Health care reform in Europe is discussed in the light of the Ljubljana Charter, with particular reference to progress made in Estonia and Lithuania.

Voir page 46 le résumé en français. En la página 47 figura un resumen en español.

In 1996 WHO organized a ministerial-level conference in Ljubljana, which was attended by 46 European Member States. On the basis of many years of analytical work (1), they endorsed the Ljubljana Charter on Reforming Health Care in Europe, stating that within the European context health care systems should be driven by values (such as human dignity, equity, solidarity and professional ethics), targeted on health, centred on people, focused on quality, based on sound financing, and oriented towards primary care. Additionally, the Charter identifies as principles for managing change the need to develop health policy, listen to the people's opinions, reshape health care delivery, reorient human resources for health care, strengthen management, and learn from experience.

A sceptic might ask: “What is new in the Ljubljana Charter?” The main thing is that this was the first time that some elements of common knowledge about health care reforms had been presented simply and clearly in an agreed statement at ministerial level. Very few politicians would have dared speak out individually on these matters. Most so-called health care reforms have not focused on health improvement at all, and in fact have made things worse as far as the general public is concerned. Financial and administrative adjustments alone are not enough if reform is meant to have the connotations of improvement and betterment.

First and foremost, health care reform should be about reforming health. This seems to be a statement of the obvious, yet health has been losing ground in the profound political and economic changes sweeping through Europe. In most countries the reforms have focused on cost-cutting, while too little attention has been given to their longer-term effects on health.

What has worked...and what hasn't

Health sector reform is multifaceted and multilayered. At one end of the continuum is the administrative and managerial quest for cost containment to keep health care expenses within sustainable limits. At the other end is the individual citizen's wish to obtain the best possible care. These aspirations may seem irreconcilable. However, as citizens ultimately pay for health services—whether public or private—it is clearly in their interest that money be spent in the most effective and efficient ways.

First and foremost, health care reform should be about reforming health. This seems to be a statement of the obvious, yet health has been losing ground in the profound political and economic changes sweeping through Europe. In most countries the reforms have focused on cost-cutting, while too little attention has been given to their longer-term effects on health.

From theory to practice

The ability to achieve objectives in health systems depends on the capacity of policy-makers to respond...
flexibly and creatively to the policy environment they confront. Cross-national learning about reform experiences is an essential element in this process, as is the adaptation and adjustment of reform mechanisms to accommodate local circumstances. While the basic principles of health reform are universally valid, their application varies with each country’s needs and expectations and with the understanding of reform issues by politicians, health professionals and society as a whole.

Particular difficulties have arisen in Central and Eastern Europe and the newly independent states of the former Soviet Union. A major contributory factor has been the deterioration of economic circumstances, output having declined and with it the tax base. Failing state enterprises and increased demand for compensatory social expenditure has exacerbated the fiscal burden on most transitional economies. Strong social and economic pressures are building up in many of these countries. The medical profession, moreover, has been very vocal in promoting changes that would strengthen the position of doctors.

The pendulum continues to swing: dissatisfied with an initial position, policy-makers set out to make fundamental changes, then move in the reverse direction as the shortcomings and problems associated with the changes become apparent. The countries of Europe are in various stages of this cycle. Several Western European countries are setting out on major experiments. In Northern Europe, where reform began, there has been a substantial retreat from the most radical position, that of market-oriented incentives, towards the original position of publicly planned coordination and cooperation. In some of the newly independent states there is a tendency to compare today’s extremely difficult conditions with those of the Soviet period, when the health systems at least functioned, and to hesitate about how to proceed.

**A health care reform laboratory**

Being small can sometimes be an advantage. In spite of economic constraints, the Baltic countries have made remarkable progress in reorganizing their health care delivery and financing systems. Mistakes have been made, but in the light of them reassessments have been made and corrective measures taken to the extent politically possible.

