SEE Dialogue South-East Europe

The Performance of Public Health-care Systems in South-East Europe

A comparative qualitative study

(Main conclusions translated into regional languages)

Manuela Sofia Stanculescu (coord.), Georgiana Neculau

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FOREWORD

The Friedrich-Ebert-Stiftung (FES) is committed to the ideas and basic values of social democracy: promoting democracy and development throughout the world; contributing to freedom and security: shaping globalization with solidarity; and supporting the enlargement and consolidation of the European Union are the basic principles of its international work. Through projects implemented in more than 100 countries, FES provides its active input and support towards the building and consolidation of civil society and State structures for the enhancement of democracy, social justice, strong and free trade unions, as well as of the advocating for human rights and gender equality. FES is also intensely active in the area of global and regional issues. Special emphasis is placed on the enlargement and consolidation of the European integration processes, promotion of transatlantic relations and reform of the system of global governance.

In South East Europe (SEE) Friedrich-Ebert-Stiftung is represented by offices in Albania, Bosnia-Herzegovina, Bulgaria, Croatia, Kosovo*, Macedonia, Romania and Serbia. From these offices FES co-operates with partners in all the countries of SEE, promoting the rule of law and vital democracy, justice and social security, economic progress and sustainable natural and cultural environments, as well as regional cooperation and integration into the European Union. The establishment and development of effective labour relations, which protect workers' rights, is always an integral part of the work of the FES and within this context the co-operation with free trade unions is especially significant.

The framework conditions and challenges for the countries in SEE have numerous common features, which may only be resolved adequately, and in a sustained manner, through close cooperation. Exchange of information and experience, and transfer of knowledge about successful solutions, are especially helpful in overcoming historical differences and mastering contemporary socio-political challenges. Friedrich-Ebert-Stiftung keeps abreast of current developments through a regional programme which supports regional cooperation and European integration and accession processes; creating and supporting platforms for political and civil society dialogue in order to deal with common problems and the challenges of strengthening trade unions and social dialogue.

Social policy has always been one of the most important topics for Friedrich-Ebert-Stiftung due to the fact that the capitalist market economy always tends towards social exclusion and needs to be regulated by strong social correctives. The past two decades have brought painful experiences to South-Eastern European societies following the end of socialism, during which time socio-economic inequality and poverty has increased dramatically through the introduction of the capitalist market economy. Additionally the capacity of the region's social security systems was not great enough to cope with the contemporary necessities; consequently the quest for social inclusion has become one of the key challenges in SEE. The situation has been aggravated furthermore during the continuous economic crisis since 2009. Against this background FES launched a regional working focus on "Social Policy in South East Europe". A number of thematic ideas were put forward and further sequences of studies and conferences were initiated, the results of which are published in a series of FES Regional Studies in South East Europe. The first book on "Social Inclusion in South-East Europe – National and Regional Policy Priorities for a Social Europe" was published in 2010. The second, "Equity vs. Efficiency – Possibilities to Lessen the Trade-Off in Social, Employment and Education Policy in South-East Europe" - followed in 2011. In the same year a study on "Welfare States in Transition – 20 Years after the Yugoslav Welfare Model" was published. "Employment Policies – Common Challenges and Different Scenarios" was the title of the next publication in 2012 and with the present study entitled "Performance of Public Health-care Systems in South East Europe" we continue our work.

* *This designation is without prejudice to positions on status, and is in line with UNSC 1244 and the ICJ Opinion on the Kosovo Declaration of Independence.*

This latest study analyzes the performance of the public health-care systems in South-East Europe, focusing on the needs of patients in relation to five health problems: myocardial infarction, stroke, cancer, injuries and diabetes (type 2). These problems were selected as the focus of the research after taking into account the major causes of death in the region, both chronic and acute, but also after assessing the type of health-care response that they require (e.g. emergency versus long-term monitoring and care). The aim of the study was to provide qualitative insights about the *expected* versus the *actual* performance of the public health-care systems and to indicate which are the major areas that require intervention and development at both national and European levels. The research has been designed with a view to providing information on topics and issues that are difficult to capture through quantitative research methods. Therefore this empirical comparative study relies on qualitative research techniques and gathers both the perspective of knowledgeable observers (1,006 interviews with family phisicians, medical specialists and nurses in hospitals and emergencies, representatives of regional or national directions of public health, of patient organizations and of NGOs) and of individual witnesses (432 interviews with patients and familiy members of the patients). The research covers eight SEE countries, namely: Bulgaria, Croatia, Kosovo, Macedonia, Moldova, Montenegro, Romania and Serbia.

I would like to thank Manuela Sofia Stanculescu and Georgiana Neculau for this excellent and substantiated study. I would like to thank also all the contributors and interviewers for their arduous work, namely Peter Atanasov, Vanesa Benkovic, Milos Bjelovic, Jakob Goldstein, Ilir Hoxha, Agima Ljaljevic, Lolita Mitevska, Andrei Mecineanu and Elisaveta Stikova. We especially would like to express our gratitude to all the 1,438 individual witnesses and knowledgeable obeservers. Without their interest and patience this study would not have been possible.

If this book can contribute to the encouragement of all political authorities and social stakeholders to promote and implement improvements of the health care systems in the region, then it will have fulfilled one of its most important goals.

Belgrade, April 2014

Roland Feicht
Director
Friedrich-Ebert-Stiftung, Regional Project for Labour Relations and Social Dialogue in South East Europe

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Manuela Sofia Stanculescu and Georgiana Neculau

The production of this volume benefited of the financial and administrative support of the Regional Project of the Friedrich-Ebert-Stiftung for Labour Relations and Social Dialogue in South East Europe, based in Belgrade. We would like to express our gratitude to all countries' contributors for their dedication and expertise, to Roland Feicht and Emilija Grujic for their patience and support in the production process, and to Alfred Pfaller for taking initiative on the idea of this study.

This report would not have been possible without the outstanding work and determination of a team of young researchers at the Romanian Centre for Economic Modeling (Bucharest): Simona Anton, Bogdan Corad, Catalina Iamandi-Cioinaru and Andreea Trocea. We thank them for their consistent efforts put into identifying, collecting and preparing analysis of additional data and information about all countries within the international studies and databases.

The authors would also like to express their gratitude to all Friedrich-Ebert-Stiftung country offices for their involvement and support in data collection, to the country research teams that put all the pieces together throughout the qualitative data collection process, to all individual witnesses who took the time to share their stories and to all knowledgeable observers who facilitated the translation of the medical experience into social indicators.

Countries included in the study

1. ABOUT THE STUDY

Manuela Sofia Stanculescu

The study *Performance of the Public Health Care System* is an empirical comparative study that analyses the performance of public health care systems in South-East Europe. The study focuses on the needs of patients in relation to five major health care problems that represent the major causes of death in the region and require diverse types of health care response, namely: (1) Cardiovascular – myocardial infarction, (2) Stroke, (3) Cancer, (4) Injuries (general surgery and orthopaedics) and (5) Diabetes (type 2).

