Chapter 14 Lessons from two decades of health reforms in South East Europe

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What lessons can be drawn from two decades of health reforms in South East Europe? While countries of the region exhibit many substantial differences, it is intriguing that, in embarking on reforms of their health sectors, they responded to many of the same challenges. These included a challenging socio-economic context in the first years of transition, widespread dissatisfaction with the health systems inherited from the communist or socialist period, and, in many countries, the poor health of the population in the 1990s. Increasingly, the ageing of populations is also becoming a concern for health policy-makers.

Reform objectives and trends were also broadly similar, often aiming to overcome the inefficiencies of the previous systems. Major changes involved the introduction of social health insurance systems in those countries that had relied mainly on taxation (Albania, Bulgaria and Romania) and, at least formally, an increased emphasis on primary health care. In most countries of the region, there was also an increase in both formal and informal out-of-pocket payments (Rechel and McKee 2009). Decentralization was another common trend, although in several countries of the former Yugoslavia this was preceded by a period of centralization.

The growing role of the private sector was another red thread throughout most countries of the region, moving away from the almost exclusive public provision of health services in the previous period. This was initially confined to the privatization of pharmaceutical and dental care, but then expanded in a number of countries to primary health care, with GPs becoming

self-employed health care contractors. However, degrees of privatization differ across countries, with most GPs in Croatia still working in the public sector. Private hospitals have also emerged, often with better equipment, higher salaries and more qualified health workers.

Another common change was the introduction of a purchaser-provider split, with contracts being concluded between newly established health insurance bodies and both public and private providers. This introduced market or quasi-market conditions and some degree of competition between providers. While the hoped-for effects of this major change did not always materialize, the example of the national tender in Slovenia shows that, when the rules of the games were appropriately drawn up, competition led to efficiency savings.

Payment mechanisms for health services also underwent broadly similar reforms. Payment of primary health care was changed to being based on capitation, thus becoming dependent on the number of patients registered with primary care physicians. However, capitation payment as such, meant to facilitate competition between physicians, does not depend on the volume or quality of the services they provide. It provides no incentive to treat patients, can give rise to unnecessary referrals and physicians may aim for selective registration of patients on their lists, giving preference to young and healthy persons who are less likely to use primary health care services. Other problems that emerged in some countries of the region were a decline in home visits and preventive check-ups, and lacking capacity to offer services for emergencies out of normal office hours (Mastilica and Chen 1998; Vladescu et al., 2008a). Recognizing the perverse incentives that can result from capitation payments, a number of European countries have opted for a combined payment system for primary health care, comprising a combination of capitation fee, fee-for-service, and payments for implementation of certain programmes, as well as various forms of performance-based payments and payments for further professional training and scientific research. Several

countries in South East Europe have revised their payment systems for primary health care and adopted such combined payment systems, with payment for service reaching 50% in Montenegro. A particular challenge will be to revise payment systems for primary health care to provide incentives to improve quality and performance. Another problem noted by contributors to this volume was that primary health care reforms were sometimes undermined by a lack of simultaneous reforms in other parts of the health system.

Reforms in the hospital sector have typically involved attempts to reduce over-dimensioned hospital infrastructures and improve efficiency. Public hospitals have remained in public hands, but in several countries of the region, such as Bulgaria, Croatia and Romania, the ownership was shifted to the regional level. Hospitals also gained more autonomy and, in Bulgaria, became for-profit organizations. However, major question marks remain over the efficiency and effectiveness of hospital care in the region. Hospital performance measurement and analysis are still at an early stage of development and there has been a major backlog of investment in infrastructure and technologies. Hospital infrastructure developments that aim to increase operational efficiency, such as those in Serbia, are few and far between. Instead, private hospitals have emerged. In Macedonia, this has resulted in two-tiered hospital system, with more modern and better equipped private hospitals that are recruiting highly skilled professionals and a growing number of patients, and gloomy prospects for the public sector, unless the country decides on comprehensive reforms of its public hospitals. New payment mechanisms for hospital services have been another common trend in the region, aiming to move from paying inputs and structures to paying outputs. However, debt is a major problem for public hospitals in several countries of the region.

