After the breakdown of the state socialism, a number of changes have occurred in the legal framework, as well as governmental policy, ownership, production, financing, and reimbursement of health care in Central and Eastern Europe (CEE). However, the policy context in CEE makes priority setting a necessary step to ensure the efficient use of public funds for health. The problems with prioritizing of health services in the Central and Eastern Europe are, in essence, related to the general position of health care within broad national priorities. The percentage of gross domestic product spent on health is insufficient and many cost-effective interventions are currently neglected, under-funded or provided with low quality standards. If the health status is to be improved, such interventions should be granted a greater priority. The experience from the established market economies indicate that: (a) overall future system of priorities setting in health care in the CEE should be driven by new democratic values; (b) new systems must be people-centered, more oriented to the needs of individual patient and specific groups, and sensitive to inequalities, unemployment, and social poverty; (c) they should be health-focused; and (d) they should be evidence-based and oriented towards primary health care.

**Key words:** access to health care; health and welfare planning; health care rationing; health care reform; health priorities; insurance, health; medical care costs; policy making

Setting new health priorities is a first step to health sector reform, usually concerned with defining priorities, refining policies, and reforming institutions (1). The aim of this study was to compare the methodology and reality of priorities setting in the health care in Central and Eastern Europe and established market economies (2). Differences at the macro, mezzo, and micro levels of priorities setting in health care between Central and Eastern Europe and developed countries are analyzed, compared, and possible solutions proposed. The research methodology is the one used in the international comparative studies of health care services (1).

Our a priory hypothesis is that the problems with prioritizing of health services in the Central and Eastern Europe are to the greatest extent related to the general position of health care within broad national priorities, although the rationing of extensive hospital services and health manpower are also on the agenda.

**Theoretical Background**

Evans (3) illustrates the theoretical relationship between a health care resource input and health care outcomes (Fig. 1). Initially, as health care resources increase, the outcomes improve. However, the slope of the curve diminishes above a certain level of resources, i.e., increasing investments in health care yield more marginal benefits (3). The slope of the cost-benefit curve would become steeper if a system eliminated the components of increasing expenditures that have flat slopes (no medical benefit) or negative slopes (3). Setting priorities in health care is one of the possible methods developed to face such issues.

Macro priority depends on the economic development but also on cultural values, for which there are no experts. Since there is no ready theory and the problem with measuring health outcome is that many factors other than health services affect the outcomes, there are arguments to leave the process to politics and politicians (2). To avoid such voluntaristic situation, the key priority setting decisions should be revisited on a regular basis due to the dynamic nature of health care systems and services. It is usually difficult to disentangle the influence of health care from the impact of basic social factors, such as poverty, education, lifestyle, and social cohesiveness. For example, the World Bank’s 1993 World Development Report (4) places substantial emphasis on the point that many factors outside the health sector, especially household income and education, influence health outcomes. At the same time, the Report concludes that countries can greatly improve health outcomes by making available a minimum package of highly cost-effective public health and clinical services (4). That principle is especially important when one has to decide in a situation of “distribution of scarce
Figure The relationship between health care costs and health outcomes (3). [view this figure] 1:

1. Macro level (intragovernmental and intersectoral level): (a) drawing up a set of principles and priority categories to guide debate about priority setting; (b) defining a process for determining priorities between different social sectors; and (c) defining procedures for determining priorities by establishing expert groups.

2. Mezzo level (concentrating resources, limiting availability and introducing assessment): (a) transferring responsibility for certain health services to the private sector; (b) defining a list of services to be funded; (c) limiting the availability of some services through positive or negative lists, such as those for medications; (d) concentrating resources on services of proven effectiveness; (e) introducing assessment and regulation of technologies; (f) cost-sharing arrangements for services, utilization review and disease management (market-based approaches); and (g) commissioning research to better inform decision-making on priorities.

3. Micro level (clinicians and general practitioners (GPs) implicit rationing): (a) clinicians and GPs as the ultimate rationers deciding on the best use of available resources; (b) waiting lists as a "magic hand" to regulate access to services for non-life-threatening conditions; (c) following evidence-based guidelines to determine access to services; and (d) providing information to users to encourage an appropriate use of services (5,6).