In this paper, by definition, a performing health care system delivers state-of-the-art diagnosis, treatment and recovery, and is accessible to every citizen covered by health insurance, free of major additional charges. According to the logic of insurance, the system is being paid for by contributors and/or tax-payers and carries the implicit promise of adequate delivery in the case of need. Thus, the performance of the public health-care system is analyzed in this study based on the framework to analyze actual access of the population to health care services developed by Wismar et al. (2011), where accessibility is defined as 'a measure of the proportion of the population that reaches *appropriate* health services' (WHO, 1998, p. 2).

Objective

The ultimate objective of this study is to collect qualitative information regarding the performance of the public health care systems in South-East Europe.

The discrepancies between (i) the expected and (ii) the actual performances (in 'standard' cases) of the public health-care system are thought to indicate the major areas that need interventions in order to enhance not only the average levels of population health but also the health equity[1] both at the national and European levels.

Context

Health plays an important role in the *Europe 2020* agenda as 'promoting good health is an integral part of the smart and inclusive growth objectives for Europe 2020. Keeping people healthy and active for longer has a positive impact on productivity and competitiveness. Innovation in health care helps take up the challenge of sustainability in the sector in the context of demographic change.'[2] Also, the actions for reducing inequalities in health are vital to the aim of 'inclusive growth'.

Considering the health challenges facing Europe, the 53 Member States of the WHO European Region together with partner organizations[3] adopted, in September 2012, the *Health 2020* policy[4] which contains *two strategic objectives*: (i) improving health for all and reducing health inequalities within countries and between different countries and (ii) improving leadership and participatory governance for health, and *four priority reform areas*: (1) investing in health through a life-course approach and empowering people; (2) tackling the major health challenges of non-communicable and communicable diseases; (3) strengthening people-centered health systems, public health capacity and emergency preparedness, surveillance and response; (4) creating resilient communities and supportive environments.

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[1] Health equity refers to the 'absence of unfair and avoidable or remediable differences in health among population or groups defined socially, economically, demographically or geographically' (Macinko and Starfield, 2002).

[2] EC Communication of 29 June 2011, A budget for Europe 2020, p. 49, available online at: http://ec.europa.eu/budget/library/biblio/documents/fin_fwk1420/MFF_COM-2011-500_Part_II_en.pdf

[3] E.g. EU, OECD, Council of Europe, Civil Society and Professional Associations.

[4] WHO Europe RC 62 Resolution on Health 2020, available online at: http://www.euro.who.int/__data/assets/pdf_file/0005/173651/RC62rs04-Health-2020-ENG.pdf

Given the substantial gap in health opportunities and outcomes between the South-Eastern countries and the EU, in particular the Western countries, the SEE Health Network (SEEHN),[5] under the SEE Regional Cooperation process,[6] is in the course of developing the *SEE 2020 Strategy* for advancing the common European health goals and priorities within the context of Southern and Eastern Europe and the Western Balkans. This process is fully supported by the EU and the *SEE 2020 Strategy* is expected to be aligned with the *Europe 2020* policy and the WHO Europe *Health 2020*. The *SEE 2020 Strategy* represents an opportunity to address the persistent health challenges within and between SEE countries, including the non-communicable diseases, social inequalities in health and the early onset of illness and premature death. This strategy is expected to be endorsed by the Governments of the SEE Member States of the SEE Regional Cooperation process and, thus, to serve as the document for further funding using the EU financial mechanisms and tools.

Country coverage

The research covers eight SEE countries, namely: Bulgaria (BG), Croatia (HR), Kosovo (RKS), Macedonia (MK), Republic of Moldova (MD), Montenegro (MNE), Romania (RO) and Serbia (SRB).

1.1 METHODOLOGY

Performance of the Public Health-care System is an empirical comparative study that analyzes the performance of the public health-care systems in South East Europe based on qualitative research techniques. The project involved a team of 11 researchers from 8 countries, supported by country teams of interviewers (researchers, students, doctors) and a large number of contributors from each country. The project was coordinated by the Regional Project of the Friedrich-Ebert-Stiftung (FES) for Labour Relations and Social Dialogue in South East Europe in Belgrade and supported by the FES offices based in the other SEE countries.

The project has faced a number of challenges and a number of strategies were employed to address these. Firstly, the project team[7] defined the research questions and debated the scope of research for measuring, through qualitative research techniques, the performance of the health system, via indicators such as availability, geographic accessibility and affordability. Secondly, the selection of countries aimed to cover the whole SEE region. For this reason, in the initial phase, when the methodology was developed, Albania participated also. However, given the available resources (time, budget and national experts), only eight countries eventually took part throughout the course of the project. Thirdly, variations between countries (historical, in institutional arrangements, characteristics and organization of the health-system, etc.) do not allow direct comparison so the issue of comparability was thoroughly considered and an agreement upon the content of country studies was reached during a second workshop.[8] Five health problems were selected as focus of the research taking into account the major causes of death in the region, both chronic and acute, but also the type of health-care response that they require (e.g. emergency versus long-term monitoring and care). Fourthly, the wide differences in data availability within the international

[5] SEEHN member countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Israel, Macedonia, Moldova, Montenegro, Romania and Serbia.

[6] Within this process, the Regional Cooperation Council established a Regional Working Group for preparing the *Social Agenda 2020* - a regional long term social development strategy and action plan for the Western Balkans, based on the current national and regional social development priorities and actions.

[7] The first workshop was held in Belgrade on 28-29 September 2011.

[8] The second workshop was organized in Podgorica on 11-12 September 2012.

studies and databases (especially regarding Kosovo and Moldova) as well as the limited body of robust and updated national research and literature on performance of the health system (that would allow comparison among the SEE countries) imposed a quality assurance mechanism for the country studies. To this end, an analytical framework supported by a resource package was developed containing: (i) detailed instructions on the size and profile of the national samples (types and number of respondents per country per health problem), (ii) interview guides by type of respondent and by health problem; (iii) other indicators to be collected from national and international publications and databases (data types and data time points).

Thus, this report draws heavily on the country's studies, which collected data, analyzed information and reported the results in a systematic and uniform way across the eight countries. In addition, a team of young researchers from the Romanian Centre for Economic Modeling (Bucharest) collected additional data and information about all countries and prepared all data for analysis.

