

# New Medical Management Trends and Policies throughout Central and Eastern Europe

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## **Abstract**

*Most east-European countries in post-communist era were obligated to adopt a new medical care system, a system based upon policlinics and other medical care institutions that would have provided special extensive health services, from the first level contact. All countries in East and Central Europe have expressed their wish to totally change their health system. The changes in these countries are as it is:*

- *introducing market economy mechanisms in the health system;*
- *concentrating intensively over population's health needs when planning the system base, and finally,*
- *making possible the introduction of a more general care health system from the first contact.*

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## **Medical politics**

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- -making possible the introduction of a more general care health system from the first contact.

Patients expectations to the access, to the choosing and to the utilities are important factors into producing a success model of healthcare system, and choosing the right time is the essential key to have the success in reforming. The beginning of the 90's was the time when few social interests groups have speculated the changes in the medical care system. Later, in 1999 and after, the

reforms have changed the initial plans and new elements were introduced in The National Healthcare System, such as:

- A list of patients for the general practitioner;
- Personal (pecuniary) contribution to the treatment;
- The patients registration.

The reform for general practitioners has two principal objectives:

- Introducing general practice as a one-self specialty in the healthcare system;
- Modifying the remuneration way for first contact level doctors.

The specific tasks are:

- To offer the opportunity to the general practitioners to work and get the experience as specialist in the primary care;
- To create a general data base for the population to the general practitioner;
- To offer the possibility to the general practitioners to be an independent services contractor through a partial registration.

At the end of the 90's, in Eastern and Central Europe had been performing profound changes, encompassing political and economical transformations, making way to modifications in the social system, which also lead to changes in healthcare system. In these countries the option was not between reforming the health system and preserving the status quo. The real problem was either the politicians would accept the change to be randomly, or, to be guided through a national reform program. The main problems in reforming the healthcare system were as it is:

- ✓ The complexity of alternative strategies, compared with a closed system elaborated and guided by the central government.
- ✓ The lack of a universal model of reforms.
- ✓ The possible opposition from certain groups of interests.
- ✓ Keeping functional the whole health system, during the long reforming process.

Estonia was one of the first east-European countries who had reformed her national health system. During her first independent period (1918-1940), Estonia had a traditional personal medical practitioners system. Under the Soviet regime, this system was abolished, so it could fit with the hierarchical system Semashko, a health system controlled from the Center, in which the primary care was provided by different specialists working in polyclinics. Nevertheless, in village areas, there were general practitioners and district pediatricians working to provide medical services as a primary care. After reestablishing her independency through international recognition in 1991, Estonia carried out the new health system and medical training, a shift started just few years earlier and now was gathering more and more ground.

The object of this comparison was to describe and dissect the Estonian reforming process of health care system, regard our country, emphasizing the following features:

- The key-contextual factors that generate the reform;

- The reform it-self and its objectives;
- The process through which the reform is accomplished.

In planning the healthcare system, the ever-growing costs are the main factor, which all nations are confronting. In the majority of the cases, the cost is influenced by:

- ❖ New technological progress in diseases diagnose and treatment.
- ❖ The growing population's mean life expectancy.
- ❖ The growing burden of chronic diseases.
- ❖ The reaction of a more health services consuming population, a population better informed and more exigent and interested about their quality.

Simultaneously, the trends to privatization and the well-known effects of economic globalization, are, at their turn, factors which affect the offer and costs of health services.

At the beginning of the 90's, the conditions in Romanian society were in favor of change. The primary care practitioners had the opportunity to found their specialty as an independent-one in the system, and the other specialists had the aim to offer better conditions to practice their quality work. The politicians have tried to better control the growing prices of health services, being attracted, the same time, by this novelty. One also knows that, the main factor for a successful change is finding the right timing to make it. Otherwise, during a great social and political transformations period, radical shifts may bring unpleasant and, most frequently, unwanted effects.

During the 70's and the 80's, had progressively appeared agape between East- and West-Europe health state indicators, a difference generated mainly by the growing number of premature deaths in eastern European countries and their impotent health systems to handle it. At the end of the 80's and the beginning of the 90's, a unique historical timing driven by the profound social transformations, a new opportunity came out for the eastern and central-European countries to perform the reform in their national health care systems. As for the people concern, they expressed their dissatisfactions, such as:

- The lack of equity accessing the medical services.
- The limited freedom of option.
- The discontinuity in caring services.
- The continuing degradation of health state.
- (occasionally) the lower standard of health care services.
- The ignoring of patient's rights, the main population keeping the perception of the old system – with its well-known deprivations.

Thus, the patients expectations about the access, choosing and possibility to the care guided as essential factors to elaborate new models of furnishing medical services, promoting the growth of a more reasonable and organized medical care system.