Despite these common trends, however, there was a considerable diversity of reform efforts and trajectories across countries. One major reason for this was the broader political context

of the country in question, which included different exposures to the violent disintegration of the former Yugoslavia. The political make-up of Bosnia and Herzegovina resulting from the Dayton peace agreement, for example, had major consequences for the administrative make-up of the health system and the efficiency with which it can operate (Cain et al. 2002; Deets 2006). Health system developments in Kosovo, now under UNMIK administration, have been shaped by international policy advisors from the World Health Organization and the World Bank. In Macedonia, the politicization of Macedonia's health system following the Ohrid framework agreement has made reforms of the hospital sector particularly challenging, as the appointment of hospital managers has remained linked to the political party affiliation of potential candidates. The political isolation of what was then Serbia and Montenegro in the 1990s has resulted in a delay of health reforms in these countries. Frequently changing governments and ministers of health were another factor of relevance to the initiation and continuity of health reforms in several countries of the region.

Reforms of primary health care, which was often the first segment of the health system that underwent substantial reforms, have taken on different forms. Several countries of the region, including Bulgaria, Croatia, Macedonia, Romania and Slovenia, have to various degrees moved from the previous organizational model (health centres or polyclinics staffed with specialists) to single private practices run by general practitioners (GPs). However, this trend was at odds with trends in many countries in Western Europe that moved towards group practices providing community-based primary care. In Serbia, the decision was taken to retain the prevailing primary health care model, consisting of health stations (small, local outpatient centres staffed with a general practice team, emergency medicine physicians, and a paediatrician) and 'ambulantas' (small, local health posts, staffed either with a general practitioner and nurse, or with a nurse only, supported by a visiting doctor once or twice per week). A similar model has been chosen in Montenegro, where primary health care is provided by chosen medical practitioners working in group practices and community health

centres acting as reference centres for primary health care. Primary health care centres are also still in operation in Bosnia and Herzegovina, Croatia, Macedonia and Slovenia, but they have to various degrees been replaced by private practices.

While the decision to retain the previous system in Serbia was not only taken due to the objective merits of the previous system of primary health care, but also due to the resistance of health professionals and concerns about high levels of unemployment among medical specialists, they suggest that a more careful approach to reforms and policy transfers was sometimes warranted. Doubts have in particular been raised as to whether the polyclinic model inherited by the communist countries behind the iron curtain or the model of community health centres bequeathed to the Yugoslav successor states was really as ineffective as suggested by foreign advisors in the 1990s (Rechel and McKee 2009; Rechel and McKee 2008). The emergence of family doctors working in single practice resulted in the failure to pool resources and problems in providing on-call services out of regular office hours.

This raises the question of who was driving the health reforms in the region and on which evidence (if any) they were based. External donors were of major importance in determining the agenda of primary health care reforms, with a particularly prominent role of the World Bank, although other external actors were relevant too, such as the World Health Organization or the European Union. However, the reforms they were advocating did not always have a firm evidence base and it was observed with regard to health reforms throughout Central and Eastern Europe that they were often driven more by political pressures and ideology than by research evidence on the effectiveness of different approaches, and few reform initiatives have been the subject of robust evaluations (Rechel and McKee 2009).

Question marks have for example been raised about how appropriate the widespread (re-)introduction of social health insurance was and whether it would have been better to switch to or retain a model based on general taxation and universal population coverage. Only Kosovo has moved in this direction, in part because of the large size of its informal economy, making it difficult to raise contributions from employers and employees (there is also no income tax for this reason). Social health insurance is increasingly seen as being inappropriate to transition countries with ageing populations and large informal sectors. In Croatia for example, the revenue base for the social health insurance system has been narrow, due to the low employment rate, and the Health Insurance Fund has until recently been in constant deficit. High rates of payroll tax have placed an additional cost on labour, reducing the willingness of employers to hire. The high contribution rates also encouraged employers to operate in the informal economy. There are also equity concerns, as the burden of payment is heaviest on those in formal employment, although taxation-based financing also faces the problem of raising revenue in economies with large informal sectors. In Croatia, one emphasis of reforms has been on reducing the range of benefits covered by health insurance, through for example reducing the range of exemptions and raising the proportion of revenues obtained from non-public sources such as patient co-payments. This has been criticized as a creeping privatization of health financing (Voncina, Kehler et al. 2010), although it is worth noting that private expenditure constituted only 15.1 per cent of total health expenditure in Croatia in 2009 (WHO 2011a). Nevertheless, critics argue that less attention has been given to improving the efficiency and effectiveness of services provided at both primary and secondary level, which they believe would have allowed to offer a wider scope of services, even in an environment of financial stringency. A study of the effects of introducing social health insurance in 28 transition countries in 1990-2004 carried out by Wagstaff and Moreno-Serra (2009) found that social health insurance typically increased the costs of providing health services, with no evidence of improvements in