Decisions at the micro-level are influenced by decisions at the macro-level, and responsibility of politicians at the macro level is parallel to the responsibility of clinicians at the micro-level.

Regional, National, and International Strategies for Priorities Setting in Health Care
While trying to resolve the problem of ever increasing health care expenditures, several different players in the health sector started actions to set priorities in health care and to conduct health policy on the basis of such priorities. Local governments (Oregon, USA), national governments (Sweden, Norway, the Netherlands, New Zealand, and UK), regional associations (the European Union), and international institutions (WHO and The World Bank) significantly contributed to a theory and practice of prioritizing in health care.

Oregon State Health Commission
This was a commission appointed in 1989, with a clear responsibility to make recommendations to the state legislature on how Medicaid coverage could be expanded and how priorities could be set within the Medicaid program (7). Oregon has led the way in emphasizing the importance of cost-efficiency in setting priorities in health care. The idea was to set priorities in health care system by limiting benefits coverage and freeing more funds for uninsured vulnerable groups, such as the disabled, prematurely born, and children. In the beginning, 1,600 conditions/treatments were ranked in cost-efficiency terms. It was a pioneer effort to establish priorities founded on efficacy and treatment effects – an approach based on economic evaluation. The quality of life approach was completely abandoned (8). Oregon State Health Commission says little about the plan, social solidarity was not much in focus, and only the poor were the object of setting priorities. The final results were anomalous (e.g., tooth capping had higher priority than appendectomy). The Commission resorted to a judgmental approach, supported by a number of exercises in public consultation (9).

Sweden
In Sweden, a Parliamentary Priorities Commission was established by the government in 1992 and it made its final report in 1995 (10). The report was relatively short, only 132 single-spaced pages. It accepted rationing as inevitable and provided an important example of how the subject could be publicly addressed (10). Policy makers were strongly influenced by work originally undertaken in Norway. Priority setting in Sweden, like in Norway and the Netherlands, has been influenced by an attempt to reduce waiting lists and the perception of a growing gap between the need for health care and available resources. The gap was a result of decline in the growth of the Swedish economy, a growing elderly population requiring greater health care, expanding but expensive capacities for diagnosing and treating disease, and social changes that make it more difficult for the traditional nuclear family to provide care and support (10). It is interesting that the Swedish diagnosis of the problems in the health care sector resembled that presented by the American analysts (11). The prescribed treatment in Stockholm, however, differed from the one in Washington, showing that even the same problems have a different solutions in different socio-cultural and political environments.
Compared to the American approach, the term “rationing” has never been used in the Swedish report (8). Compared to other strategies, the task of the Swedish Commission was to obtain ethical values and principles that could be used by the national government. The report’s strength is in its effort to establish ethical principles for guiding, which should not be based on the attitude surveys involving the public, administrators, doctors, nurses, and politicians. The Commission maintains that any scheme for prioritizing must accept three core principles in order to distinguish political and administrative prioritization from a clinical one.

1. The principle of human dignity: all human beings have equal dignity and same rights, regardless of their personal characteristics and their functions in the community.
2. The principle of need and solidarity: resources should be committed to those fields where needs are the greatest and special attention should be paid to the needs of those groups unaware of their human dignity or who have less chance than others of making their voices heard or exercising their rights.
3. The cost-efficiency principle: when choosing between different options, one should aim for a reasonable relation between cost and effect. This principle should only be applied in comparison to the methods for treating the same disease (10).

**New Zealand**

The government appointed a Core Services Committee in 1992 to advise on the services that should be included within the publicly funded health system. The Committee decided (12) that it would not be appropriate to draw up a list of services in the Oregon style. Instead, it argued that the services provided at that time were those that should be provided, and a process for determining priorities within specific areas of provision should be initiated. Every year, the government outlines a small number of key performance expectations for regional health authorities. The priority areas for 1996 were mental health, child health, Maori health, as well as the development of booking systems based on clinical priority assessment criteria.