The government supported in a limited way the opportunity to control the growing prices for medical care services, being at the same time attracted by the

new original model of general practitioners function. In order to go beyond the disadvantages of the old system, the Ministry of Health had expressed a more generous purpose of its medical politics, those intended to further apply, having in view the improvement of the entire population's health, by elaborating a core of primary care services that would strengthen the health promotion and protection and diseases prevention. In 1997 the development of general care was seen by the ministry of Health as the immediately next step after the founding of a compulsory health insurance system.

The physicians who had previously experimented a strict controlled medical system, have gained, after the Revolution, more freedom, preserving their professional standards, but also have expressed major dissatisfactions as:

- The low level of incomes;
- The low social recognition;
- The inequity about patients access to medical services and utilities;
- A proper professional training and education.

It has been well supported the idea about remunerating the general practitioners in the *per capita* way, because:

- This might bring a more efficient paying model for medical services.
- This might lower the administrative bills.
- This might generate a more stable financial field for the health services supplier.
- This might facilitate a progressive improvement for population's access and equity to medical services.

There are many models to calculate *per capita*, the difference between them consisting in the way they are in real life applied. For example:

- The fee for general physician's medical care.
- Letting the general practitioner to appoint another specialist to take care of the patient and therefore to pay him.
- Allowing the general practitioner to pay the admitting into a hospital.
- Supplementary bills for prevention services.

Because the doctors from the old system were not used to be in the middle of the financial risk, it has been chosen the most common way to pay *per capita*, a financial source which would pay for other specific bills too, like laboratory findings and specialist exams.

So, the sparkling force for politics and reforms in health system came out from the general practitioners and specialized trainers, together with the population's and tertiary payers support. The growing interest of different interested parts allowed a relatively quick and constantly progressive change rhythm. Even among countries that had a majority public medical services suppliers, their governments recognized the beneficial concurrence from the personal medical care suppliers by improving the efficacy of the public medical sector and enlarging the public satisfaction about the quality of medical services.

Approximately 40 years ago, Campbell had defined the reform as a "social experiment". Like him, other authors too had been studying the mechanisms and

the passing through steps toward a liberal health insurance system, starting from a centralized one. An interesting aspect captured by these studies was the connection between a people's cultural profile and its relationship with the health system.

If we look at our country since 1989, we can say without making wrong, that Romania had been a natural experimenting lab for reform implementation in health system, in a larger context of political and economic management modification, which had a sinusoidal trajectory following the electoral changings. It is worth to add that the history of Romania and its position in Europe are giving the opportunity to study the way of implementing the reform into the health system, from the perspective of the socio-cultural features and economic Romanian specific activities. This connection has been noticed in other countries too, like the countries from the former Soviet Union which, like Romania, had experienced the transition, for example Ukraine and Moldova. Definitely, a profound solid study over the inter-relationship between cultural features and the ways adapting to the reform (and also changing) can be of a great help for the political-decisional instances into taking measures.

Over decades under the communism, Romania was marked by a paternalist behavior in acting and reacting against changes, every command had to come from "upstairs" and everyone should accept it move as likely. No longer ago than the last years, freshly arrived in the work field and "freshly" contributing towards health insurances, raised the issue of changing the system, starting from a very important feature: the payer's *active* share to the modifications coming in the health system. Otherwise stated, the young people wish the reforms:

- ❖ To answer primarily to their need for medical services.
- ❖ To adjust to their purchasing power and their paying for medical services capacity.
- ❖ To insure unlimited access to medical services against social, territorial and ethnic differences.

In actual fact, these wishes had never been taken into account in the last 20 years of Romanian history. The discussions I had with people aging between 20 and 40, employed either in public either in nonpublic institutions, pointed out mostly the need to have an access to a health system that *functions in real time*.

Hofstede had studied the mechanisms through which the culture sways the behavior in organizations, portraying the culture as "a collective mind programming, which helps to make the difference between groups and communities". He emphasizes that religious and cultural affiliation creates strong bounds among individuals from a cultural region. In the last 20<sup>th</sup> century half this propensity for regional differentiation appeared as secessions claims. In Europe this phenomenon has reached the highest point with the War of Yugoslavia; the countries originated from the former Yugoslavian Federation are still confronting problems when implementing reforms in health system because of ethnic and cultural differences among their populations.