Research questions

The study provides insights into the following research questions:

(i) *Expected performance of the public health-care system*: What is the state-of-the-art treatment (including diagnostics, monitoring etc.), which is provided by the public health-care system in each country, with regard to the selected health problems? To what degree does it comply with the European Guide (ESO) of diagnostics and treatment (if any) of the given health problem?[9]

(ii) *Actual performance of the public health-care system*: What is the actual treatment that the public health-care system offers as 'average', 'most likely' or in 'standard' cases? Are there groups of the population which systematically are less likely to receive the state-of-the-art treatment available within the public health system? If yes, which are these groups? Which are the main factors that prevent state-of-the-art performance?

Research design

This study relies on qualitative research techniques for gathering information that can be of use to those engaging in the reform of the health-care system. The scope of work has been designed with a view to providing information on topics and issues that are difficult to be captured through quantitative research methods.

For answering the research questions, information regarding the public health-care system was collected from knowledgeable observers such as doctors and other agents involved in public and private health-care service delivery. This data was then checked, completed and calibrated with individual witnesses' accounts.

– *Knowledgeable observers*: family physicians, medical specialists, representatives of regional or national directions of public health, hospitals, emergency centers, NGOs or patients' organizations, World Bank experts and alike.

– *Individual witnesses*: patients who were diagnosed during the period 1st January 2010 - 31st December 2011 and their families, who were recommended either by doctors or by NGOs, mutual help groups or social networks.

Successful healing or prevention depends on a number of factors, including patients' behavior and attitudes. Nonetheless, this study concentrates only on the systemic determinants of performance. Correspondingly, the information obtained from individual witnesses is analyzed only according to the lacunae we still have to fill for consolidating the picture provided by the knowledgeable observers.

Data collection was based on structured interviews that followed ten interview guides (see Research instruments) common to all coun-

[9] The questionnaires for this research were elaborated based on the information and recommendations included in these guides.

tries. The interviews began with a few opening questions about general perceptions on the public health-care services, followed by tailored questions depending on the particular therapeutic scheme of each health problem. National research teams carried out the fieldwork in each of the eight countries, during the period March 2012 - March 2013.

Data sources

From the viewpoint of analyzing and understanding health systems, the present state-of-the-art systems show two major limitations which, in turn, represent the main aspects of specificity in the present report. First, at a methodological level, the existing literature provides limited information on the SEE countries that are not EU member states. This report provides an analysis based on a common analytical framework. Second, at the empirical level, many of the existing health indicators do not cover all eight countries. These two main limitations motivate the structure of the present report, based as it is on three main sources: i) the WHO European HFA Database, ii) European statistical data drawn from various Eurostat databases iii) World Bank World Development Indicators; national statistical data; national information, provided by national studies.

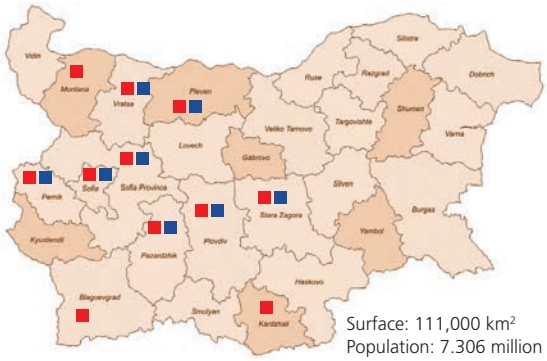
A total number of 1,438 interviews were realized, of which 432 were with individual witnesses and 1,006 with knowledgeable observers (conducted in all 8 countries with regard to all 5 health-care problems).[10]

In order to capture a diversity of circumstances, the study covered in each country various regions (figure 1), including metropolitan, urban as well as rural areas (figure 2).

[10] The number of interviews per country and per health-care problem varied between 10 and 30 individual witnesses and between 13 and 37 knowledgeable observers respectively.

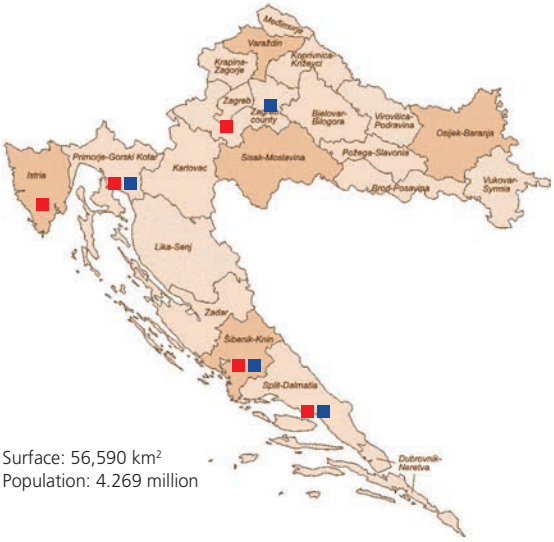
Figure 1. Distribution of the sample by interviewee's type by region and by country

Bulgaria



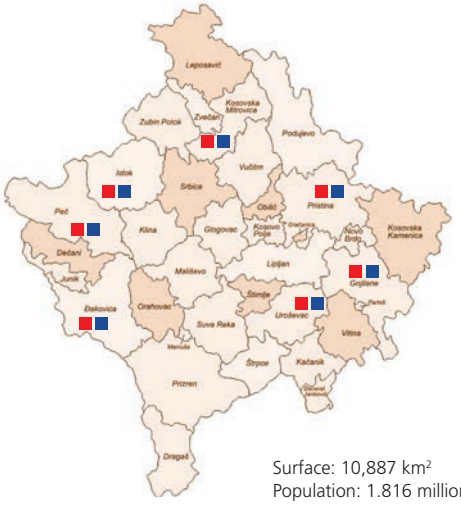
Surface: 111,000 km²
Population: 7.306 million

Croatia



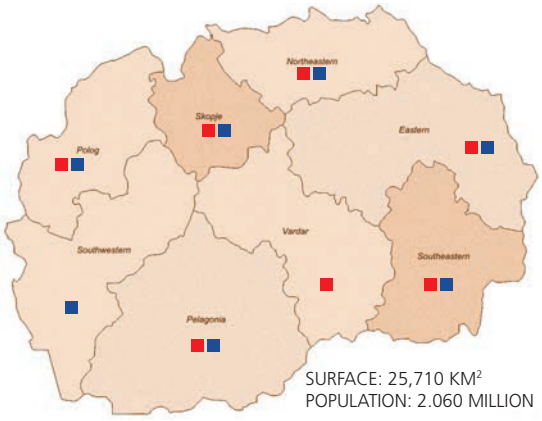
Surface: 56,590 km²
Population: 4.269 million