Estonia and Lithuania have received technical assistance and material aid from major international and donor agencies, and have been closely involved in WHO networks and engagements, including the analysis and preparation for the Ljubljana Conference and Charter. This has been an important factor, together with internal motivation and determination, in both countries’ progress in health development. They have not allowed themselves to be unduly distracted from the main issues by the plethora of actors who sometimes advocate and, indeed, seek to impose their own values and systems. Estonian and Lithuanian health administrators and planners realized at an early stage that copying others was not desirable and that quick fixes did not exist. Thus, for instance, up to the present there has been only a moderate degree of privatization of health care institutions. Both countries have given special attention to reform of health care delivery. Lithuania has developed a strong national health policy in collaboration with all major interest groups. In addition to the measures taken in primary care, public health and the pharmaceutical sector, a very important principle was introduced for the remuneration of inpatient care providers, involving performance-related payment (4). This is intended to be the main tool for increasing the productivity of health care providers. Payments to hospitals are based on a cost-per-case system, cases being classified in 50 diagnostic groups. The number of cases treated is contractually agreed between each health facility and the State Patient Fund, a newly established social health insurance system. There is a ceiling on the total payments that the Fund can make, and if the institutions increase their throughput of cases the cost per case is proportionately reduced.

A new payment system has also been developed for outpatient services in Lithuania. In the first half of the 1990s, there was strong support, especially from physicians, for adopting fee-for-service remuneration on the German model. A need was felt to increase physicians’ productivity, to improve patient care, to reduce under-the-table payments, and to increase doctors’ job satisfaction. However, the economic recession and a dramatically reduced public health care budget demonstrated the importance of financial affordability and the desirability of concentrating on health promotion and health education. WHO drew attention to the disadvantages of creating a payment system that rewarded maximization of the volume of medical services aimed at treating illness. The cautious approach was strongly supported by WHO and tied in with the principles of the Ljubljana Charter. A mixed formula for payment of physicians was initially agreed on, whereby about 70% consisted of capitation, based on the number of people on the lists of doctors at the first-contact level, and additional, clearly specified items were paid for on a fee-for-service basis. In practice, however, a system based entirely on capitation was adopted in 1997, and the fee-for-service component is expected to be introduced gradually as the system develops. Time will show how well the new scheme performs, but the focus on the delivery of services has a much better chance of success than would be the case if the system were wholly at the mercy of market forces. This transitional solution does not limit access to health care but does contain and balance the health care budget.

Estonia has been very active in establishing a functioning family doctor system. The Department of Polyclinic and Family Medicine was set up in the Faculty of Medicine of the University of Tartu, and
Vers une réforme des systèmes de santé fondée sur des faits concrets

En 1996, l’OMS a organisé une conférence ministérielle à Ljubljana au cours de laquelle la Charte de Ljubljana sur la réforme des services de santé en Europe a été approuvée; cette Charte stipule que dans le contexte européen, la réforme des systèmes de santé devait être guidée par certaines valeurs (dignité humaine, équité, solidarité et éthique professionnelle), être axée sur la santé, centrée sur l’individu, inspirée par un souci de qualité, être financièrement viable et orientée vers les soins de santé primaires. Il est également ressorti que la gestion du changement est en fin de compte l’épreuve décisive de toute réforme. D’un côté, il y a cette tendance, dictée par des impératifs administratifs et gestionnaires, à réduire les coûts; de l’autre, il y a l’individu qui souhaite obtenir les meilleurs soins possibles. Il ne semble guère que le fait d’insister sur le rationnement, la concurrence entre compagnies d’assurance ou le copaiement ait des effets positifs sur les réductions de coût, et à moins d’être accompagnées de mesures de protection, ces dispositions risquent fort de menacer la santé des populations. Les réformes qui ont le mieux réussi à améliorer la santé et à réduire les coûts sont celles qui se sont attachées à modifier les comportements des agents de santé et du personnel hospitalier.

