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# CHALLENGES TO INSTITUTIONALIZING SUSTAINABLE TOTAL QUALITY MANAGEMENT PROGRAMS IN HEALTHCARE SYSTEMS OF POST- SOVIET COUNTRIES

Patricia A. Cholewka  
Department of International and Transcultural Studies  
Teachers College, Columbia University

## **Abstract**

*Critical changes are occurring on a worldwide basis in the organization, financing, and delivery of healthcare services. A little over a decade after declaring their independence, the nations of the former Soviet Union continue to restructure their political and socioeconomic infrastructures as they move from centrally-planned to market-driven economies. In order to do this within social transition efforts, healthcare program managers realize the need to utilize more effective management methods if social services are to continue to be provided. Organization management concepts developed and used in the countries of the West, that is, the United States and the European Union are being sought for incorporation into these evolving administrative systems. Demands by practitioners and patients for advanced technology and improved healthcare services, as well as economic restraints imposed by their governments and external investors, are driving this economic sector's transformation. Economic impact studies performed by global organizations have recommended that management programs be developed for these countries at the microeconomic (organizational) level using Total Quality Management concepts. This is because, for sustainable development, the structuring and functioning of their institutions must be reformed, strengthened, and stabilized using more democratic means. In other words, implementation of decentralized, cost-effective, market-oriented management policies and practices by these nations is a crucial determinant for their continuing integration into the global community.*

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## **Introduction**

This paper will be presented within an East-West perspective, i.e., post-Soviet-US/EU, regarding the sustainable development of the healthcare systems of post-Soviet nations. Its primary focus is not to propose specific economic solutions or discuss program outcomes but to share the author's insights gained from her experiences presenting healthcare management programs in the Central and Eastern European (CEE) nations and Newly Independent States (NIS) of Bulgaria, Lithuania, and Ukraine. Discussion will also include the enabling and inhibiting transcultural issues that healthcare educators, advisors, consultants, and policy makers should be aware of before attempting to design and implement Total Quality Management (TQM) programs within these healthcare systems. General policy recommendations for the development of sustainable TQM programs will be posed considering the operating environments into which these programs will be introduced.

## **Reforming Post-Soviet Healthcare System Management**

Economic impact studies performed by the United Nations World Health Organization (WHO), the World Bank (WB), the United States Agency for International Development (USAID), and the Commission of the European Communities (CEC) have recommended that management programs be developed for post-Soviet countries using TQM concepts (Cleland, 1997; Commission of the European Communities, 1997; International Bank for Reconstruction and Development/The World Bank, 1993, 1997). In 1997 the CEC concluded that globalization and increased economic integration of these nation-states make cost-effectiveness a crucial determinant of sound economic policy for nations seeking integration into the enlarging European Union. Thus, the composition of institutions and their functioning must be reformed, strengthened, and stabilized.

This need for new management systems, and for healthcare improvement programs in particular, creates a challenge for healthcare management consultants to develop and present management training programs that are culturally sensitive, adaptable, and sustainable to the organizational and socioeconomic needs of these countries. McLaughlin and Kaluzny (1994) define Total

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Quality Management as a comprehensive approach to improving an organization's economic competitiveness through efficiency, effectiveness, and flexibility by involving each individual at every organizational level in the planning, organization and understanding of each activity. TQM must start at the top of the organization with a continuing demonstration of executive management commitment to quality. This commitment ensures the adoption of a strategic overview of quality with a focus on the prevention, not detection, of problems through process management. Thus, theoretically, organization management is not just implementing interventions in response to day-to-day responses to spontaneously occurring 'crises.' The core of TQM is the customer-supplier relationship. Holt (1993) defines efficiency as the result of making decisions that lead to doing things right, which helps to achieve the objectives of an enterprise with fewer resources and at lower costs. He defines effectiveness as the result of making decisions that lead to doing the right things which helps to fulfill the mission of an enterprise.

