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## Volume 3 / Issue 5 / 2008 - Country Focus: Eastern Europe

### Healthcare in Eastern Europe

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#### A Multi-Speed, Multi-Dimensional Matrix of Change

Though generally behind their counterparts in central Europe (the Country Focus in our previous issue), significant developments are also underway in the healthcare systems in eastern Europe (Bulgaria, Lithuania, Romania, Serbia and Ukraine). As in central Europe, a major driver is the impact of transition from the Communist systems inherited by each country and the priority given to health care by national governments.

In principle, most countries in the region have transitioned from an era of 'free' care to one modelled on the mixed, social insurance systems of their counterparts in western Europe. Membership in the European Union by Bulgaria, Lithuania and Romania has clearly helped, and is likely to stretch the gap vis-à-vis the other two, Serbia and Ukraine.

Nevertheless, many challenges remain to be overcome by all five countries – not least that of access to financing resources from a relatively weak economic base.

The growth of private hospitals and practices is relatively slow (and in Ukraine's case, non-existent). This, in turn, has impacted downstream on engendering efficiency in healthcare financing – although many countries have begun assessing DRG-like schemes. Ironically, partial transformation of the healthcare delivery system has, in some cases, led to a spike in in-patient admissions.

Given below is an overview of the healthcare system in each of the five eastern European countries.

#### Bulgaria

Bulgaria witnessed dramatic changes to its health care system over a very brief period of time in the late 1990s, and then followup efforts to fine tune the first burst to later realities.

Like other transitional countries in the region, the passage of a new Health Insurance Act in 1998 set the legal basis for both compulsory and voluntary health insurance in Bulgaria.

The new system was financed by payroll contributions (6% of monthly wages, shared in a 1-4 ratio between the employee and employer – with a target 50-50 split by 2009). Meanwhile, the role of the State (at both federal and local government levels) was circumscribed to coverage of retired citizens and lower-income groups.

In tandem, a National Framework Contract laid down a basic benefits package.

Structurally, the key goal of the reforms has been to separate healthcare financing from provision. 28 regional insurance funds currently reimburse both public and private facilities on a contractual basis.

Seven years before the Health Insurance Act, the government had already moved to legalize private practice in the healthcare area (labs, clinics, surgeries and pharmacies), and begun to reorganize government health facilities.

Physician practice groups, diagnostic centres, pathology laboratories were established or transformed into companies and cooperatives, including joint ventures with State entities.

At present, hospitals in Bulgaria are divided into specialized or general/multidisciplinary facilities. National hospitals, though Stateowned, have

been corporatized. Regional and inter-regional hospitals are joint ventures between the State and local governments. Local hospitals are owned by the municipalities where they are located.

Financial restructuring in Bulgaria was backed up by reforming the payments system for hospital providers and the launch of a DRG-like scheme based on performance and case payments. Accompanying this was an overhaul of the primary care system with GPs progressively designated as gatekeepers for access to specialized care.

Reflecting the separation of healthcare financing from provision, reforms in the hospital funding system have been designed to bring about competition between health care providers, and increase both choice for patients as well as quality of services.

Though near-universal, the system is still some way from achieving the 'free' status of its counterparts in northern and southern/ western Europe. Co-payments continue to be required for the basic benefits package: at 1% of the minimum monthly salary per out-patient visit and twice this level per day of hospitalization, up to a maximum of 10 bed-days a year.

In the period to 2012, one of the government's principal priorities is to set up and implement a quality/accreditation scheme for players in the healthcare sector. This is clearly an area where healthcare IT will play a central role.

### **Lithuania**

Lithuania's healthcare system attained a watershed in 1996, when legal changes saw the country move away definitively from its historical centralized, integrated delivery system towards a contract-based model.

Two major changes have accompanied this process: the emergence of third-party payments in the shape of a Statutory Health Insurance Fund (SHIF), alongside legislation redefining the status of health care institutions and private property rights.

Tentative steps towards statutory health insurance date back to the 1991-1995 period, when the scheme was limited to pharmaceuticals and spa care (partly reimbursed through a general social insurance scheme, administered by SODRA, the State Social Insurance Agency, and supervised by representatives of the Government, trade unions and employers.

In 1992, the government established a State Sickness Fund under the Ministry of Health, with the role of financing recurrent costs of healthcare facilities on the basis of prospective payment contracts. In 1997, SODRA's responsibilities were transferred to SHIF.