quality. The increase in costs appears to be associated with higher salaries of medical practitioners, the administrative and transaction costs associated with administering individual insurance accounts, and the costs of contracting the provider organizations. No improvements in amenable morbidity and mortality were discovered that could be attributed to the introduction of social health insurance, although there was typically a decrease in average hospital length of stay, increased bed occupancy rates and an increased rate of hospital admissions. A major reason for the failure of social health insurance systems in transition countries were the gaps in population coverage, such as those affecting the Roma minority, leading to a greater incidence of cases in which patients had not attended primary health care until their illness had progressed to a later stage, requiring avoidable (and more costly) hospitalization. There is also anecdotal evidence that formal sector workers avoid signing up for health insurance until they become ill (Wagstaff and Moreno-Serra 2009). As pointed out in the contributions to this volume, despite its compulsory nature, nearly 1.2 million people were not insured in Bulgaria in 2010, although there are also positive examples, like from Slovenia, which has a very high coverage of the population with health insurance.

Despite more than two decades of reforms, many aspects of health system performance remain problematic. One of the main goals of health systems – and one of the main objectives for health reforms in South East Europe – is to improve population health. Trends in life expectancy in the region are encouraging, but it remains unclear how far these trends are due to improvements in the performance of health systems. Indeed, several contributions to this volume have highlighted that health systems have failed to respond adequately to the specific health needs of populations. Despite improvements in population health, there seems to be huge scope for further health system interventions, in particular with regard to non-communicable diseases, including the treatment of hypertension and stroke, anti-tobacco policies, and the promotion of healthy lifestyles. These conclusions were

confirmed by a recent analysis of mortality amenable to health care in Romania, which found that rates have only fallen slowly between 1996 and 2008 and that there is much scope for further improvements (Karanikolos and McKee 2011). There are also major health inequalities between different population groups, reflecting socioeconomic differences (Buzeti et al. 2011), but also a divide between rural and urban areas, and the discrimination and social exclusion of the Roma (Bogdanović et al. 2011; Kohler and Preston 2011; Masseria et al. 2010).

Financial protection and equity in financing are another challenge for the performance of health systems in the region. As mentioned above, the breadth of coverage of health insurance schemes in some countries of the region is limited, particularly affecting vulnerable groups of the population, such as the Roma (Atanasova, Pavlova et al. 2011). Private out-of-pocket payments for health services (including both formal co-payments and user fees, and informal, under-the-counter payments) are widespread (Holt 2010; Tomini et al. 2011); they tend to be highly regressive, with a larger relative burden on poorer households. Considering the composition of health expenditure, it is striking that in several countries of the region private expenditure constituted a major share of total health expenditure in 2009, reaching 59.1 per cent in Albania, 38.7 per cent in Bosnia and Herzegovina, and 39.3 per cent in Bulgaria (WHO 2011a). This underlines problems in financial protection, as households are exposed to the risk of catastrophic health expenditure.

Equity of access to health services is another major problem. Patients throughout the region are confronted with a divide between urban and rural areas, with a concentration of health facilities and professionals in the respective capitals and urban areas and a shortage of them in rural areas. In Romania, for example, a number of policy initiatives aimed at improving health service provision in rural areas were unsuccessful, partly because financial incentives

were not sufficient to retain physicians in isolated rural areas. This leaves the country's rural areas particularly exposed to the brain drain of health professionals (Dragomiristeanu et al. 2008) and many rural localities have no family doctors (Pertache and Ursuleanu 2006). Apart from divisions between urban and rural populations, vulnerable groups, such as the Roma, face additional barriers in accessing health services (Rechel et al. 2009). Many health professionals are seeking greener pastures abroad, in particular when they are now part of the European Union. This creates additional pressures for health systems in South East Europe, as they struggle to retain the health professionals they have trained. It will be essential for them to improve systems of human resource planning and management, as well as to create systems of incentives for health professionals to remain in their countries of origin, such as through improved salaries and working conditions.