Although over ten years have elapsed since the CEE and NIS nations declared their independence from Soviet Russia in 1991, few sustained economic results have been observed although various socioeconomic transition programs have been 'instituted' by various Western countries. Why have the economic objectives of these programs not been realized? Why has socioeconomic 'progress' toward more democratic and market-oriented economies been sluggish at best? Perhaps it is because no clear, obtainable goals, or accountability for meeting these goals, consistent with cultural norms, have been factored into these externally imposed development programs. Perhaps it is because the West overestimated the collapse of failed Soviet ideology with a victory, and supposedly overwhelming acceptance, of its own democratically oriented system. Most likely, these privatization 'reforms' have been carried out in a poorly managed, uncoordinated manner within a system that had no stable base to readily incorporate democratic, market-centered tenets of a civil society.

Few in-depth, long-range studies have been undertaken to address the total healthcare system management needs of these nations, as well as the results of these programs, in a comprehensive manner. But far more importantly, the extent of dissatisfaction by the populace of these nations with the depth of political corruption and social disintegration of the Soviet system has never been effectively

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gauged nor fully acknowledged and addressed by the West. Issues that have effected the state of health and quality of life issues in these nations such as extant political ideology, widespread corruption, pervasive cynicism, entrenched mistrust of the West, lack of initiative and motivation, intellectual heritage of both leadership and citizenry, and the lack of components of a basic civil society have to be considered when designing any organizational change effort. In addition, acknowledgement by the West of the rebirth of a national consciousness concerning their ethnic identity and cultural heritage once suppressed by Russification will play a major part in establishing a working relationship with government and organization officials in these nations. TQM offers managerial concepts and techniques for self-governance and self-determination to post-Soviet organizations to become more effective, efficient, and more community focused. However, TQM will be sustainable only if accepted and promoted by organization leadership within a more transparent and democratic political environment (see Table 1).

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**Table 1**  
**Total Quality Management Program**  
**Development and Sustainability Factors**

**External organizational factors:**

- Political and economic stability of healthcare system.
- Government (Ministry of Health/MOH) support; consistent, non-conflicting, non-ambiguous policies.
- Government-healthcare practitioner partnership to develop practice standards, audit criteria, reachable goals, and corrective action plans.
- Financial incentives to organizations to meet quality and cost-containment goals.
- Micro- versus macro-economic approach.
- Acknowledgement of consumer role within system.
- Western management and information technology support.

**Internal organizational factors:**

- Management long-term commitment and support with demonstrable “buy-in.”
- Resource support to encourage and reward innovative ideas.
- Managerial knowledge and skills to assess, motivate, support, and maintain staff behavior change (as well as **readiness** to change).

The difficulties with post-Soviet socioeconomic reform efforts by these nations should touch the conscience of American (and other Western-sponsored) economists, political scientists, and other reform ‘experts’ who presumed to merely ‘re-adjust’ the former ‘evil empire.’ Although well-meaning, these ‘experts’ should have been more alert to the underlying and all-encompassing political ideology that perpetrated the economic and social problems that people of the former Communist countries would face en route to the promised land of democracy and its market economy (Sims, 1999).

Social change should not be gauged in economic terms alone. It involves more of an ideological shift based on education to build human capacity and influence entrenched behavior. This is a long-

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term commitment on the part of the West to encourage, and accept, incremental change. The building of trust in the West by these societies can be accomplished through successful, evidence-based program implementation and outcomes realization with an observable and tangible impact on an individual's work environment and economic condition. Successful implementation of healthcare TQM programs in the post-Soviet political environment involves consideration of pre- and post-independence system environmental factors (see Table 2) as well as all of the following: 1) the political will to acknowledge that a problem exists; 2) agreement by leadership to commit resources to establishing the program; 3) managerial ability and continued strength of commitment of leadership; 4) an implementation plan; 5) active, visible involvement by leadership; and 6) policies to promote and support the establishment of an infrastructure to carry out the program. A system of accountability built into these programs is necessary to gauge progress. Current development programs should be seriously re-evaluated regarding the accountability of attaining development goals based on the collaborative establishment of reachable criteria and sustainable results by the recipient organization.