We can notice in Romania too the cultural and ethnical differences and their interference over the way of perceiving the reform. In Moldova and in the

former mining areas- regions with different specific cultural features- where there is a high unemployment rate and a high poverty level, the resistance against the reforms is much higher than in other regions or in the capital-city Bucharest. The reform and mostly the critical method (regarding the human part) in which the reform was implemented so far in Romania directed the population's conviction – population founded particularly in those areas- toward the idea that the reform steps against people's access to the medical services. The people felt abandoned into a bureaucratic chaos, which led to a lowering trust into the institutions and also into the health professionals. All these are, nonetheless, standing on the lack of humanistic compound on which had the formulation and the insertion of the reform relied. It has been required some years to pass before professionals with knowledge and thought closed to the western values to arrive and to replace the former leadership trained at the "socialism-realism" school. Compared to Romania and Bulgaria, countries nearer European West (like Poland, Slovakia, Czechia, Hungary) were more strongly influenced by the managerial thinking trends inspired from capitalism, even if they had had, at their turn, considerable problems to come up against.

The same Hofstede noticed that traditional cultural values or values came into traditional, are fairly resistant to the change, quoting as a case in point the former Soviet block countries which, after 45 domination years, step very slow toward liberal type orientations, more characteristic for countries with a long tradition in democracy. At his turn, DiMaggio points out the influence of cultural level – social, organizational, national- over the economic behavior of a country, over the production and investment level in key-domains such as health system. He compared the workers behavior from two different countries powerfully industrialized, like United States and Japan, pointing out the lower frequency in Japan of strikes, daily work nonattendances, sick leaves and low suits against doctors for *malpraxis*, compared to United States. This is an example of constructive collectivism of Japanese working class, with positive bearings over this country's health system, in which there are big investments in medical technology and with generally well-known diagnostic and therapeutic results. (We must add that the number of public and personal health insurances is equal in Japan.)

Francis Fukuyama emphasized in one of his books that one nation's progress through the ethic and social line has a great influence over economic development, this could be in the same time, "bless" and "course" too. The author is trying to explain this way the major economic differences between Eastern and Western European countries, with negative reflections upon the health system. He states that, though a cultural attitude may be transformed without any costs, the same attitude can bring the costs up in one domain-like health for instance, which is a domain mostly unpredictable, and so it cannot be confined into precise mathematical calculations.

## Bringing reforms in health system, on a free market

Bringing reforms in health system should take into consideration that:

- One needs free access to medical cares.
- One needs to save time in the consulting room.
- There must be a distribution of medical services to the population in the territory.

We resume that idea, on the strength of what we had said previously, from a study about the young taxpayers in Romania.

One of the outstanding goals of reforming the health system is the diminishing of social inequity. The *World Bank* is an institution which, together with *World Health Organization*, have tried through field taken studies (in developing countries) to find real solutions to help bringing the reforms in health system in. One of the strategies suggested by the *World Bank* is to cut the excessive financing for the hospitals, to the benefit of a financing grounded on selective contracts, already proven to be cost-efficient and clinically-efficient. In this scenario the hospital managers should demonstrate their institution performance considering:

- The convenient account between checking in and out of patients.
- The raised number of successfully solved cases in record time.
- The efficient use of resources.

To accomplish this, in the last 6 years in Romania, the DRG system has been introduced, which binds all three feat points previously announced. Nevertheless, in order to raise the feat indicator for the hospital (a condition which would bring more money from The National/Regional Insurance House), the hospital manager allowed the presence of pervert management, namely the artificial DRG raise-up.

An alternative to increase the hospital productiveness and efficiency is to rise the degree of the bed numbers use, which may be possible by reducing the hospital accommodation period. In Romania, the mean period for a bed is from 5 to 7 days in emergency-type hospitals and from 7 to 10 days in clinical hospitals. On that score, the major problem that the Romanian health system is fighting with is the lack of chronic diseases care hospitals, especially for old age people and for terminal state diseases (for example: oncologic patients with slow evolution). This goes to all type hospitals, emergency, clinical and geriatric, to be very crowded and with a very high level of medical services demand, which leads to a costs rise year after year more difficult to cover up. As a matter of fact, Romania does not have the financial resources necessary to complete the whole field of medical services – both for emergency states and particularly for chronic conditions, a status that led to an increasing number of co-pay or all-pay services for the patients. And here sprang another side of pervert management, against whom the authorities do not argue: the inequity in accessing medical services – those with big incomes can afford to pay, while those with lower incomes remain uninvestigated, untreated or wrong treated. Unfortunately, so far Romania cannot boast with a real success in

bringing the reforms in health system, quite the opposite, she is on top among eastern-Europe countries that constantly have problems to put reforms into health system.