**European Union**

The European Union (EU) roles and responsibilities for health care are defined in the Article 129 of the 1991 Maastricht Treaty and they are mainly related to public health rather than to health services. A recent revision of the Article 129 has raised considerable expectations that politicians would take the opportunity to create legal and institutional basis of an integrated health policy (13). The new Treaty retains many of the limitations of the previous one. It states that priority setting should be based on major diseases, failing to consider the broader determinants of health (14). This may be attractive to some local or state governments, as it was to Oregon (7), Sweden (10), and New Zealand (13), but it marginalizes issues such as welfare policy, inequalities in health, and access to health services. Intersectoral approach relating public health and health services to areas like poverty alleviation, employment, transport, environment, housing, education, and agriculture are still dominated by disease-oriented ideology, serving as a basis for priority setting process (13).

**The World Bank**

The World Bank's “Health Sector Priorities Review” was conducted by Dean I. Jamison and W. Henry Mosley and a group of 32 collaborators organized around specific health problems, e.g., cancer or acquired immunodeficiency syndrome (15). The World Bank approach to setting priorities in health care sector included four steps (16): (a) description of the health problems (incidence, prevalence, natural history, morbidity, deaths, etc.); (b) analysis of the opportunities for prevention, including their effectiveness, costs, and cost-effectiveness; (c) analysis of the opportunities for improved case management, including their effectiveness, costs, and cost-effectiveness; and (d) identification of research that could provide new approaches for prevention or case management in the near future. The authors were asked to assess the condition regarding a specific disease or a group of related diseases for a representative population of 1 million persons in the developing world. The goal was to indicate health programs that should, in general, command high priority. For example, the programs at the top of the interventions for improving child health were: measles vaccination (in high-mortality environments), vaccination to prevent neonatal tetanus (in high-mortality countries), and an integrated program of antenatal and delivery care (15). From an analogous analysis of adult health, the leading three programs were blood screening for HIV, rehabilitation for persons with leprosy, and passive case-finding and short-course chemotherapy for tuberculosis. All these programs cost US$1 or less per “disability-adjusted life year” (DALY), or the equivalent of US$2,500 per death averted. To evaluate the cost-effectiveness of these leading programs, they should be compared with some of the less cost-effective alternatives. Examples of the latter category are the performance of coronary-artery bypass surgery and the use of zidovudine in the management of AIDS. Shortly, the most favorable interventions cost 100 times less per unit of health improvement compared to other acceptable medical practices (16).
Efficiency, Effectiveness, and Equity as Priorities

The first choice on priorities to be made in any country is at the macro level. At that level, health care is related to other competing claims on resources, such as social policy, housing, defense or science. There are also choices to be made on the allocation of the budget for health care among different geographical areas (2). Such choices are usually implicit and related to inequalities in health care. Decisions have to be made on the allocation of resources to particular forms of treatment within service areas, and also choices on how to prioritize access to treatment among patients and for individual patients. The important questions that policy makers have to face are: How to allocate resources, taking into account the conflict between individual and social priorities, as well as that among the primary, secondary, and tertiary care? How to apply cost-effectiveness analysis even in very urgent situations?

A possible principle for setting priorities across health care services is to rank treatments by the benefit they provide to an individual patient. This priority approach to allocation of health resources might give: (a) priority to treatments that address urgent, life-threatening problems; (b) priority to treatments that address problems that are life-threatening but more chronic; (c) priority to the treatment of problems that are severely debilitating but not life-threatening; and (d) priority to the treatment of problems that are not life-threatening but produce high burden of disease (5).

Although this approach has a strong appeal because it applies most of the resources to the most serious problems, it has some rather questionable implications (5). For example, its application could provide all possible treatments of an acute life-threatening disease regardless of their futility, low probability of success or the cost level. Indeed, this principle does not even use the information on the amount of benefit provided by different treatments. It is based on an assumption that, if a treatment is used for an important problem, it must have an important benefit, which is not always true (6). For example, in the United States, the rescue principle has led to inappropriate actions, such as huge sums spent to separate Siamese twins with a joint heart even though one will inevitably die and the other has only a tiny chance of surviving and no chance of living a normal life (5). Such an approach ignores the cost of the treatment and does not take into account the number of patients who could actually be helped within the available budget. The strategy ignores the fact that different treatment could be given for the same amount of money to five times as many patients (17). Current practice with health care expenditure is based, more implicitly than explicitly, on such a model. This postulates that health care is fundamentally different from other goods, that equality of access is essential for health care because it is so different, and that, when something can be done acutely to avoid death, it should be done (“the rescue principle”) (17).