**Table 2**  
**Factors Influencing Adoption of a Total Quality Management Culture into a Post-Soviet Healthcare System**

**Pre-independence healthcare system factors:**

- Imposed system of centralized control and decision-making; restriction of professional activity; financial and economic dependence (passive system).

**Post-independence healthcare system factors:**

- New political, economic, and social environment (active system).
- Budgetary constraints promoting organization self-management.
- National insurance system; primary healthcare; privatization of healthcare services with focus on provider accountability.
- More focus on patient/customer satisfaction.
- More focus on quality service and cost-containment.

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The post-Soviet transitional economies inherited a daunting legacy of healthcare management and financing policy challenges. Eleven years after transition efforts began, overall progress is still unsatisfactory according to both Western standards and these independent nations' perceived right to be immediately at equity with Western healthcare system functioning. Various uncoordinated attempts are being made to analyze: 1) the kind of healthcare services, facilities, and provider networks that are currently in place, 2) what community-based healthcare services are needed, and 3) a way to scale down the generosity of the present system. Since the continuation of a government-funded healthcare system is becoming overwhelming, economic reform efforts have included the indexing of benefits to prices rather than wages, transforming a part of this system into individually funded accounts by promoting voluntary private savings and a fee-for-service system. The most important challenge is increasing the efficiency of the existing system. Central to this process is creating a group of well-trained health professionals with high morale. Again, TQM can assist in this effort by providing healthcare providers with the management techniques to increase their ability to more effectively manage their departments, their organizations, and, eventually, their own private primary care practices when the privatization process takes hold.

## **Transcultural Issues Effecting TQM Program Design and Implementation**

Within the context of building human capacity through education and skills training, transcultural transfer can be defined as the movement of issues, such as knowledge, ideas, and concepts, back and forth across cultures with or without total acceptance, although some adaptation can occur. Some major issues associated with the transcultural transfer of management concepts to post-Soviet nations include dealing with the following: non-apparent behavioral characteristics of the citizens of this post-Soviet society whose personalities were traumatized by the effects of Russification and other social engineering policies, that are now being manifested as distortions in personality development and structure; current skills, abilities, and motivation of personnel and managers to accept and implement societal and/or organizational change (Gulens, 1995); and the lack of understanding by personnel of their role and accountability within the healthcare system. As previously mentioned, consideration of transcultural issues influencing the

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acceptance, implementation, and/or sustained development of economic programs in healthcare system management of post-Soviet nations, has not been given consideration in program planning. These issues do affect the success or failure of US consultants and/or Western organizations establishing lasting business relationships with healthcare providers and/or government Ministries of Health (MOH) of these healthcare systems (see Table 2). At present, most healthcare programs from US healthcare systems are transculturally transferred as inconsistent, fragmented, pre-packaged additions to the inadequately functioning healthcare administration in post-Soviet nations.

An issue such as the compatibility of the program with the recipient organization and its culture should be considered when institutionalizing US or EU 'Western-style' healthcare management improvement training programs. The new accountability focus for these healthcare systems creates a challenge to develop and present healthcare management training programs that are adaptable and sustainable to the organizational and socioeconomic needs of these countries without compromising the quality of patient care. In other words, programs should have a tangible impact. They should be usable, pertinent, understandable, economically feasible, and culturally adaptable, to the organization's new management needs, service population needs, and reimbursement criteria (Cholewka, 1999, p. 26-37). And this is why their design has to be value-centered and culture-specific but should also hold healthcare managers and practitioners accountable for program results. Many of these healthcare management programs initiated and/or imposed into this existing system are usually politically motivated and are generally neither comprehensive nor long-lasting since there is inconsistent emphasis on accountability, self-sufficiency, and community sustainability after external funding is withdrawn. The models currently used are based on Western parochialism, that is, beliefs, values, and ethnocentrism that are embedded in and have shaped the concepts of Western organization management theories. These concepts are central to human behavior within a Western social environment of organization management and do not acknowledge awareness of non-Western or intercultural contexts, models, or values. They were shaped with the assumption that these beliefs have universal applicability.