Kosovo



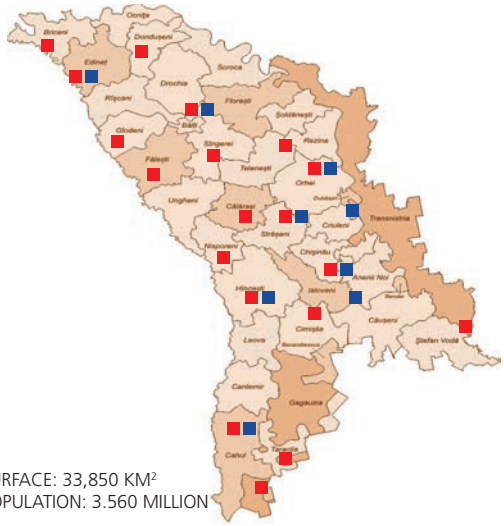
Surface: 10,887 km²
Population: 1.816 million

Macedonia



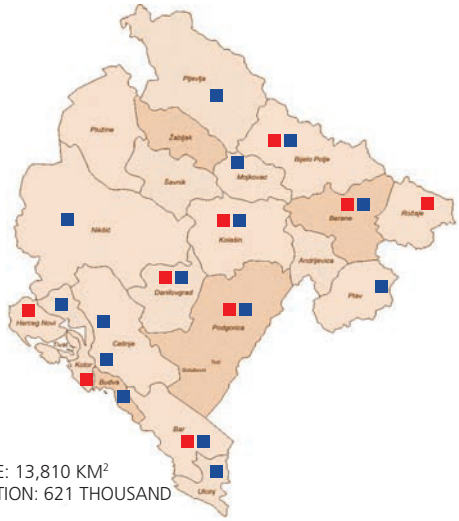
SURFACE: 25,710 KM²
POPULATION: 2.060 MILLION

Moldova



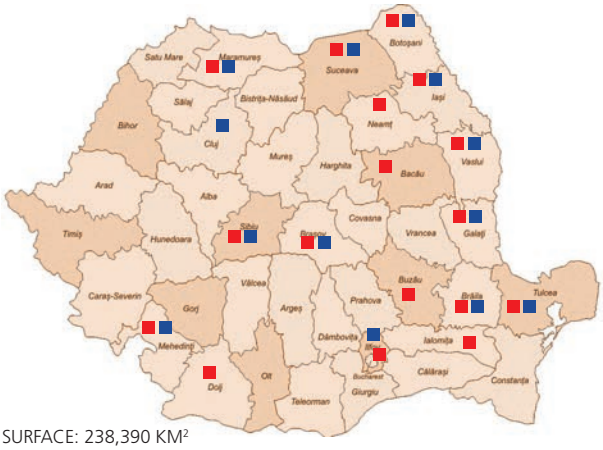
SURFACE: 33,850 KM²
POPULATION: 3.560 MILLION

Montenegro



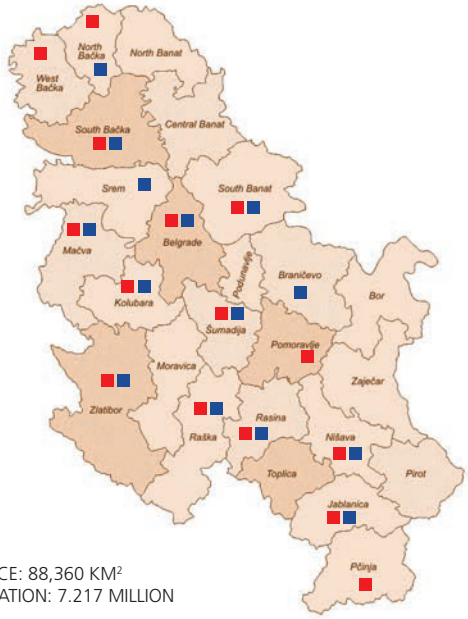
SURFACE: 13,810 KM²
POPULATION: 621 THOUSAND

Romania



SURFACE: 238,390 KM²
POPULATION: 20.077 MILLION

Serbia

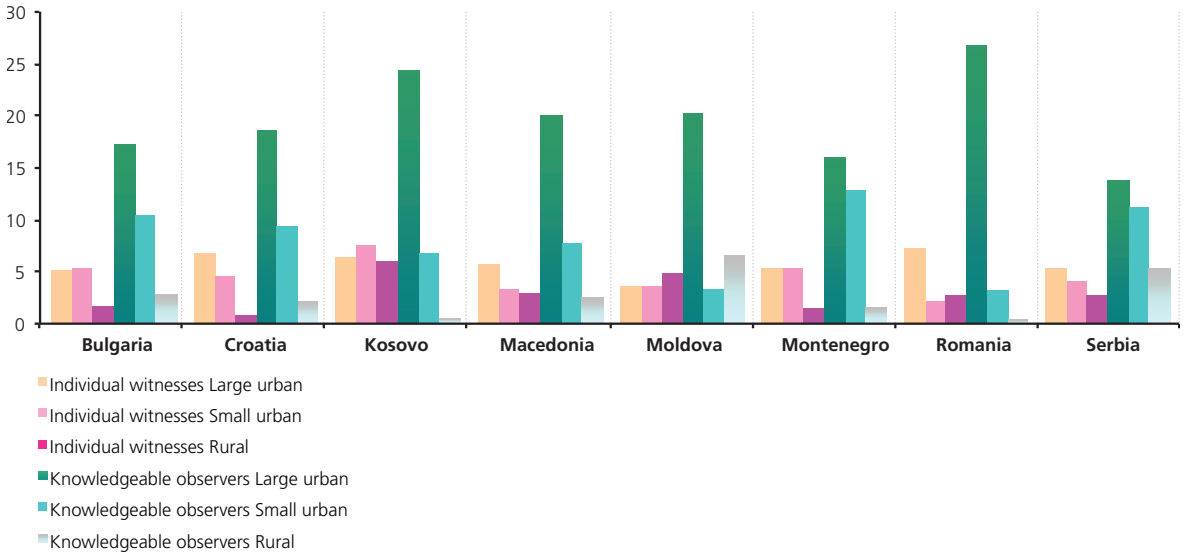


SURFACE: 88,360 KM²
POPULATION: 7.217 MILLION

Legend: ■ Individual witnesses
■ Knowledgeable observers

Maps source: http://d-maps.com.
Data: Surface - World Bank, September 2013;
Population - Eurostat, September 2013.

Figure 2. Distribution of the sample by interviewee's type by area and by country (number of interviews)



Data: FES (2012-2013) *Performance of the Public Health-care System*.
Note: Types of areas (rural or urban) according to the national administrative definitions.