Currently, the majority of Lithuanian health care institutions are non-profit-making enterprises.

The federal Health Ministry provides overall supervision of the Lithuanian health care system, via laws and regulations, and shares control of two major Lithuanian university hospitals at Vilnius, and the Kaunas Medical University (with a highly regarded telemedicine center).

The country's 10 counties and 56 municipalities are responsible, respectively, for implementation of the state health programmes in their regions and providing primary health care.

To encourage competition, Lithuania's citizens are free to choose hospital providers, primary health care institutions and physicians (within a selected institution).

Public health care institutions are financed by SHIF, while ownership and operational responsibility lies within the jurisdiction of the Ministry of Health (shared with the counties and municipalities).

Counties have ownership of nursing homes and outpatient facilities (with progressive separation of polyclinics and ambulatory services from hospitals), while municipalities are principally responsible for operating smaller hospitals within their territories.

Lithuania has about 150 polyclinics. These employ a wide range of specialist physicians- equipped with a full range of diagnostic devices, and providing a full spectrum of primary and secondary outpatient care in the towns where they are based, and outreach/referral facilities for the rural population.

In recent years, outpatient surgery (principally revolving door minimally invasive interventions) have begun to be increasingly carried out by polyclinics.

The country also has about 200-plus ambulatory services. These are essentially group practices in small towns, and provide unspecialized primary care centred on a general practitioner and/or an internist, a midwife and a paediatrician. The budding private healthcare sector in Lithuania mainly provides out-patient services. These are largely (though not wholly) paid out-of-pocket.

## **Romania**

Since the 1989 Revolution, Romania's centralized, tax-funded Semashko healthcare system has been drastically overhauled in an unremitting series of reforms. This has led to tangible improvements across the entire spectrum of healthcare delivery.

Healthcare financing is now based on a mandatory social health insurance system, covering the entire population. This is organized under 42 District Health Insurance Funds as well as two funds for government employees.

The Funds contract, on the one side, with purchasers (employers and employees), and on the other with providers.

Hospitals are organized at the regional, district and municipal levels, with specialized units (clinics and some dedicated teaching and other hospitals) providing tertiary care.

At present, a combination of budgetary allocations (determined by Parliament) and fee-for-service arrangements cover the delivery of primary care services – principally via family physicians under contract with the Funds. Specialists providing ambulatory treatment as well as home care are almost wholly funded by fee for service.

Acute care hospitals are financed by a mix of budgets and fee for service, with tertiary care provided in specialized units (hospitals or institutes as well as dedicated centres in acute care facilities). Long-term care for chronic patients is delivered, among others by "medico-social" facilities and sanatoria, and is financed principally via the State budget.

There are some moves to implement diagnostic- related group (DRG) systems in the Romanian hospital system. The key motive is to reduce a high rate of in-patient admissions a result of an incomplete transformation of primary and ambulatory care, as well as a fragmentation of service delivery.

Over the past decade, the foundational Health Insurance Law of 1997 has been adapted to changes in the economic environment, mainly to continue whittling down the financing powers and responsibilities of the Ministry of Public Health.

A new legislative reform package in 2006 increased decentralization further, along with a boost to preventive care and a guaranteed minimum service package (covering drugs, medical devices, hospital/clinic services and emergency care). It also offered Romanians the possibility of obtaining private insurance to supplement the mandatory scheme.

Overall, the Romanian healthcare system currently incorporates a northern European style redistribution of funds from wealthier districts to poorer ones, along with free choice of providers by patients.

Nevertheless, the system remains in a state of transition. Out-of-pocket payment levels remain significant (for services beyond the statutory minimum package) and taxes continue to account for about one-sixth of health spending, principally capital spending by hospitals.

The overall health status in the country also remains below the European average, with life expectancy of 73 years as against 79, and – in spite of reductions - a persisting high rate of both infant and maternal mortality (about 14 and 15.5 per 100,000 births, respectively).

## **Serbia**

After years of upheaval, Serbia is systematically rebuilding a stressed and severely underfunded healthcare system. Although the country's healthcare professionals are trained to global standards, outdated equipment and infrastructure has impacted in a major manner on the quality of healthcare service delivery.