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## **Global Changes in Healthcare Management**

Healthcare is redesigning itself worldwide. In the US, the trend in healthcare is that it is becoming more global in focus with a greater awareness of multicultural definitions of health. This trend is causing a movement toward the concept of designer healthcare systems and keeping the needs of specific population groups in mind when providing essential services. Shifts have occurred from an obsession with curing diseases to an interest in prevention; from problem identification toward outcome-specification; to systems designed for patients rather than physicians; from isolation to networking; from the bottom-line and profit to community good; and from competition to collaboration. Innovation is replacing an emphasis on maintaining the status quo. Community interest is taking the place of self-interest or organization interests. And in the future, community resources, rather than institutional resources, will help shape the healthcare system. These trends require a transformation in education, practice, and system administration. Therefore, in order for international programs to succeed in meeting the goals of both the donor and recipient countries, healthcare management programs have to be designed within a transcultural approach.

In the United States healthcare industry, TQM programs gradually evolved into the Continuous Quality Improvement (CQI) approach to healthcare service delivery. This approach adapted concepts from the industrial quality management model and also used teams to measure the effectiveness (quality) and efficiency (resource utilization) of these services to identify and pursue opportunities to improve service outcomes to meet or exceed customers' expectations. Since these expectations are subjective and can change continuously, improvement would have to be considered continual (McLaughlin & Kaluzny, 1994). Thus, the healthcare management consultant plays a pivotal role in guiding healthcare organizational management change strategies. The consultant assists in the stabilization of transitional organizational processes by providing technical assistance and guidelines that can improve the way healthcare resources are utilized, how they are managed, and how healthcare service outcomes or results are monitored.

Healthcare reform in countries of the former Soviet Union is still slow and fragmented. Although healthcare providers are anxious to

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acquire technological advancement within their individual practices, they are also anxious to see improvement in the total quality of clinical practice, service provision, and overall organizational management. However, their ability to monitor and control costs, to develop and implement professional practice standards like those being used in Western countries, and to manage and develop human resources, is rudimentary. Sustainable programs for improvements of system management are hampered by changes in governance and policy at the MOH (national) level and the managerial ability and strength of commitment to change programs by leadership at the organization (local) level (Cholewka, 1999, p. 26-37).

The newly independent nation-states of the former Soviet Union are faced, to varying degrees, with managing a healthcare system that was once operated within a centrally-planned, hierarchically-structured economy that appropriated and used resources without consistent accountability regarding how, when, for, and by whom these resources were used. Management directives were forcibly imposed by this centralized authority, and innovation was seen as counterproductive to the Communist Party influence, direction, and control (Lefties, 1985; Schubert-Lehnhardt, 1995; Yanowitch, 1979, 1985). Various socioeconomic and managerial reports have shown that under the Soviet system, hospital management, medical practice, and finance and accounting standards for monitoring the use of resources were either ineffective or inadequate according to Western management standards (Gefenas, 1995; Kaminsky, 1995; Lee, Luthans, & Hodgetts 1992; Leites, 1985; Yanowitch, 1979). According to Leites (1985), the regard for quality of life, and hence the quality of patient care and effectiveness of treatment, was never addressed effectively. To question patient care practices or healthcare management methods by practitioners would have been questioning the authority and management expertise of the central Communist Party. It was more important within the Soviet economy, including the healthcare system, for Communist Party officials to create jobs to keep people employed than to achieve efficiency, quality, or equality in the services being provided. In Western terms, the Soviet Union suffered from over-employment, using too many people to deal with too little work (Shapiro & Godson, 1994).