Examples from two war-affected regions, city of Mostar in Bosnia and Herzegovina and Manica region in Mozambique, could serve as an illustration of the rescue principle in an international perspective (18, 19). Developed market economies with effective specialist services could find the treatment of a small number of incoming patients more cost-effective than providing aid and training in specialist care to the countries with armed conflict and political instability, or where adequate primary health care had not yet been achieved. In addition, a conflict of interests might appear even between two countries in war, both in need of aid (rescue principle). Experience from the city of Mostar in Herzegovina addresses the controversial principles of cost-effectiveness compared to medical or humanitarian priority (18). The program of medical evacuation of children was established as a part of an initiative to support health care. In a war-torn country with a severely disrupted health delivery system, it provided adequate management of complex medical or surgical conditions that were not by themselves life-threatening but could not have been completed in any other way (18). The estimation was that the treatment of each child amounted to US$16,352 on an average (US$4,890 for the evacuation and US$11,400 for the treatment) (18). The Mostar rescue action was criticized by the members of the intervention group from Mozambique (19). In the Manica province, two years after the devastating war that lasted for more than 15 years, there was an estimated population of 858,000, of whom 153,000 were children under 5 years of age. The total government budget available to the province for health services in 1996 was about US$96,740 at 1996 exchange rates (about US$0.11 per person per year). The total spent on recurrent costs for 76 health units in ten districts, plus the capital city, was unlikely to be more than US$3.52 per person per year. Compared to Mostar, where a total of US$228,200 was distributed to 12,000 children, that would have been an investment of more than US$19 per child. The Mosambican team reports that nobody offered them the opportunity to evacuate children overseas for medical treatment. Even if they had received such an offer, they would have rather recommended that the money be spent entirely on primary health care instead (19).

“Having recently completed our annual planning process for the Province of Manica, Mozambique”, wrote the physicians from Manica “we were struck by the economic differences between our situation
and the help offered to Bosnia” (19). Medical evacuation project from Mostar was based on compassionate rather than economic grounds. The message is that comparing the cost-effectiveness of primary health care with specialist services in any country might be difficult. However, when a state is receiving international aid because of war or extreme poverty, the current approach is to focus on the primary care since the need for it may be overwhelming (19).

**Public Health Measures as Priority?**

If an ounce of prevention is worth a pound of cure, then the replacement of expensive end-stage disease treatment with low-cost disease prevention would appear to be an ideal candidate for the “painless cost-controller award” (20). Providing prenatal care or childhood vaccinations costs less than caring for premature newborns or children with life-threatening infections (20). However, in many cases, the cost of implementing a prevention program may exceed the costs of caring for the illness that occurs without it. For example, screening the general population for elevated blood pressure and providing long-term treatment to those with mild or moderate hypertension to prevent strokes and other cardiovascular complications have been found to be more expensive than treating the eventual complications themselves (21). This is true because in some cases the complications are rapidly fatal, whereas successful prevention leads to a long life with high medical costs perhaps for a different illness. A program of routine mammography screening and biopsy after an abnormal finding costs far more than it saves by detecting breast cancers at earlier stages (22). Blood pressure and breast cancer screening programs result in improved health of the population but require a net investment in additional resources.

