept of social policy, since there was at that time no university-level education in social care in the country. Concepts such as family doctor, public/community health nurse, social worker, primary health care, preventive health care and community-based social care were unknown or had a misleading connotation.

In the Soviet era, all administration was structured to ensure hierarchical connections to the federal level, and there was little horizontal contact between districts and sectors. This was also noted in the planning reports of the project, and a great attempt was made to manage the project in such a way as to increase communication between different sectors.

The Russian management structure is highly hierarchical and is based on authority. Personal contacts are important, and it is vital to convince the highest decision-maker in order to proceed with the reform.

Other cultural traditions also date back to Soviet times: traces of the central planning ideology can be seen in the service structure, training and the educational system as well as in working attitudes. For instance, client or parental associations are still lacking, and people are still learning to be clients of the health care or social service. Changes in mentality take time, and it is unrealistic to expect a complete change in two or three years. This does not mean, however, that continuous support is needed.

Projects of this complexity have to ensure that both partners reach an early agreement on what can be realistically achieved within the time-scale. In general, this was not an obstacle. However, development is sometimes seen as a technical and economic challenge in the Russian Federation: "if one could afford computers, almost all problems would be solved". In this respect, it seems that the Finnish and Karelian experts still look at the development process from very different perspectives.
5. **Current status of the collaboration**

The bilateral collaboration continues now on a different level. The current aim is especially to gather together ministries and other actors into a project implementation and management group, led by the Karelian authorities, to coordinate different health care and social development projects. Dissemination of previous project results to the whole Republic level is another focus. Unfinished activities, as for example the centre for disabled children in Medvejegorsk, are to be brought to a sustainable level.

The emphasis is on coordination since there are many actors aiming towards social development. New actors are also expected to join the field. For instance, in February 2000 three Finnish provinces and the Republic of Karelia signed an agreement on interregional cooperation, the first such contract between the European Union and the Russian Federation.

For the effective continuation of activities in the health and social sectors, it is essential that future activities are planned according to reliable information on living conditions in Karelia. In parallel with development projects, therefore, STAKES is also now carrying out a study of living conditions and service needs in Karelia. The results of the study are to be published by the end of 2000.

6. **Conclusions**

The involvement of Finland in the setting up and running of these projects was strongly influenced by its position bordering on the Republic of Karelia. The changes in eastern Europe in the 1990s, when the projects were first planned, caused a great deal of uncertainty about what might happen. It was easy to draw up scenarios whereby poverty, shortages of food and energy or the collapse of health care systems would lead to a real social and humanitarian crisis. It cannot be asserted that the threat of possible crisis was avoided because of the Finnish–Karelian and Tacis projects, but they certainly contributed to some of the positive development that we are able to see now. Therefore, this style of collaboration can be considered as the social sector contribution to the modern broad concept of civil crisis control.

Briefing the local partners about the analytical and logical setting of objectives (for example, the use of the logical framework approach)\(^2\) seems to have been motivating and useful for many. It has made a positive contribution to the development of such approaches for other projects as well, and to the planning of future bilateral cooperation. How easily or clearly we can measure achievements of an individual project depends on its scope, its profile and the

\(^2\) The logical framework approach (LFA) is a widely used analytical tool for project planning, monitoring and evaluation. It is also used in strategic planning. The LFA system is based on wide participation by various stakeholders, selection of the main beneficiary group, analysis of the problems of the beneficiaries, the setting of hierarchical objectives and the use of problem analysis. An essential element is the identification of key risks and assumptions for ensuring sustainability. LFA is commonly used by various funding agencies, nongovernmental organizations and other institutions working in the development field (6).
definition of objectives at different levels of activity, as described in the logical framework hierarchy \((4, 5)\).

Measuring the impact of large social and health sector projects is difficult, owing to the fact that such projects aim (or should aim) at influencing overall social development. Such large-scale social development can be influenced through, for example, policy development, capacity-building, improvements in planning and other fields of management, and changes in attitudes and work culture. This is a long process to which a single project can only contribute. A quantitative assessment of the project’s impact is difficult, and therefore qualitative or proxy indicators must be used.