Les petits États de l’Europe centrale et de l’Est sont devenus des « laboratoires de réformes du secteur de la santé ». L’Estonie et la Lituanie, deux petits États baltes, se sont particulièrement concentrés sur la réforme des prestations de santé. La Lituanie a su se donner d’une politique de santé nationale efficace et a entrepris des réformes touchant les soins de santé primaires, la santé publique et le secteur pharmaceutique. Les sommes perçues par les hôpitaux sont calculées sur une base forfaitaire par cas et la rémunération des généralistes repose sur la capitation, contrairement aux recommandations des groupes de pression médicaux qui étaient favorables à la rémunération à l’acte. L’Estonie a instauré un système national d’assurance-maladie obligatoire pour la population et non sélectif et non concurrentiel pour les compagnies d’assurance. Le médecin de famille est considéré comme le pivot du futur système de soins de santé en Estonie, ce pays ayant...
Hacia una reforma de la atención de salud basada en pruebas

En 1996, la OMS organizó una conferencia de nivel ministerial en Liubliana que adoptó la Carta de Liubliana sobre la reforma de la atención de salud en Europa, en la que se declara que en el contexto europeo los sistemas de atención sanitaria deben estar guiados por valores (como la dignidad humana, la equidad, la solidaridad y la ética profesional), enderezados a la salud, centrados en las personas, focalizados en la calidad, basados en una sólida financiación, y orientados hacia la atención primaria. También se llegó a la conclusión de que la gestión del cambio es la prueba decisiva de toda reforma. En un extremo de la cadena se halla el empeño a nivel administrativo y gerencial por contener los costos, y en el otro el deseo de cada ciudadano de obtener la mejor atención posible. Hay pocas indicios de que la insistencia en el racionamiento, la competencia entre aseguradores o los sistemas de copago tenga un efecto positivo en la contención de costos, y no estar acompañadas por reglamentaciones de protección, esas medidas pueden constituir una grave amenaza para la salud de la población. Las reformas que con mayor éxito han permitido mejorar la salud y reducir los costos se han concentrado en el cambio del comportamiento de los trabajadores de la salud y los hospitales.

Los pequeños países de Europa central y oriental se han convertido en «laboratorios de la reforma de la atención de salud». Estonia y Lituania, los pequeños Estados bálticos, han otorgado especial atención a la reforma de la prestación de asistencia sanitaria. Lituania ha elaborado una sólida política sanitaria nacional y reformado la atención primaria, la salud pública y el sector farmacéutico. Los hospitales cobran según el costo por caso y los médicos generalistas son remunerados por lo común conforme al sistema de capacitación, contrariamente al deseo de los grupos de presión médicos que propugnaban un método basado en el pago por servicios prestados. Estonia estableció un sistema de seguro nacional de salud que no permite a los aseguradores la opción de retiro ni la competencia para apoderarse de las mejores partes de mercado. El médico de familia se considera una pieza fundamental del futuro sistema de atención de salud de Estonia, que ha comenzado a construirse a partir de la base adecuada, a saber, estableciendo una formación universitaria de alto nivel para los especialistas en medicina general. En la segunda fase de la reforma, se creó una red de médicos de familia y se instauró un sistema de remuneración atractivo mediante el seguro nacional de salud. Los hospitales y policlínicas de nivel secundario han considerado esta evolución como una amenaza para su antigua hegemonía y han tratado de ganarse al público. Sin embargo, el Gobierno de Estonia está comprometido con la reforma de la APS y, con el apoyo de la OMS, las reformas siguen adelante.

Los ejemplos de Estonia y Lituania muestran lo difícil que es en la práctica la gestión del cambio. Para los políticos y administradores nacionales pueden ser una considerable ayuda las declaraciones de consenso internacionalmente acordadas, como la Carta de Liubliana, lo mismo que los elementos concretos que aporte el análisis de las reformas en curso que está realizando la OMS. Esto puede atenuar el innecesario efecto péndulo, que tan habitualmente acecha a las reformas de la atención de salud en Europa central y oriental.

References