**Equity as Priority**

If we agree that the available resources should be distributed equally, the operational question is: how do we achieve that? There is a view developed by “Paretian welfare economics” (23) that decisions ought to maximize subjectively perceived welfare, that the only identifiable improvements are those where no one loses such a welfare and at least one gains some, and that in situations where some gain and others lose one can only sit on one’s hands. A particular weakness of the traditional Paretian approach is that it affords no leverage on choices that have to be made, causing that some people lose while others gain, which is, unfortunately, the usual situation in Central and Eastern Europe. An egalitarian response to such a question will not drive us to a solution. The debate on the individual vs society in health care was resolved in favor of society in consistence with the maxim “the greatest good to the greatest number” (6). In short, for reasons unrelated to health services, the poor are less able to “produce” good health outcomes, and less likely to utilize health services that are available to them. At the same time, the equality in health outcomes requires much greater public spending on the poor per person than on the rich. One can calculate efficiency without including equity objectives, similar to the maxim “it is not important what we are doing, as long as we are doing it efficiently”. Individuals with the same health problems fare systematically different, depending on their income. However, this leads to decisions based on what will win votes rather than on what is rational.

**Cost-effectiveness and Cost-efficiency: Easy Solutions?**

The most controversial strategy for making health care more efficient is the redistribution of resources from services with some benefit to services with greater benefit relative to cost (5). This approach to efficiency is commonly guided by the cost-effectiveness analysis. An example is a cost-effectiveness analysis of different strategies to prevent heart disease, showing that the cost per year of life saved (in 1984 US dollars) was approximately $1,000 for advice about smoking cessation during a routine office visit, $24,000 for treating mild hypertension, and nearly $100,000 for treating elevated cholesterol with drugs (24). To allocate resources to the best treatments, the actual benefits of the treatments must be estimated.

1. Cost-effectiveness analysis measures the net cost of providing a service (expenditures minus savings), as well as the outcomes obtained.
2. Outcomes are reported in a single unit of measurement, either a conventional clinical outcome (e.g., years of life saved) or a measure combining several outcomes on a common scale.
3. The treatment is cost-effective if, compared to no treatment, it is effective in improving health outcomes. There should be convincing evidence about that.
4. Compared to no treatment, its beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
5. Compared to the next best alternative treatment, the treatment should represent a good use of resources (5,6,20,24-26).

The relation of health care costs and health outcomes delineated in Figure 1 shows not only that, to the certain point, the increase of the investment will increase the outcome (quality of health) but also that the inverse process may adversely affect the quality of health. The cuts to the health care costs on the level of the curve’s plateau will not adversely affect the quality of health. However, if the
investment in health further decreases, it will reach the steep part of the curve, and further health care costs cut will diminish the quality of the health. At this level, relatively small cuts in spending may cause great harm, just as small increases in the investments may considerably increase quality of health.

Cost-effectiveness analysis must be used with caution. If the data are inaccurate, the conclusions will be incorrect (25). The cost-effectiveness analysis should not discriminate people with disabilities. Researchers are likely to assign less importance to a year of life of a disabled person than the person himself/herself would. Analyses using quality-adjusted life years may have a built-in bias against persons with less capacity to function independently (26). Short-term and unsustainable efficiency gains are also often used to justify inequitable decisions. If the Central and Eastern European countries adopt more market-driven health care systems, there is a risk that access to care for the most needy will decrease at the very time when they need health services most (Fig. 2).

Figure Cost-effectiveness of 47 health interventions (according to references 4,14,27). DALY - 2: disability-adjusted life years. [view this figure]

New Priorities for Health Care Reforms in Central and Eastern Europe

Comparison of health policies in the Central and Eastern Europe and the west (European Union, North America, Australia, New Zealand, and Japan) reveals significant differences. If we consider the amount of the financial resources allocated to different sectors of national economy (GDP), the health sector appears the leading public and governmental priority in the West, followed by defense and social security. Most of the western countries recently spent on health between 7% (UK) to 14% (USA) (4) of their GDP. Health care is at the top of public interests and concerns. As a result of economic development, significant allocation of resources in health care in the West has been steadily increasing (1).

The major question that policy makers, experts, and tax-payers in established market economies are facing today is not how to allocate more resources to health sector but how to increase health gains and reduce expenditures (2). The same indicators for 28 countries of Central and Eastern Europe (Table 1) could hardly testify in favor of the conclusion that health care is a national priority in almost every country in the region. In Central and Eastern Europe, health care is not among priorities for public financing (Fig. 3).