According to Minev (1990), important questions to consider when analyzing the Soviet healthcare system are why the system of

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healthcare failed to abolish, or at least sharply reduce, inequalities of outcomes in Soviet healthcare between rural and urban areas and between the Soviet healthcare system and that of developed countries. These questions become very important because the idea of equal access and treatment lies at the heart of the Soviet healthcare system. Thus a major factor to consider must be the character of the system. Early Soviet improvements to the healthcare system were based on widening public access to existing facilities. However this idea for improvement was quickly checked. Health problems became more complex and soon demands for more resources, better quality of services, better working conditions, and increasing ecological issues quickly surfaced (Minev, 1990).

In 1935 Semashko, the founding father of the Soviet public health system, wrote that the duty of every member of the Soviet of Workers' and Peasants' Deputies was to inspect the work of the medical and prophylactic institutions to secure efficiency, help to overcome shortcomings, improve the economic management, and ensure that proper attention be given to the needs of the workers and peasants. Lisitin (1967) writes that the basic principles upon which the public health system of the Soviet State was established, included: (1) the State nature of the system, including planning on a State basis and the fact that it was free of charge, universally accessible, and provided a high standard of medical care; (2) an emphasis on prophylaxis; (3) close links between medical research and practice; and (4) the broad participation of the people themselves in developing the public health system. The State assumed full responsibility and control for the organization, planning, and provision of services. As outlined in the economic plans for national economic development, the Supreme Soviets of the Union Republics determined expenditure on public health in the budgets of the republics. But in reality, the social welfare system continued to enjoy a low priority after the introduction of central planning, and in practice, this resulted in making most cash benefits dependent on prior employment, of introducing the principle of earnings-relatedness for those who were entitled, and of excluding substantial occupational and ethnic groups from coverage altogether (Shapiro & Godson, 1994).

Rowland and Telyukov (1991) stress that post-Soviet reformers are striving to reconstruct a healthcare system that was plagued by chronic under-funding, antiquated and deteriorating

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facilities, inadequate supplies and outmoded equipment, poor morale, few incentives for health care workers, and consumer dissatisfaction. The central planning process embodied in the five-year plans emphasized quantitative rather than qualitative goals and resulted in concern with expanding the absolute number of facilities and providers without regard to quality or competence. New construction [and expansion] rather than renovation was rewarded. Mezentseva and Rimachevskaya (1990) write that seven million people were employed in the Soviet public healthcare system, that is, 6% of the total active population, but lack of proper attention to public healthcare led to a level of salaries that was among the lowest in the national economy. According to Minev (1990), the achieved level of the Soviet public healthcare did not meet the population's requirements. And there now is the problem of the economic self-interest of the medical employees to raise the efficiency of their work. In these Soviet, centrally planned societies, collective goals were set and did not involve the participation or input of those directly involved in carrying out the production process (Leites, 1985; Rowland & Telyukov, 1991; Schubert-Lehnhardt, 1995; Yanowitch, 1979). A worker or manager was not necessarily matched to a position by experience or educational qualifications. It was not necessary to monitor and evaluate a worker's performance, since it would mean that the worker and the manager had to be accountable for what good was produced or service provided.

According to Cantor (1978), accountability means the condition of being answerable for one's own action and lack of action. Under Soviet healthcare administration service or quality problems were not discussed because by not acknowledging them they did not 'officially' exist. Yanowitch (1979) contends that even a cursory acquaintance with the Soviet literature on labor problems provides abundant evidence of chronic difficulties with excessive labor turnover, poor work discipline, faulty work organization, and disappointing productivity performance. In order to counteract these factors that affected production capability, Soviet sociological and managerial studies from the mid-1960s through the 1970s had begun to stress greater democratization of work with worker participation in the management of production which meant more than just using the official channels of participation. Serious efforts were made to pose the issue of changing distribution of managerial authority and providing opportunities for genuine forms of worker initiative in organization-level decision-making.