Socio-economic status effect's empirical valuations over medical insurances use have a big importance in health strategies domain, as the providing of a socio-economic equity of the health system is a major priority. Since the medical assistance is essential in keeping and improving and functioning individual health status, the lack of accessing the medical services or the prohibitive access to them for those socio-economically disadvantaged can cause (or, at least worsen) the unpredictable fluctuations into the health system. Nevertheless, not all people need the same intensity medical care services. In order to improve and better administrate the quantum of medical care services for one individual, this amount should rather depend upon individual health condition features and associated risk factors, as also upon the availability over cost-efficient treatment technology.

The last statement emphasizes the essential difference between the need for medical assistance on one hand and, on the other hand, the "health-disease" concept. Particularly, it allows us the argument: "one considers that a healthy individual needs medical assistance in such a way in which one's health would be better in the future if one gets (now) medical care." Therefore, medical assistance resources supply should mirror the degree of the medical assistance need independent of the socio-economic patients status.

The distinction between medical assistance necessity and socio-economic status, as the source for a legitimate or illegitimate differentiation over using the medical services, is crucial for almost all empirical studies about the equity in using medical services. Although the conceptual seclusion is ever present in the valuations about the equity with which the medical assistance services are furnished, the flexible yet practical integration puts before a practical researcher many grounds to ponder over. Often, the parametrical patterns may seem too restrictive to fully incorporate the necessity to integrate a flexible interaction of the socio-economic status, because they usually enforce a convincing hypothesis of allowed functional forms.

As far as the care's value concerns, without extensive economic knowledge, non-parametric approaches seem more appropriate for modeling the interaction between socio-economic status and medical assistance necessity. However, the actual applications of these methods are often impossible. Socio-economic status modeling and medical assistance necessity usually need multiple indicators to mirror the many-sided nature of every concept, while non-parametric methods have well-known difficulties to dwell on multidimensional problems.

It is suggested to use bivariate methods with semi-parametric indices, as a heavy implement on modeling the seclusion between socio-economic status and medical assistance necessity in furnishing health services. Semi-parametric models are grouping a share of parametric and non-parametric approaches in order to diminish the dimensional problems from non-parametric modeling and keeping the same time the flexibility. More specifically, this models class adjusts parametric

structures with socio-economic status and medical care necessity (respectively, they keep a complete non-parametric approach about how these concepts can interact in order to induce medical care use). Consequently, this model is well fitted to estimate the observable non-unitary feature of socio-economic status effects over medical assistance use, in different care stages.

Certain parametric and non-parametric strategies for modeling the interaction between the socio-economic status and medical care need, especially regarding the use of the medical services and the want to mark the near advantages and disadvantages, allow the creation of a balance among these concepts, by inserting bivariate models categories with semi-parametric indices.

Also, according to another approach proposed for this domain, a mere empiric illustration (more precisely a semi-parametric bivariate model) for an analysis about education's effects and the necessity for medical assistance used upon the mean number of calling annual visits to the physician, may clarify one of the most important strategic objectives of the model.

By the means of this model for determining the degree of medical care services use, the semi-parametric method with double index, as a potential valid instrument for researching applications about the interaction between the socio-economic status and the necessity for medical services, may guide to convincing valuation results. On the other side, semi-parametric approaches are combining the parametric model with non-parametric estimative value. This approach seems to be advantageous particularly when there is not, *a priori* in the examined data, any information about potential complex features – although some parametric structures can be theoretically justified.

Drawing a conclusion, semi-parametric with double index approach proposed here is grunted by these facts. As far as the micro-determinant factors for medical care services use concerns, almost all studies show that the differentiation source in the medical care domain, respectively bi-sided conceptual features between the socio-economic status and the necessity for medical care services, are directing to obvious delimitations among medical care sorts, even if each concept can be actualized only through multiple substitutions. Taking into account this one-size measurement, the analysis continues alike as for a non-parametric function. Plus, regarding the way in which the socio-economic status and the medical services necessity interact with each other in order to realize certain medical care intensity, one cannot take upon oneself any specific functional form. Our approach allows, thus, an observable heterogeneity into the socio-economic degree from the entire distribution area of medical services, enabling a better knowledge, more than necessary to guide the politics over public health.

Similar to Abasolo and collaborators, we can perceive our regression results as the inequity concept in furnishing medical care services. Yet, this approach is more advantageous, because it may consider explicitly how socio-economic status gradient alter depending on the necessity distribution, and giving the example above, it has been pointed out that a particular heterogeneity is important – been itself a good informer for the medical politics. Plus, this analysis

produces certain sensible aspects about the conventional parametric approaches on the way in which one considers this heterogeneity.

As a conclusion, the semi-parametrical estimation is a promising instrument for flexibly modeling the relationship between the socio-economic status and medical care services furnishing, even if, in order to attest this conclusion, one requires supplementary proves to exist (the possibility of a non-parametric valuation).

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