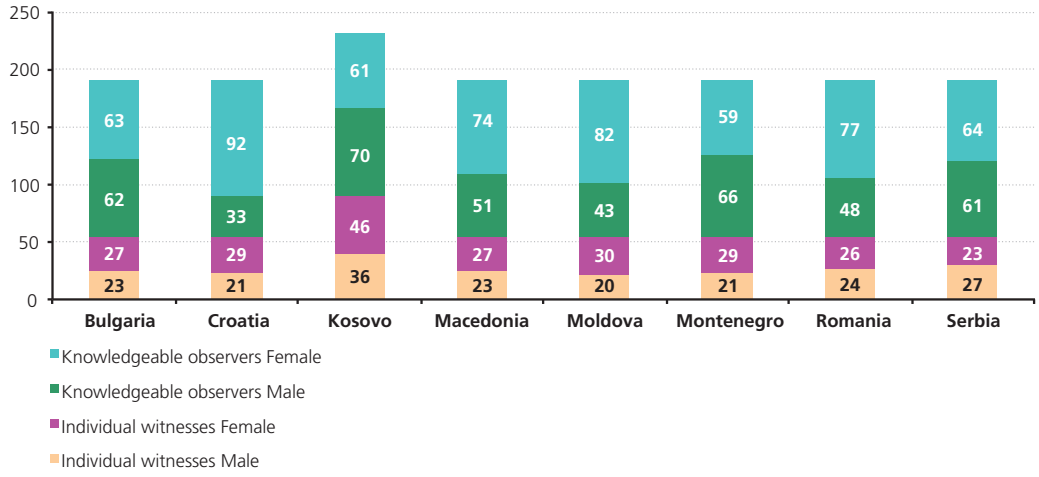
The knowledgeable observers from large urban areas make up the largest group of interviewees, which account for 45% participants to the study (with a minimum of 38% in Montenegro and a maximum of 63% in Romania). Actually, these data reflects the concentration of the specialized health services (i.e. medical specialists, hospitals, regional or national directions of public health, emergency centres, NGOs or patients' organizations, experts) in the large cities of these countries.

Interviews were done both with women and men. The female interviewees represented 55% of individual witnesses[11] and 57% of knowledgeable observers.[12]

[11] With a maximum of 60% in Moldova and a minimum of 46% in Serbia. The large proportion of females among individual witnesses is a combined effect of the interviewer's gender with the higher propensity of women to accept an interview on the subject of health-care problems (either personal or related to close family members such as children, husband or parents).

[12] The proportion of female interviewees among the knowledgeable observers was considerably lower in Kosovo and Montenegro (about 47%), particularly compared with Moldova (66%) and Croatia (74%). However, in all countries, the relatively high share of females is a result of the prevalence of women employees in the health-care systems (be it public or private).

Figure 3. Distribution of the sample by interviewee's type and gender and by country (number of interviews)



Data: FES (2012-2013) *Performance of the Public Health-care System*.

Individual witnesses who participated within the study were mainly patients diagnosed during the period 1st January 2010 - 31st December 2011 (68%), aged between 9 and 98 years old (with an average age of 55 years old), from a range of ethnic groups, with various levels of education, employed (50%), pensioners (32%) or other economically inactive persons, and from all social strata. The main characteristics of the sample, regarding both individual witnesses and knowledgeable observers, are presented in table A.1 in Annex.

1.2 STRUCTURE OF THE REPORT

This report is divided into four chapters. The first chapter presents the project, the methodology, challenges and data of the study.

The second chapter starts with a short presentation of the eight countries in terms of geography, population, demographic long-term trends, well-being measured both as GDP per capita, poverty and human development. The next section 2.2 opens the cross-country analysis by quantifying the population health status, including trends in life expectancy, child and maternal health, major causes of death, risk factors and the main socio-economic inequalities in health and health care, which relate to poverty, ethnicity (Roma), financial barriers, geographical barriers, and migration. This chapter ends with section 2.3 that reviews the literature and data on health-care provision, addressing four major issues: the financing of health systems, health-care delivery, outmigration of health professionals and the health consumer index.

The third chapter presents the analysis of the data collected through the study. Section 3.1 explains the analytical framework, while section 3.2 moves to the general assessment of the public health-care services expressed by our interviewees. This is followed by subchapters dedicated to each of the five health problems considered in the study, based on a common pattern: a short presentation of the general situation (incidence, prevalence and death rates), an analysis of the accessibility of the state-of-the-art treatment in the specific disease and a list of major access barriers identified.

The concluding chapter aims to address the needs of policy-makers by bringing together all major obstacles to be surmounted if universal access is to be achieved. These are followed by key observations from the research, and ending with the identified six major policy reform areas in the health-care sector.

2. THE LANDSCAPE

Manuela Sofia Stanculescu and
Georgiana Neculau

On 1st January 2007, Bulgaria and Romania joined the European Union. Croatia followed in 2013. This process was accompanied by profound economic, political and social changes in each of these countries. These changes had a direct impact on labour markets, opportunities and behaviours, household incomes, poverty risks and, finally, on social policy responses. Most developments have been country-specific due to differing pre-transition starting points, but also due to the different approaches and efforts (political as well as economic) invested in social policies.

At the Thessaloniki Summit in 2003, the EU granted all countries of the Western Balkans a clear perspective of EU membership, subject to fulfilment of the necessary conditions, in particular the Copenhagen criteria[13] and the conditions of the Stabilisation and Association Process (EC, *Enlargement Strategy and Main Challenges 2013-2014*).[14] The year 2013 has been a significant year for the enlargement countries (not only for Croatia; which was the first country to complete the Stabilisation and Association Process).

In April 2013, Belgrade and Prishtina reached a historic agreement, following which in June 2013 the European Council decided to open accession negotiations with Serbia and the Council authorized the opening of negotiations for a Stabilisation and Association Agreement between the EU and Kosovo. Also, in June 2013, Montenegro adopted comprehensive actions plans for several chapters.[15] Regarding Macedonia (that has emerged from its political crisis of early 2013), steps have been taken to improve good neighbourly relations.

Moldova actively pursues EU membership, but it is poorer than any other European country and has to resolve issues over Transnistria before it can join. Currently, the relations between Moldova and the EU are shaped via the *European Neighbourhood Policy*. Nevertheless, Moldova has strong ties to the EU member Romania and the EU is developing an increasingly close relationship leading to gradual economic integration and a deepening of political cooperation.

This study is about the performance of the health-care systems in eight countries: Bulgaria, Croatia, Kosovo, Macedonia, Moldova, Montenegro, Romania and Serbia. Thus, it covers three EU member states and five candidate countries which are in the early stages of the accession process. Firstly, it draws on country-specific experiences and proceeds to the identification of some common features and reform areas. Secondly, it looks at the situation as of 2010-2012. Thirdly, while providing the basic comparative background, it focuses on a perspective from below, i.e. the public health system from the patients' and specialists' perspectives. Fourthly, it relates these informed opinions to social policy reforms.

2.1 POPULATION AND SOCIAL TRENDS

This section presents the selected SEE countries by using a set of indicators regarding geography, population growth and ageing, demographic trends (including fertility and mortality) as well as the general standard of living. Graphs and tables are displayed at the end of the chapter.