Assuming that economic development continues and political conditions remain stable, it seems clear – and this is also the opinion of the Karelians themselves – that the efforts made during the project will have a positive impact on everyday life and thus contribute to the prevention of possible negative developments. How sustainable this will be is difficult to say. The Finnish–Karelian collaboration has strong and deep roots. The effect of relationships in collaboration and integration on both sides of the border cannot be overestimated. The more formal collaboration, through joint projects, is supported by various actors on both sides, and this is one of the strengths of such collaboration.

On the other hand, from the Finnish point of view, there is felt to be some risk in such collaboration in that it can only succeed if there is strong and systematic input by the Karelian authorities to improve coordination among the different actors in the Republic. At the republic level, intersectoral cooperation is still managed more through personal than institutional contacts; although this can be effective in the short term, it increases longer-term vulnerability. The republic- and district-level administrations will need to be more involved in guaranteeing continuity of collaboration.

From the Karelian point of view, one of the risks is financial sustainability. Under the collaboration, all model services were financed from the district administration’s basic budgets and not as experimental extras. Appropriate follow-up support and, in some cases, even continuation of some projects will be indispensable if sustainable results are to be obtained. One positive indication, however, is that cooperation has reached the stage where the focus of reform has filtered through to the grass-roots level. When people see how the reforms can affect their daily work, the transition has achieved its best guarantee of sustainability.

The core idea of the collaboration was and still is to support and reinforce the Karelian authorities in their own policy-making, and not to impose models from other countries. In examining progress made towards the more specific aims of the projects, this seems to have been achieved to a considerable extent. One of the main aims was the integration of basic health and social services by broadening the scope of the daily work of social and health care personnel. In
practice, discussion and collaboration between the authorities and workers across traditional sectoral borders has increased. This, in turn, has had a positive impact, both on general attitudes to managing organizational and administrative change and on the quality of services delivered to the population, thus creating a positive developmental cycle. The development of different models has shown that there can be different options for tackling the same problems, and that pilot schemes can be a way of testing these.

International cooperation is a question not only of learning what to do, but also how to act. This cooperation prompted new ideas concerning the skills and ways of working needed for implementing new projects. Also, the changes in the way of thinking towards what might be called a more “western” project-oriented approach facilitated the use of a common language in the planning of further objectives and activities.

STAKES has strongly promoted a participatory approach in its widest sense. All levels of personnel were included in the human resources development plans, and it was considered of crucial importance to encourage everyone to accept responsibility for achieving progress. This was the only way of convincing all actors in the field that reform was not an order from outside (from the government of the Republic or of the Russian Federation, from Finland or from the European Union) but that it could facilitate everyone’s own daily work and in that sense be seen as reasonable. This outcome can be seen as one of the best assurances for the sustainability of reform.

Participatory approaches, however, require a considerable investment of time, which neither top-level administrators nor grass-roots professionals may have. One way of achieving participation, while at the same time providing a valuable learning experience, was seen to be the use of study tours. When developing human resources, nothing can replace the efficacy of a living example of how things can be. Nevertheless, participants in such activities need to be carefully selected and programmes designed to suit their individual requirements. Future projects might be advised not to plan too many such tours, but to focus on a number of small-scale, well planned and targeted visits by key people, preferably mixed groups who have some basis for working together afterwards.

Projects dealing with the development of new curricula need to take employment opportunities into consideration. This is also one of the most important factors in securing sustainability of a project. For example, three out of eleven general practitioners moved to Finland after finishing their training, since there were no proper working conditions for them in the Republic of Karelia. In contrast, a proper incentive system was created in the Suna health centre and this proved successful. Similar precautionary measures should be taken into account in generating new training systems.

Reforms in the health care and social sectors can succeed as planned only if people change their old ways of thinking and learn new skills. Since this depends on human resources and cultural values, profound changes never
occur instantly. This means that a project implementation period of two or three years may only introduce new methods and systems – psychological and cultural changes take many more years.

The very process of creating a well designed project plan can help influence such cultural changes, encourage information flow from the bottom up, and increase horizontal contacts between the different sectors at local and republic levels.

Owing to the participatory approach, the overall enthusiasm generated, the strong commitment of the national and international partners and the deep desire for improvement by the Karelian authorities at all levels, and despite the difficulties along the way, the collaboration is eventually felt on both sides of the border to have turned out remarkably successfully.

REFERENCES

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