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Some more progressive Soviet managers argued that the enrichment of the work process must be seen as significantly dependent on the production independence, or on-the-job independence, of the worker, that is, the degree to which the functions of planning, organization, and control of the work process are directly delegated to the ordinary worker. However, these recommendations were never put into practice, since loss of control threatened the political ideology of the Soviet system (Yanowich, 1985). Acknowledging poor performance would mean perhaps a demotion, loss of employment, deportation, or worse (depending on political regime) for the worker and manager. Accountability was important only when the system failed to produce prescribed quotas imposed by the central governing authority. Leites (1985) writes that the Communist Party used degrees of 'kontrol,' that is, the surveillance and correction of one's performance by others, to insure work success and the feeling of responsibility to society. Although, in theory, the Party believed that the worker's conscience was the best controller, in reality, when performance was low, the Party looked for low 'kontrol' as the cause. Conversely, when 'kontrol' was high, the Party believed that its decisions would be carried through. And, the Party promoted norms favoring cohesion, that is, the principle of collective responsibility for defective performance. Minev (1990) contends that the patient was the last to be considered in the healthcare scheme. The system was not geared to take into account the large impact of individual lifestyle on health status. Health status was considered partly dependent on individual behavior, but the health system was depersonalized and collective in focus, and could not influence health status by changing individual behavior. And, according to Leites (1985), in managing forces in combat and in managing the society and economy, there was a pervasive distrust by Soviet authority of ordinary human beings, of human nature, and perhaps of what was seen by the Soviet leadership as distinctive attributes of the human material that made up the mass of Soviet society.

## **Policies of Crisis Intervention and Maintenance of Status Quo**

Although US government-contracted non-profit organizations are working diligently to provide post-Soviet healthcare systems with programs to address their need for more effective and efficient

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management solutions to market economy reforms, my observations and personal field experience tend to convince me that outcomes are not effectively reaching preliminary expectations. And, as a consequence, money allocated by well-intentioned professionals is being misallocated because, in reality, progressive and sustainable development results are not being achieved. And a reason for this failure in sustainable program development is the failure of these organizations to understand that some issues such as accountability do not translate transculturally to the persistent Communist ideology still held by many in the post-Soviet countries. (Cholewka, 1997, p. 29-33).

In addition, these Western organizations continue to fail to understand that these post-Soviet countries are now independent entities, both ethnically and culturally, from Russia. They fail to address the national pride and linguistic differences that exist in these countries. Many proposals for project personnel advertise for proficiency in Russian language usage. This, I believe, serves only to alienate the donor country and to perpetuate the Russian/Soviet hegemony in the region and stifle change and democratic progress. An ethnic nexus needs to spur the change. And, the retention of those who once held positions under the 'old' Communist regime is counter-productive to institutionalizing a new management paradigm compatible with a more democratic approach. Instead, new leaders who are democratically elected might be able to establish a more democratic-oriented paradigm although they face constant politico-legal challenges from entrenched pre-independence, Soviet-style administrators.

## **Cultural Sensitivity and Culture-Specific TQM Program Design**

In Western healthcare systems the evolution of TQM, translated to CQI, stressed an interdisciplinary, cooperative, team effort to continuously manage (monitor, evaluate, coordinate, plan, direct) and improve healthcare related services to meet and exceed a patient's/customer's perceived value, standard, or requirement for that service. These concepts are in complete opposition to previously espoused Soviet ideology of sacrificing individuality for the collective good of the State.