Negative results are also evident through the fact that the mortality of adult men stopped declining over the past two decades and has actually started to increase. The increase in male mortality in Central and Eastern Europe as compared to the European Union (29) is largely the result of extremely high death rates from cardiovascular disease, associated with smoking and drinking (30). Predictions for the next 30 years are pessimistic (31).

Table 1. Priorities in health care reforms in selected Central and European Countries. [view this table]

In the case of Central and Eastern Europe, we face the inverse law of health care. The more money you need for your health the less you get! That health paradox could be applied not only on the individual but also on the global level. Countries which should place health care as their first priority because of negative health and social trends, high mortality rates, and risky health behavior, have very low level of investing in health care. Low level of resources allocated to health care in the region was a result of low priority of health care within the communist ideology (28): (a) disease was considered largely as a product of class relations under capitalism; (b) total Soviet medical system in the former Soviet Union was divided into medical system working under Ministry of Health and a departmental medical system (Ministry of Railroads, Academy of Sciences, Ministry of Defense, etc.); and (c) investments in health care system were following such division, which consequently resulted in sub-divisions (strict branches as adult medicine, child medicine, preventive medicine) and hierarchy. Only departmental medical system received serious funding but still mainly as an excessive hospital system.

Such an ideological approach had and still has a strong impact on the health care sector. The problem of resources allocation to the health sector in Central and Eastern Europe is even broader and includes major historical, cultural, and social components. In most of the countries in the region, prioritization of health care is not related only to the level of national wealth expressed in GDP. Health
could become a national priority and significant increase in allocation of national wealth to health care can be measured only if changes in cultural values, social structure of the population, education, gender relations, and behavioral patterns, and changes from collectivist to social and individualistic values occurred (32).

After the breakdown of the state socialism, many changes have occurred in the legal framework as well as in governmental policy, ownership, production, financing, and reimbursement of health care. However, two things remained the same: facilities once used by the former nomenclature were inherited by the new one, resulting in high inequality in access to health care, and allocation of resources to health care remained on an extremely low level. Most of the countries in the region spent between 2-7% of their GDP on health care (5.5% on an average). On an average, they spent only US$272 per capita on health care measured by parity purchasing power, which is little more than a half of the world average (US$525) and only 12.1% of what is actually spent on health in high income countries of the West (US$2,243) (33). Countries like Croatia, Slovenia, and Czech Republic are exceptions only in relative terms (percentage of GDP spent on health in Croatia is 8.5% of GDP, in Czech Republic 7.7%, and in Slovenia 7.4%). When measured by the real amount of money spent on health expressed in parity purchasing power, those “high spending countries” became low or very moderate. Only Slovenia spent more than the world average of US$525 per capita: Croatia US$302, Czech Republic US$417, and Slovenia US$740.

Such situation is not only rooted in the previously existing ideological barriers and burden of underdevelopment. After the 1990 production collapsed, inflation soared and economies suffered real declines in income, similar to the decline experienced in the United States during the Great Depression. As a consequence, the governments faced budgetary pressure to cut the already low level of public health spending in proportion to the decrease in revenues (34,35). Lower public demand for health capital was also influenced by fewer job opportunities, and lower real wages might have reduced the economic costs of being sick or of choosing to consume products, like tobacco, that accelerate the depreciation of health capital (34).

Epidemiological evidence indicates that the first priority for the Central and Eastern Europe health systems is to become more adjusted to the real needs of the population – burden of disease and illness expressed in DALYs and quality-adjusted life years (QALYs), specific groups (males, cigarette smokers, alcohol users) – and of individual patients. Burden of disease and DALY methodologies have already been used in the studies of priority setting in Central and Eastern Europe (2). Most of these studies have limited their scope to measuring the burden of disease in terms of mortality, morbidity, and disability. Little work has been done to assess cost and effectiveness of health interventions and no work has been done to assess social preferences for health outcomes (2). What should be done? At least a relevant change in national and sectoral priorities, including: (a) change of national/macro priorities in resources allocation – this means an increase in the portion of GDP spent on health, and identification and exploitation of the intersectoral avenues for promoting health; (b) reduction of the high prevalence of avoidable deaths and illnesses (29,30); and (c) forming of delivery systems offering a range of affordable interventions which better correspond to the major causes of illness disability, and death among population (29-30,34).