While health reforms were often concerned with securing the financing of health systems and containing costs, less attention was paid to the quality of services health systems deliver (Rechel et al. 2010). Yet, in a number of countries, such as Macedonia, the poor quality of care, in particular in the public sector, has been a major concern and led to the growth of a poorly regulated private sector. In a 2009 Eurobarometer survey, 74% of respondents in Bulgaria rated health care provision as 'bad' (European Commission, 2010). Negative views were also common about the promptness and efficiency of services, access to specialized medical care, care for patients with chronic diseases, and timely prophylaxis. There are, however, signs of progress. In Serbia, a continuous quality improvement initiative has introduced a systematic monitoring of quality indicators in primary health care. In Slovenia, the national tender for prospective programmes could be used not only as a tool to reduce costs, but also to introduce quality indicators.

Allocative efficiency, i.e. the extent to which health funds are used for purchasing an appropriate mix of health services, is another area of health system performance where

improvements can be made. The countries of the region have tried to move away from the oversized hospital systems of the past, embracing a new focus on primary health care, but hospitals continue to dominate health service provision and financing. Many services which could be provided in primary health care settings are still provided in hospitals, such as for high blood pressure and back pain (Vladescu et al., 2008b; Holt 2010). In 2008, Bulgaria and Romania ranked highest within the EU in terms of the share of total health expenditure spent on inpatient curative care (39% and 37% respectively), and only 16% of total funds were spent in Romania on out-patient care, compared to an EU average of 30% (OECD, 2010). These imbalances are also reflected in terms of human resources, with a continued tendency towards specialization among physicians. In most countries of the region, the ratio of general practitioners (GPs) per population is lower than the EU average and the ratio of specialists higher (WHO 2011b).

Finally, public participation and involvement was found to be inadequate in almost all countries of the region. While democracy was one of the aims of broader reforms in the region, there is still a long way to go to improve the accountability and transparency of health systems in the region and their responsiveness to the needs and expectations of populations. The introduction of the free choice of providers, with patients being able to register with a GP of their choice, was a common element of reforms, but the public was not involved in health policy decisions and reform aims and processes were poorly communicated to the public. Changes were introduced in a top-down manner, often without prior piloting or consultation. Furthermore, health systems are rarely evaluated from the user perspective. Initially it seemed that the public were enthusiastic for reforms, especially in the countries of the formerly centrally planned economies which were keen for change (Balabanova and McKee 2004). However, this support soon evaporated and a nationally representative survey in 2010 in Bulgaria found that 76% of respondents were dissatisfied with the health system and 91% thought that further health reform were needed (MBMD,

2010). Critical views on the reform process were also recorded in Croatia (Mastilica and Chen 1998; Mastilica and Babic-Bosanac 2002). Since the health reforms – faced with a challenging fiscal climate and declining government revenue – often restricted the scope of health services free at the point of use, these findings may not be entirely surprising.

Health professionals were also resistant against reforms (Scott, Powles et al. 2011) and emerged as a powerful interest group in several of the former Yugoslav countries. In Serbia, a strong lobby of primary health care paediatricians and gynaecologists were successful in preventing primary health care reforms introducing the concept of family medicine, despite the involvement of significant donor funds and the recommendations of external agencies (Simic, Milicevic et al. 2010). In Macedonia, resistance from health professionals achieved that the capitation system was applied only to physicians working in the private sector, replacing their previous fee-for-service contracts (World Bank 2003).

With the global plunge into economic crisis which began to affect the region in 2008, the period of strong economic growth between 2000 and 2007 has come to an end, unemployment and poverty have started to rise again in several countries of the region (World Bank 2011), and it can be expected that there will be adverse effects on health systems and the health of the population. As governments seek to reign in budget deficits and restrict public expenditure on health services, it is more important than ever that the countries of the region improve the effectiveness and efficiency of their health systems. In the wake of the global economic crisis the need for governments to ‘do more with less’ has become ever more urgent, underlining the challenge of improving the quality of health services, reducing costs, and ensuring equity and accessibility.

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