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Understanding and respecting the norms, values, and beliefs held by people of diverse cultural backgrounds is an integral part of providing culturally acceptable healthcare programs in these countries. Each culture has a value system that dictates behavior directly or indirectly. These beliefs may center on issues such as body language, personal space, communication, economic issues (capitalism versus socialism). Understanding the culture and its influence on the healthcare system is central to working within these systems to implement change. Culturally-based attitudes, based in ethnic affiliation, religion, political system, and socially accepted behaviors is reflective of cultural norms, i.e., reluctance to discussing personal/business issues in the presence of outsiders; environmental control/the ability to control their own destiny.

In many instances, Americans possessing the same ethnic background, religion, and historical/political understanding of the country, will usually be more readily accepted and welcomed into the change process since there is a built-in trust relationship based on an inherent 'connection'.

Culture-specific program design can be interpreted as designing programs developed in one nation's economic system that are sensitive to the cultural differences of another system, that is, the recipient country's history, language, values, customs, religious beliefs, education, gender issues, financial resources, health services, legal regulations, standards of practice, and so forth. The following are a few examples of culture-specific issues that might affect the successful institutionalization of a TQM-focused program:

- 1) Promotion of political policies that are opposite to a country's culture, i.e., religious practices/norms of target population, e.g., a large US government agency providing \$5,000 worth of condoms (now sitting in warehouse storage) versus a request by Ukrainian physician for informational pamphlets on health promotion and pre-natal care.
- 2) Promotion of Western social policies that are opposite to the recipient country's culture and social norms, e.g., US business entity in Poland using US-based business policy of name badges that state, "We are here to serve you" (female employee in Poland refused to wear badge because she understood the translation to mean that

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she would be advertising/"prostituting" herself). Clearly, this shows a bilateral misunderstanding of cultural practices and terms of openness and client interaction.

- 3) Lithuanian doctor smoking cigarettes who states, "Everybody has vices. We are not God. Besides, if people smoke and then die because of the effects of smoking, it saves the government the expense of providing pensions."
- 4) In Bulgaria, a hospital Medical Director stating that the Emergency Department is just used to assign 'problematic' doctors, and, that the Emergency Department doctors are not trained as other hospital doctors.
- 5) According to this same Medical Director in Bulgaria, the design of an Emergency Department is to give doctors their own cabinets/offices and not to provide conveniently located facilities for patient care or comfort.
- 6) US agency demanding demonstrable, macroeconomic results in post-Soviet Ukraine within a 1-year timeframe (without providing reachable criteria) versus perpetual economic assistance programs to countries such as Mexico, Central and South America, Africa, and Asia.
- 7) According to a Lithuanian consul, a Ukrainian Medical director, and a former member of the Albanian MOH, US-sponsored consulting firms producing reams of economic and management reports, computer programs, and healthcare training programs in English that use US sports, management, or business-related terms that are unfamiliar or not applicable to recipient countries. These same organizations fail to provide the means of replenishing materials, supplies, or high-end technological equipment connected with initial, and much-touted, 'successful healthcare projects,' e.g., disposable airways, intravenous tubing, drugs, updated computer programs, or equipment maintenance contract. (It should be noted here that machines that are donated are usually out-of-date in Western countries, i.e., MRI and X-ray machines) and therefore do not have existing service contracts or replaceable

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- parts). In other instances, donated equipment is not compatible with existing electrical capacity or equipment and remains unused.
- 8) US government agencies and US government-contracted non-profit organizations advertising for consultants/advisors to work in the CEE and NIS who are 'familiar with the use of the Russian language' (a non-native, non-ethnic language) in countries now establishing or re-establishing their national identities (culture, language, religious beliefs, political ideologies in direct opposition to previous political ideology of Communism advocated by Soviet Russia). This practice indicates an insensitivity or misunderstanding of post-Soviet nations' revived nationalism, cultural differences, and local preference.
  - 9) According to a Lithuanian consul, US consultants arriving post-independence and producing reports, implementing pre-structured quality improvement programs, getting paid, then moving on to the next post-Soviet nation while leaving the previous nation's healthcare system without a usable, sustainable program, e.g., consultants hold training sessions and dispense certificates/diplomas, but do not stay long enough to assist in implementing and monitoring an actual improvement project that produces demonstrable change.