The main question in the CEE region is how to adjust the choice of affordable interventions and the major causes of illness, disabilities, and deaths. This will include analysis of emerging strategic challenges, revising priorities, and devising mechanisms for implementing the required changes. Health priorities for Central and Eastern Europe are similar to those in the World Bank strategy for Europe and Central Asia (33), including the following.

The first priority is reorientation of economic policy by increasing the amount of resources aimed to eliminate the increasing poverty and high unemployment rates (35) and contribute to overall development of most of the countries in Central and Eastern Europe (4,33,34). The second priority is the implementation of measures that preserve health environment, including effectively targeted public health and disease control interventions and healthier lifestyles (health diets, reduced tobacco and alcohol consumption, low risk sexual behavior, and adequate physical exercise) (30,31). The existing structure of health manpower and hospitals is a result of extensive, hierarchical, and disease-oriented health care systems (Fig. 4). Whereas the average number of physicians per 1,000 population in EU is 2.89, for Central and Eastern Europe it is 3.15; the average number of hospital beds per 1,000 population is 6.88 and 9.64, respectively. These data show that the whole hospital sector, and education and management of health manpower have to be restructured and sometimes rebuilt from scratch.

Figure 4: Number of physicians (upper numbers, in bold) and number of hospital beds (lower number) per 1,000 population in European Union (EU, white) and Central and Eastern Europe (CEE,
shaded). Averages per 1,000 population in EU and CEE amount to 2.89 and 3.15 for physicians and 6.88 and 9.64 for hospital beds, respectively.

The third and fourth priorities are directly related to reorganization of hospital system and reorientation of hospital services.

The third priority is the creation of population-based health care which should include shifting health services from the secondary and tertiary to primary care, reduction in the number of specialists, and creation of effective network of general physicians, primary care centers, and outreach services for home-based care (36).

The fourth priority is the introduction of leaner hospital systems, such as reduction of high-cost acute hospital beds for long-term care and social admissions (2,34).

The fifth priority refers to the expanded role of the private sector in the delivery of health services and greater managerial autonomy for health providers within public or state owned institutions (2,4,28,33,36).

The sixth priority should include the introduction and application of population-based and evidence-based medicine and disease management, including development of clinical guidelines (2,6).

The justification and the importance of setting health priorities depends greatly on the policy context. The policy context in Central and Eastern Europe makes priority setting a necessary step to ensure an efficient use of public funds for health. The average expenditure per capita is insufficient and many cost-effective interventions are neglected, underfunded or provided with low quality standards (28).

The policy of prioritization in Central and Eastern Europe at macro, mezzo, and micro level was in many cases selective during the last eight years. The strategy in most of the countries did not include broader determinants of health and was oriented only to health system reform (32). In some cases, it was driven by the interest to increase income or by narrow clinical interests of the medical profession (32). The “imperative” to implement health insurance also had an important impact in most of the countries in the region (32).

If the health status is to be improved, broader social, ecological, and intersectoral interventions should be granted greater priority. These changes imply a more accessible and equitable health system, oriented to the needs of an individual patient and specific groups (37). The experience from the established market economies indicates that the overall process of health care reforms and a future system of priorities setting in health care in Central and Eastern Europe should include new democratic values, people-centered and sensitive to inequalities, unemployment, and social poverty, health policy focused on health and not only on disease-oriented, as well as evidence-based system and a system oriented to primary health care.

References


31 Murray CJL, Lopez A. Mortality by cause for eight regions of the world: global burden of disease study. Lancet 1997;349:1269-76.


Received: April 26, 1998
Accepted: July 8, 1998

Correspondence to:
Stjepan Orešković
A. Štampar School of Public Health
Rockefellerova 4
10000 Zagreb, Croatia
soreskov@andrija.snz.hr