THE HEALTH SECTOR IN EASTERN EUROPE AND PROPOSALS FOR REFORM

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This article describes the current state of the health sector in Eastern European countries. We have focused on similarities, although the health sectors, just as the political and economic systems, differ in many aspects not highlighted here. The first part of the paper presents considerations regarding the current state of the health sector, its financing, delivery, doctors' incomes and the widespread phenomenon of under-the-table payments. Furthermore, we have presented some guiding principles for reform in this sector, mainly focusing on the health system reform in our country.

Key words: health expenditure, health system financing, health system reform

The Current State of the Health Sector in Eastern Europe

In the Eastern Europe of the 1990s, the spending on social services, including health spending, generally decreased less than GDP. The majority of Eastern European countries spent less than 6.5 percent of GDP on health in 2007 (Albania 3.5%, Bulgaria 4.8%, Hungary 5.3%, Macedonia 6.1%, Poland 6.2%, and Romania 4.1%). Although population health depends on the combined effects of several factors, certainly if health sector performance improved, it would help to improve population health, ideally in conjunction with other favorable changes.

Financing

Compulsory social-insurance contributions finance the majority of health services in Eastern Europe. The contribution rates as a percentage of earnings vary significantly across countries, from the modest 3.4% in Albania to the alarming 23.5% in Hungary and the nominal distribution of the contributions between employers and employees ranges from 0 : 100 [%] in Poland to 100 : 0 [%] in Macedonia[59]. However, the central state budget continues to play an important role, through financing public health, specialized research and clinical institutions and, nevertheless, financing the deficits of the social insurance fund.

Private financing, through voluntary insurance and out-of-pocket (both legal and illegal) payments, plays a role in almost all countries in the region. Private medical insurance in Hungary, Poland, and other countries is increasing, but from a very small base. If proper account could be made of the extent of semi-legal "gratuity" payments to providers, the scope of private financing would most likely appear much larger than the official figures reveal.

Delivery

- Public Institutions

The legacy of socialistic planning is clearly evident in the region's health-care delivery system. Even though hospitals must mainly cover their expenditures out of their revenues, in practice, they repeatedly exceed their budgets. The outcome is usually a bailout by the central or local state budget. In Romania, the public hospitals' budget is strictly supervised by the Regional Health Insurance House that aliments them, together with local budget sources and own sources. The budget must not be overcome according to the frame-contract and the legal norms for applying it.

- Legal Private Activity

[59] The size of the health-care social insurance contributions and the nominal distribution of the contribution between employers and employees in Eastern Europe, at the beginning of the century.

The largest change has occurred among doctors practicing individually, in primary care and dental care. All the Eastern European countries legalized private practice in the early 1990s, and some undertook "privatization campaigns"[60]. Several—the Czech Republic, Hungary and Romania—"privatized" primary care, by converting doctors from state employees to self-employed professionals, working under contract with the insurer and the local (or regional) government, which provides the premises and equipment. Privatization of dental care is even more extensive, and pharmacies are overwhelmingly private nowadays.

The first nonpublic hospitals, clinics and other health-care providers have also appeared in the 1990s in most Eastern European countries. Some are nonprofit, owned and operated by churches and private foundations. Most are for-profit institutions. Still, in the Eastern European region as a whole, the nonpublic share in total service volume remains very small. Hungary also has a high private-sector proportion for certain special diagnostic and therapeutic treatments.

Purchasing and Payment

By the end of the 1990s, most countries had moved away from historical-cost budgeting—towards alternative payment methods (*see Table no.1*). Fee-for-service (FFS) predominated in some countries, such as the Czech Republic. In that case, real health care spending increased by almost 40 percent in two years, with health expenditures jumps as a percent of GDP, too. Private practice physicians paid on a FFS basis billed significantly more in every category of service than public (primarily salaried) providers did.