In 2002, a European Agency for Reconstruction study found 75% of the medical equipment in health facilities more than 10 years old. In addition, only one third of hospitals had operational sterilisers.

Health centres in Serbia are classified either as major hospitals (domovi zdravlja) or clinics (zdravstvene stanice), and exist in all major towns and cities. Patients are admitted to hospital either through the emergency department or via a GP referral.

Treatment is assigned to a hospital doctor. In spite of the HIF health fund (see below), drugs and basic medical supplies are obtained on payment from privately owned pharmacies. Hospitals too often require cash payments.

Serbia allows citizens to register with a doctor of their choice. However, they are charged a fee for each visit. GPs act as gatekeepers, making referrals to specialists, as well as prescribing drugs and providing preventive care.

The country's Health Insurance Fund (HIF) operates its health service. Its aim is to provide equitable access for all citizens, regardless of economic circumstances.

However, given the political pains of the past decade, quality healthcare is the exception rather than the rule. Nevertheless, the HIF seeks to cover core medical services including prescriptions, hospitalization, treatment by specialists, maternity and rehabilitation. Private healthcare is also available for those who can afford it.

Employers must register their employees with the HIF. Depending on income levels, both employers and employees make contributions, as do the self employed. The federal budget covers pensioners, unemployed and people on long-term sickness benefit.

In spite of all these challenges, many health indicators have remained steady during the 1990s, as reported in February 2007 by Britain's The Lancet. The article was based on an interview with Snezana Simic, who was then just resigning from her position as acting Minister of Health for four years. Ms. Simic was both sanguine and optimistic in her outlook.

The goal of reforms, she told The Lancet, was to "build on the good points of the old system"- in particular primary care networks. In addition, investments were being made to improve morale, with salaries hiked by 40% and buildings refurbished and re-equipped.

Such efforts are accompanied by a new patient-centred focus', with a higher profile role for healthcare IT, in monitoring indicators such as hospital mortality rates, mean lengths of stay, and utilization of health services.

Eventually, the aim is to link hospital payments to performance (in terms of patient throughputs and quality of services).

## **Ukraine**

Ukraine's independence from the former Soviet Union was followed by a massive healthcare crisis, with life expectancy dropping by almost 4.5 years (males) and 2.5 years (females) in the 1990-1995 period.

The government nevertheless persisted in seeking to reform the health care sector. Its goals were twofold, to improve structural efficiency - principally by means of decentralization, as well as standardization of healthcare technologies, alongside accrediting hospitals.

Along with, it sought to mobilise private funds for healthcare delivery; this largely consisted of attacking over-capacity in certain specialties and regions, while whittling down the scope of 'free' care. In 1996, 'user charges' were formally introduced for the first time to cover healthcare services.

Politics have, however, clouded the outlook. A social health insurance law has been on the Parliamentary agenda for many years, but, in spite of a succession of changes to accommodate a variety of vested interests, it has not made any meaningful headway was finally rejected in September 2003; a fourth reading originally considered for May 2004 has now also been withdrawn.

Formally, Ukraine's health care system is supervised by the Ministry of Health. However, the bulk of delivery is through hospitals and clinics owned and run by regional authorities or municipalities, with a mix of federal and locally-raised financing (in an overall ratio of roughly 20-80%).

Budget allocations are made on the basis of bed capacity and patient throughputs and strictly regulated. Given the chronic financial shortfalls, they are also prioritized beginning with staff salaries, followed by drugs and equipment.

Nevertheless, the capacity/patient throughput- based payment system encourages clinics and hospitals to increase the number of consultations and in-patient admissions, and militates against raising the efficiency of the system.

In effect, the basic principles of the old system still underline the new. Both cutbacks and growth in capacity have been uneven and inefficient.

The State guarantee of universal, unlimited access to free health care also remains, in spite of a huge swell in waiting lists and sub-optimal outpatient and tertiary care.

In addition, official salaries for many categories of healthcare staff have, for years, been below subsistence levels, and unofficial payments have become routine.

The bulk of the financial slack, not unexpectedly, is still taken up by out-of-pocket payments, and for items ranging from syringes to food and beds, full upfront payments are required. Overall, private payments now account for an estimated 50% of total health spending.

There is, nevertheless, a small presence of private facilities. These are however focused for now on dentistry, sexually transmitted diseases and drug/alcohol dependency.

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