[13] The Copenhagen criteria reflect the values on which the EU is founded: democracy, the rule of law, respect for fundamental rights, as well as the importance of a functioning market economy. This paved the way for the EU accession of the countries of Central and Eastern Europe.

[14] COM(2013) 700 final, Brussels, 16.10.2013. Available at: http://ec.europa.eu/enlargement/pdf/key_documents/2013/package/strategy_paper_2013_en.pdf

[15] Chapters on judiciary and fundamental rights and on justice, freedom and security, in line with the new approach to tackle these chapters early in the accession process (EC COM(2013) 700 final, Brussels, 16.10.2013).

Bulgaria (BG)

Bulgaria is bordered by Romania to the North, Serbia and Macedonia to the West, Greece and Turkey to the South, and the Black Sea to the East. With a territory of 110,898 square kilometres, Bulgaria has a diverse, mostly continental and Mediterranean climate.

The population of 7.306 million[16] people is predominantly urban (about 73.7% of the entire population)[17] and mainly concentrated in the administrative centres of the 28 districts. There are 17 cities with population bigger than 50,000. The capital and largest city is Sofia.

The proportion between men and women is 49%/51%. Since 2000, the share of children under 15 has constantly decreased, reaching 13%, whereas the proportion of people over the age of 65 years has increased up to 19% (figure 5). In 13 districts the population aged 65 years and older is more than 20%. Thus, the ageing tendency is accentuated.[18] Furthermore, the World Bank's population forecast shows that this trend will continue and the population dependency ratio will reach 54% by 2020 (compared with 45% in 2010).

The population growth rate has been negative since the early '90s. In the rural areas it is significantly lower than in urban areas (-12.7 ‰ against -2.2 ‰, with -5.1 ‰ at the national level, in 2011). The World Bank's population projection indicates that the population is expected to decrease further to 7.030 million by 2020 (figure 4).

The negative natural population growth is mainly the result of a long-term decline in fertility[19] together with an increase in mortality. Bulgaria has had a high mortality rate, both total and premature. After 1964, when the lowest mortality rate in the country was recorded (7.9 ‰), the death rate has been steadily growing (table 2). With about 110 thousands deaths per year, Bulgaria has constantly registered a death rate significantly higher than the EU-28 average (14.73‰ compared with 9.67 ‰, in 2011, table 2; see also figure 7). The trend of mortality is higher for men (15.8 ‰) than women (13.7 ‰) and higher in rural (21.4 ‰) rather than urban areas (12.2 ‰). The high level of mortality is due primarily to the deaths of people aged 65 years or over. Thus, the major factor of mortality is demographic ageing. Nevertheless, there is an increase in mortality among persons in the age group 60-64 years. Premature mortality[20] is relatively high compared with the EU average (23.4% versus 19.3%, in 2010). Premature mortality is two times higher in the male rather than the female population (31% compared with 15%).

The general standard of living, measured as GDP per capita, has constantly increased (figure 9), yet has remained well below the EU-28 level (only 47% in 2012).[21] Nonetheless, based on a broader definition of well-being, which measures the average achievement in three basic dimensions of human development - a long and healthy life, knowledge and a decent standard of living, Bulgaria belongs to the group of countries with high human development, with a rank of 57 out of 187 countries worldwide (figure 8).

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[16] Data for 2012, Eurostat, downloaded on September 27, 2013. The country is inhabited mostly by Bulgarians (84%), Turks (9%), Romani (5%) and other minorities (less than 1% each). The most common religious denomination is Orthodoxy (data from 2011 Census).

[17] Data for 2010, UNDESA (2012).

[18] With a median age of population of 42.7 years compared with the EU-28 average of 41.5 years. Data at 1st January 2012, Eurostat.

[19] In Bulgaria the decline in fertility started in 1925 (despite some compensatory effects occurred in the 1950s) and fluctuated between 1968 and 1974. The major socio-economic changes after 1989 accelerated this process and in 1997 the total fertility rate dropped to a lowest 1.09 (figure 6). With about 70 thousands live births per year, Bulgaria has had a birth rate below the EU-28 average (9.5 ‰ compared with 10.4 ‰, in 2012, table 1)

[20] Defined as the proportion of deaths of population younger than 65 in the total number of deaths. The rate of Bulgaria decreased to 22.3% in 2012. More recent data are not available for the EU average (Eurostat data).

[21] Eurostat data (in PPS).

Croatia (HR)

Croatia is located at the crossroads of Central Europe, Southern Europe and the Mediterranean. It is bordered by Slovenia and Hungary to the North, Serbia to the East, Bosnia and Herzegovina to the South, and the Adriatic Sea to the West.[22] With a territory of 56,594 square kilometres, Croatia has diverse, mostly continental and Mediterranean climates.

The population of 4.269 million[23] people is predominantly urban (about 57.7% of the entire population),[24] with a growing urban population and a shrinking rural population. Since the counties were re-established in 1992, Croatia is organized into 20 counties (including 127 cities and 429 municipalities) with the capital and largest city being Zagreb. There are 8 cities with population greater than 50,000.

The proportion between men and women is 48%/52%. Since 2002, the share of children under 15 has constantly decreased, reaching 15%, whereas the proportion of people over the age of 65 years has slightly increased (18% of the country's population, in 2012, figure 5). The ageing tendency[25] is less accentuated than at the EU-28 level, but it is expected to increase in the future (up to 53% by 2020, the World Bank forecast).

The population growth rate has been negative since 2000, at around -2 ‰ per year. According to the World Bank's population projection, the population will remain of about 4.3 million by 2020, after which it will decline at an accelerated pace (figure 4).

Years of decline in the number of births[26] and an increase in the mortality of younger age groups during the war and negative migration trends from the last decade have influenced overall population trends. Although the standardized death rate has decreased since the '90s (figure 7), the mortality rate has remained higher than the EU-28 average, but lower than other SEE countries, especially Bulgaria and Serbia (with a crude death rate of 11.59‰ compared with 9.67% in 2011, table 2). The high level of mortality is due primarily to the deaths of people aged 65 years or over. The premature mortality[27] rate is comparable with the EU average (20% versus 19.3%, in 2010).

Croatia is the most developed among the studied countries. The general standard of living, measured as GDP per capita, has increased (figure 9), but was still only 61% of the EU-28 level, in 2012.[28] Based on a more comprehensive approach to well-being, Croatia falls into the group of countries with very high human development (with a rank of 47 out of 187 countries worldwide, figure 8).

Kosovo (RKS)

Kosovo is bordered by Macedonia to the East and Southeast, Albania to the Southwest, Montenegro to the West, and Serbia to the North. With a territory of approximately 10,900 square kilometres, Kosovo has predominantly continental climate.

[22] Croatia's coast contains more than a thousand islands.