Country	Primary Care	Outpatient and Inpatient Care
Albania	Capitation	Global budget and salary Planned: FFS
Bulgaria	Global budget and salary	Global budget and salary
Czech Republic	FFS Planned: capitation	Global budget
Croatia	Capitation and FFS	FFS and salary
Hungary	Capitation	Case-based payment (DRG)
Macedonia	Capitation	Global budget and salary
Poland	Capitation and FFS	Capitation and FFS *and* case-based payment[61]
Romania	Capitation and FFS	Capitation and FFS *and* case-based payment[62]

Table no. 1 Payment systems in Eastern Europe, at the beginning of the century

Several countries have introduced supply-side cost sharing, such as capitation and case-based payment for hospitals. Capitation has already become the most common form of payment for primary care in Eastern Europe.

Doctors' Earnings and Gratuities

Another resemblance between the market-socialist period of the economy as a whole and the health sector is the tension apparent between legal and illegal (or semi-legal) earnings. One aspect of the phenomenon is the disproportionately low salaries of doctors, most of whom remain employed by public institutions. Although physicians are among the best paid professionals in the traditional market economies (3 to 4 times average earnings), in Eastern Europe, official medical earnings are only 1.3 to 2 times average. This relatively low proportion understandably embitters and annoys the medical profession in light of the widening differentiation of earnings in other fields.

[60] The Czech Republic in 1993 and Croatia in 1996
[61] According to the choice of the territorial fund
[62] Since 1999

The other side of the coin is the system of what are known as gratuities—under-the table payments made by a patient or relative to a doctor or other health-care provider for publicly-financed services. Experts on the subject consider that semi-legal payments to doctors are very widespread in Hungary, Romania, Poland and Bulgaria, and much less so in the Czech Republic and Croatia.

The two sides of the gratuity system—intolerably low official pay and the prevalence and astonishing size of the semi-legal gratuity payments—are inseparably linked. Certainly the majority of doctors accept gratuities; they have become part of their normal income, without which they could not balance their household budget.

Recommendations for Reform

Almost all the countries of the world are confronted with a discrepancy between medical services' demand and the available resources. This led to the research of different methods for upbringing the efficiency of resource usage, starting from the care process technology, up to perfecting the sanitary organization and the financing of health services. Changes within the health system, reached larger proportions at the end of the 1980s and the beginning of the present decade, their expansion embracing many countries from Europe and America. Changes focused to eliminate or reduce disturbances that turned up in democratic countries with a stable market economy, but also in countries that had an economy based on state monopoly and a centralized rigid planning system. An ideal perfect sanitary system doesn't exist anywhere.

Dissatisfactions that generated the process of health care system reform, appeared among tax payers, doctors, institutions, politic and administrative authorities. Discontents aimed increased costs of health, in an intolerable rhythm, without substantial improvement of health status, insufficiency coverage of population with services, the absence of an efficient insurance quality mechanism, exaggerated volume of daily work, inefficient management.

The need for a coherent politic, harmonized with European and internationals health objectives, assumes to complete the desideratum "health for everyone" established by the World Health Organization, based on:

- Universality, i.e. all community members must have access to health care, at a reasonable cost;
- Quality, i.e. the medical services administrated must fulfill legally standards;
- Existence of a complementary powerful and viable private sector;
- Possibility to choose;
- Efficient medical services, based on needs;
- Respect of privacy and personal dignity;
- Existence of a gathering data system used in programming, decision and reglementation;
- Facility of integration models and cooperation for the delivery of medical services;
- Initiatives of long term programs, to prevent sicknesses and to increase life quality.

Our recommendations are based on a proposed set of specific guiding principles for reform of social policies in economies undergoing post-socialist transition, further applied to the health sectors of Eastern Europe. Our main point is the ethical challenge of promoting individual choice and sovereignty while assuring social solidarity.

Guiding Principles	***Recommendations***
Sovereignty of the individual (choice)[63]	Sovereignty of the patient's choice of provider (at least for primary care); choice of insurer for individual supplementary and later for basic care; mechanisms for patient appeals and complaints; etc.
Solidarity[64]	Risk pooling at broadest level for basic care; risk

[63] The transformation promoted must increase the scope for the individual and reduce the scope for the government to decide in the sphere of social services.

	adjustment of payments to insurers and providers to assure risk solidarity, with complementary policies (mixed payment, high-risk pooling); etc.
Competition[65]	Evolutionary development of private sector in delivery and financing, including entry and some privatization; managed competition among insurers for supplementary care and later for integrated packages of basic and supplementary care; etc.
Transparency[66]	Public involvement in process for prioritizing public financing and defining and updating the basic benefit package; formal demand-side cost sharing rather than gratuity payments; etc.
A new government role[67]	A new role in order to finance government basic care for all citizens; develop institutions for prioritizing public financing and delineating basic benefit package; license providers; quality assurance, etc.