## **Conclusions and Recommendations**

The intent of this paper was to share insights and pose policy recommendations based on the author's experiences in initiating healthcare system improvement programs in CEE and NIS countries. The challenge to healthcare policymakers is to recognize their responsibility to devise policies that improve their healthcare systems in a sustainable manner. TQM is a low-cost, effective method to accomplish this goal. Overall, TQM can provide management tools and strategies but within a decentralized, team-centered venue for problem-solving and service improvement at the local level. TQM calls for not only an administrative shift but also a shift in mindset.

Factors affecting change and determining the sustainability of social welfare reform programs are not always clear. However, what

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is known in Western market-oriented economies, is that if there is not a reasonable alignment of incentives with the objectives of healthcare service improvement, TQM program measures may not be sustainable. Currently, only a few programs aimed at building physician primary healthcare practices versus total healthcare system management, and focused on short-term solutions to economic crises situations, are being attempted or are at least in the planning stages in hospitals in many of the post-Soviet nations.

Since literature about program results and their long-term system effects on these healthcare systems is still scarce for CEE and NIS nations, time and additional research are needed to understand how to develop better sustainable programs with feasible incentives that encourage desired behaviors (Cholewka, 1999). In addition, and perhaps most importantly, providing the opportunity for other trainers/educators to enter into the proposal process to provide more time, concentrated effort, and innovative program methods versus the status quo of using 'known' consultants is needed. Another important need is a more positive and democratic environment that is more conducive to change, openness, innovation, individualism, and scholarly exchange. Therefore, before developing international healthcare quality improvement programs, it is best to consider this question, "Will US/Western-developed healthcare TQM programs have the same value and impact in a different culture?" Also, a fundamental point to remember is that all societies have 'blind spots' and that cultural differences persist despite talk of globalization, an American/Western-inspired term that advocates global democracy, gender equality, and privatization operating within a civil society.

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## **Biographical Sketch**

Patricia A. Cholewka, EdD, MPA, RN, CNA, CPHQ  
6801 Shore Road, #6C  
Bay Ridge, NY 11220  
USA  
[Pacholewka@aol.com](mailto:Pacholewka@aol.com)

Dr. Patricia A. Cholewka has experience in acute, home care, and managed healthcare service management, education, and consultation. Her doctorate in international healthcare management education focuses on quality improvement and economic management of Central and Eastern Europe healthcare systems. She holds a master's degree in public administration, a bachelor of science degree in nursing, is board certified in both nursing administration and healthcare quality. Dr. Cholewka is an elected member of two international honor societies: Phi Delta Kappa, International Honor Society in Education and Sigma Theta Tau International, Honor Society of Nursing. She is listed in *Who's Who in Medicine and Healthcare* (2000), *Who's Who in America* (2002), and in Sigma Theta Tau's "2001 Media Guide to Health Care Experts."

Dr. Cholewka has authored nursing and healthcare management peer-reviewed journal articles on healthcare organization change strategies using a Continuous Quality Improvement approach, transcultural considerations in healthcare management education, and the effects of government legislation on healthcare cost and quality of healthcare services. She serves on several editorial review boards of various healthcare industry journals. Dr. Cholewka is currently the Co-Editor of an IPRO newsletter as part of her responsibilities as Intervention Specialist, Payment Error Prevention Program (PEPP) with the Island Peer Review Organization (IPRO), a regulatory entity of the federal government. She is primarily responsible for identifying and developing intervention strategies for the education of hospital administration and physicians in documentation and coding for the prevention of inappropriate payments by Health Care Financing Administration of the US Department of Health and Human Service for unsubstantiated Medicare procedures/services in New York State PPS hospitals.