[23] Data for 2012, Eurostat, downloaded on September 27, 2013. The country is inhabited mostly by Croats (90%), Serbs (4%) and 21 other minorities (less than 1% each). The most common religious denomination is Roman Catholicism (data from 2011 Census).

[24] Data for 2010, UNDESA (2012).

[25] With a median age of population of 41.7 years, compared with the EU-28 average of 41.5 years. The age dependency ratio (proportion of persons aged 0-14 years and 65 or more to population aged 15-64 years) was 47.7% in Croatia compared with 50.1% at the EU-28 level. Data at 1st January 2012, Eurostat.

[26] In Croatia, the total fertility rate has continuously decreased after 1980, reaching a low of 1.27 in 2001 (figure 6). With about 40-45 thousands live births per year, Croatia has had a crude birth rate slightly lower than the EU-28 average (9.8 ‰ versus 10.4 ‰, in 2012, table 1).

[27] Defined as the proportion of deaths of population younger than 65 in the total number of deaths. The rate in Croatia decreased to 19.6% in 2012. More recent data are not available for the EU average (Eurostat data).

[28] Eurostat data (in PPS).

The population of 1.794 million[29] people is predominantly rural (about 62% of the entire population).[30] Currently, Kosovo is organized into 7 districts, established by UNIAMK[31] in 2000, and further divided into 38 municipalities. There are 30 cities, of which 15 have populations larger than 50,000.[32] Prishtina is the capital and the largest city (with about 201 thousand inhabitants).

The proportion between men and women is 50%/50%. The 2011 Census indicates that Kosovo has a young population, with the proportion of children under 15 at 28%; much higher than in the other countries studied (figure 5). The ageing tendency is low and has a declining trend; according to the World Bank population forecast, the age dependency ratio[33] will decrease from 52% in 2010 to 46% in 2020. Also, the population growth rate has been positive (more than 11 ‰ per year, in 2011-2012) and, the population will increase by about 1.9 million by 2020, exceeding 2 million after 2030 (figure 4).

In Kosovo, the total fertility rate, although slightly declining, remains much higher than the EU-28 average: 2.2 compared with 1.56 average births per woman, in 2011.[34] The crude death rate has constantly been low,[35] but with high premature mortality[36] mainly linked to infant mortality.

Emigration from Kosovo has been important in the last 30 years, particularly during the 1990s. The total number of emigrations evidenced in the Population Census 2011 was 380,826 persons, but according to the Kosovo Agency of Statistics (2013b), there is strong evidence that the real number is likely between 450,000 and 550,000. However, after 2000, the emigration numbers have been between 12,000 and 13,000 per year.

During the past few years Kosovo's economy has shown significant progress in the transition to a market-based system and maintaining macroeconomic stability, but is still highly dependent on the international community and diaspora for financial and technical assistance. The World Bank estimates on remittances from diaspora - located mainly in Germany, Switzerland, and the Nordic countries - account for 16-17% of GDP. Funding from donors and other humanitarian activities account for 7.5% of GDP. Macroeconomic aggregate data suggest that compared to other countries in Europe, Kosovo has suffered less from the financial crisis. Kosovo and Albania are the only countries in South-Eastern Europe where GDP per capita grew in 2009, 2010 and 2011.

Kosovo is one of the poorest countries in Europe, with an average annual per capita income of only $ 2,800. Unemployment hits around 40% of the population and is a major problem that encourages outward migration and black market activity. The most recent World Bank (2011) report on poverty shows that absolute poverty has significantly declined in Kosovo since 2005. However, in 2009, about a third of the population (34%)

[29] Data for 2012, Eurostat, downloaded on September 27, 2013. According to the Statistical Office of Kosovo, the country is inhabited mostly by Albanians (92%), Serbs (4%), Bosniaks and Gorans (2%), Turks (1%) and Roma (1%). The most common religious denomination is Islam (data from 2011 Census).

[30] Data from 2011 Census, Kosovo Agency of Statistics (2013a).

[31] United Nations Interim Administration Mission in Kosovo.

[32] Data from 2011 Census, Kosovo Agency of Statistics.

33 The age dependency ratio defined as the proportion of persons aged 0-14 years and 65 or more to population aged 15-64 years.

[34] Data on fertility rate from the World Bank, www.data.worldbank.org/indicator/SP.DYN.TFRT.IN. The Eurostat data show that after 2002 the number of births was of about 30-35 thousands per year, with a sudden decline to less than 28 thousands in 2011. In the same time, the crude birth rate has declined from a high 18 ‰ to 15.4 ‰ in the same period. Nonetheless, the crude birth rate of Kosovo is considerably higher than the EU-28 average (10.4 ‰, in 2012, table 1).

[35] The crude death rate was 7 ‰ in Kosovo compared with 9.67 ‰ EU-28 average (WHO Database), in 2011. Data for Kosovo from the World Bank, www.data.worldbank.org/indicator/SP.DYN.CDRT.IN.

[36] Defined as the proportion of deaths of population younger than 65 in the total number of deaths. The rate for Kosovo was 37% in 2011 compared with the EU average of approximately 19% (Eurostat data).

lived below the absolute poverty line of € 1.55 per adult equivalent per day, and 12% were below the extreme poverty line of € 1.02 per adult equivalent per day, respectively. Poverty lines in rural and urban areas are almost equal but vary widely across the seven regions of the country.

Based on the human development approach on well-being, Kosovo falls into the group of countries with high human development (with a rank of 87 out of 187 countries worldwide, figure 8).

Macedonia (MK)

Macedonia is bordered by Kosovo to the Northwest, Serbia to the North, Bulgaria to the East, Greece to the South, and Albania to the West. With a total area of 25,713 square kilometres (out of which 25,433 square kilometres is land and 280 square kilometres water), Macedonia has a transitional climate from Mediterranean to continental. The country has a very good geographic position, because through Macedonia passes a major transportation corridor from Western and Central Europe to the Aegean Sea and Southern Europe to Western Europe.

The population of 2.060 million[37] people is predominantly urban (about 59.3% of the entire population).[38] Macedonia is divided in 8 statistical regions. Since 2004 the country is organized in 84 municipalities; 10 of these municipalities form the country's capital Skopje, which is organized as a distinct unit of self-government. The capital holds about 25% of the total population of the country. In Macedonia there are 5 cities with more than 50.000 inhabitants.

The proportion between men and women is 50%/50%. Since 2002, the share of children under 15 has constantly decreased, reaching 17%, whereas the proportion of people over the age of 65 years has slightly increased (12% of the country's population, in 2012, figure 5). The ageing tendency[39] is less accentuated than at the EU-28 level, but it is expected to increase in the future (up to 43% by 2020, according to World Bank population forecasts).

The population growth rate has been positive (with about 2.7‰ per year). According to the World Bank's population projection, the population will maintain its positive course by 2020, after which it will slightly decline (figure 4).