Table no. 2 Guiding Principles for Reform

Usually, the shaping of a system is realized in time, being both difficult and expensive. Health, as a determinant element of a democratic society, has to be ensured considering the following important facts:

- the recognition of the predominant role of health within the making of material production and services;
- the control and permanent balance of health costs, in order not to negatively affect the economic prosperity;
- in transition periods, specific indicators confirm an increased damage of health, i.e.:

1. increased lack of medicines and consumable sanitary materials;
2. preventive services are absent or inefficient;
3. the formation and allocation of the sanitary staff is inadequate.

- financing is inconsequentially supplied, on an inflationist ruling fund;
- the development of an uncontrolled private market.

The main objectives of reform for the health care system in Europe are: allocation balance of financial resources and cost control; the reduction in demand inequities and services' accessibility; the reduction of inadequate usage of modern technologies; the correction of inadequate stimulation of medical consuming; introducing the controlled competition, between the public and private suppliers, the insurance organizations, etc; separating the service suppliers (doctors, hospitals) from the service buyers; the payment of doctors and institutions based on performance criteria; introducing modern managerial methods in health services management and decentralization of the health care system through deconcentration and authorities' delegation.

Furthermore, priorities in health care system reforms for Central and East Europe are:

- to decentralize the health care system;
- to modify the administration and planning methods;

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[64] Help the suffering, the troubled and the disadvantaged.
[65] Competition among various ownership forms and coordination mechanisms.
[66] The link between social services provided by the government and the tax burden that finances them must become apparent to citizens
[67] The main functions of the government in the social services sector must be to supply legal frameworks, supervise private institutions, and provide 'ultimate,' last-resort insurance and aid. The government is responsible for ensuring that every citizen has access to basic education and basic health care.

- to maintain large accessibilities;
- the development of communitarian health services;
- the development of preventive services based on risks factors;
- Improvement of health staff's forming system.

Health System Reform in Romania

The health system reform in Romania depends on the economic system reform, on its transformation through property decentralization, the consolidation and the development of private property, as resource and spinning center.

The health reform strategy in Romania focused on the following domains :

- structural organization and system management;
- system financing;
- assuring the necessary health services for population;
- reasonable usage of human and physical resources.

The strategic objectives regarding the configuration and functionality of health services on a long term are:

- the creation of a hued and performing system (ambulatory integrated caring, day-hospitalization, diagnostics and treatment services improvement;
- the extension of primary assistance services (home care assistance, within ambulatory medicines, creating multifunctional health centers);
- suitable, sustainable and stimulating performance financing ,
- shutting down the low performing medical units;
- perfecting operational management systems;
- realizing a compatible normative frame with institutional and functional reforms;
- facilitating private financed systems of medical services
- setting up and improving the insurance for pensioners within specialized units of daily care.

By achieving the up-mentioned objectives, we foresee the perfecting redefinition of the medical units, the improved local access of the community to primary assistance integrated services, financial support, quality assurance, the development of investments, the decentralization and faster supply of health services.

To conclude, the following aspects have to be approached and solved:

- the set up of databases and the improvement of information flow and distribution within a local, regional and national system;
- the standardization of coding and implementation of the national data register;
- the development of primary and ambulatory care, through the lease of medical cabinets towards doctors;
- the finalization of the extern financing programs;
- the extension of the integrated ambulatory services;
- the operation of multifunctional health centers, the standardization of the finance methods, the hiring and usage of the medical staff;
- the implementation and improvement of regional resource allocation;
- the founding of a national organism for monitoring the health services' quality, by using a minimal set of unitary indicators;
- the implementation of improved information management systems, based on performance parameters;
- the providing of health services through stimulated public-private partnerships.

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