In Macedonia, the total fertility rate has decreased after 1980 (figure 6). However, with about 22 thousands live births per year, Macedonia has had a birth rate slightly higher than the EU-28 average (11.1 ‰ versus 10.4 ‰, in 2011, table 1). Both the standardized death rate and crude death rate have decreased since 2000 (figure 7 and table 2). Macedonia registers one of the lowest crude death rates among the other SEE countries analyzed within the report; lower even than the European average (9.3‰ compared with 9.67 ‰, in 2010, table 2). On the other hand, Macedonia registers a high premature mortality rate.[40]

Macedonia is an upper middle-income country with more than 25% of the population living in poverty and with an unemployment rate in the country of over 30%.[41] In this context, the relative poverty rate[42] was 30.9%,

[37] Data for 2012, Eurostat, downloaded on September 27, 2013. According to the last census data from 2002, the country is inhabited mostly by Macedonians (64%), Albanians (25%) and other minorities, among which Roma are estimated by the UNDP Regional Bureau for Europe at about 13%. The majority of the population belongs to the Orthodox religion (about 65%), while Muslims comprise about a third of total population.

[38] Data for 2010, UNDESA (2012).

[39] With a median age of population of 36.4 years, compared to the EU-28 average of 41.5 years. The age dependency ratio (proportion of persons aged 0-14 years and 65 or more to population aged 15-64 years) was 40.8% in Macedonia compared with 50.1% at the EU-28 level. Data at 1st January 2012, Eurostat.

[40] Defined as the proportion of deaths of population younger than 65 in the total number of deaths. The rate of Macedonia was 25.4% in 2010 compared with the EU average of approximately 19% (Eurostat data). The rate of Macedonia decreased to 24.5% in 2012. More recent data are not available for the EU average (Eurostat data).

[41] World Bank, *Country overview: Macedonia*.

[42] Measured against 70% of median equivalent expenditure.

in 2010. The most vulnerable groups to relative poverty are households with five or more members and unemployed. (State Statistical Office, 2012, p. 62)

The general standard of living, measured as GDP per capita, has constantly increased (figure 9), yet has remained well below the EU-28 level (only 35% in 2012).[43] Nonetheless, based on a broader definition of well-being, which measures the average achievement in three basic dimensions of human development - a long and healthy life, education and a decent standard of living, Macedonia belongs to the group of countries with high human development, with a rank of 78 out of 187 countries worldwide (figure 8).

Moldova (MD)

Moldova is bordered by Romania to the West and by Ukraine to the North, East and South. The country is landlocked, even though it is very close to the Black Sea. With a territory of 33,846 square kilometres, Moldova has a moderately continental climate.

The population of 3.559 million[44] people is predominantly rural (about 53% of the entire population)[45]. Moldova is divided into 32 districts, two autonomous regions (Gagauzia and Transnistria)[46], 5 municipalities (including Comrat and Tiraspol), 61 towns and 916 communes. There are 5 cities with populations exceeding 50.000 persons.

The proportion between men and women is 48%/52%. Since 2000, the share of children under 15 has constantly decreased, reaching about 16% in 2012, whereas the proportion of people over the age of 65 years has slightly increased up to 10% of the country's population (figure 5). The ageing tendency is lower[47] than the European average. Moldova actually registered the lowest median age of population among all studied countries. However, the World Bank population projection shows that the ageing trend will continue and the population dependency ratio will reach 45.4% by 2020.

The population growth rate has been negative. The World Bank's population projection indicates that the population of Moldova is expected to decrease further to 3.338 million by 2020 (figure 4).

The negative natural population growth is mainly the result of a drastic drop in fertility[48] together with an increase in mortality. Starting with 2000, Moldova has constantly registered a death rate higher than the EU-28 average (11.03‰ compared with 9.67 ‰, in 2011, table 2; see also figure 7). Also, the premature death[49] rate registered by Moldova in 2012 was almost double that of the rest of the analyzed countries.

Migration represents a mass phenomenon in Moldova and has a major impact on the country's demographics and economy. In their 2012 study, The International Organization for Migration (IOM) estimated that a minimum of 500,000 Moldovan citizens were work-

[43] Eurostat data (in PPS).

[44] Data for 2012, Eurostat, downloaded on September 27, 2013. The country is inhabited mostly by Moldovans (76%), Ukrainians (8%), Russians (6%), Gaugaz (4%), Romanians (2%), Bulgarians (2%) and other minorities (under 1% each). The most common religious denomination is Orthodoxy (data from 2004 Census).

[45] Data for 2010, UNDESA (2012).

[46] The administrative status of Transnistria is disputed, as the central government does not control the territory. The cities of Comrat and Tiraspol, the capitals of the two autonomous territories have municipality status.

[47] With a median age of population of 34.5 years compared with the EU-28 average of 41.5 years. The age dependency ratio (proportion of persons aged 0-14 years and 65 or more to population aged 15-64 years) was 35.4% in Moldova compared with 50.1% at the EU-28 level. Data at 1st January 2012, Eurostat.

[48] Among the SEE analyzed countries, Moldova together with Romania registers the lowest fertility rates and the largest drop in fertility. Between 1980 and 2011 the fertility rate decreased from 2.40 to 1.27(figure 6). However, with about 40 thousands live births per year, Moldova has has a crude birth rate above the EU-28 average (12.0 ‰ compared with 10.4 ‰, in 2011, table 1).

[49] Defined as the proportion of deaths of population younger than 65 in the total number of deaths. The rate of Moldova was 39.9% in 2010 compared with the EU average of approximately 19% (Eurostat data). The rate of Moldova decreased to 39.6% in 2012. More recent data is not available for the EU average (Eurostat data).

ing abroad, particularly in Russia and the CIS countries (meaning that 25-to-40% of the economically active population of the country have had or are in a migration experience) and nearly a quarter of households were benefiting from remittances. A great part of the economic growth between 2000 and 2010 was driven by remittances from Moldovans working abroad (remittances accounted for 23.2% of the GDP in 2010). While remittances have boosted private consumption and the construction sector, value added by agriculture and industry have collapsed. Economic growth since 2000 has, therefore, been 'jobless' and domestic unemployment has remained high, which is one of the main causes of mass emigration (World Bank, 2011).

In this context, the Moldovan population has faced serious economic challenges with a negative impact on their general quality of life. Absolute poverty, although almost halved between 2006 and 2011, still registers high levels at 17.5% in 2011, as the 2012 report of the Ministry of Economy showed (National Bureau of Statistics, HBS data). The urban - rural gap is considerable, poverty incidence in rural areas is nearly six times higher than in large cities (25% compared to 4.2%, in 2011). The most exposed groups to risk of absolute poverty are the elderly and children, employed and self-employed in agriculture, poorly educated people and members of households without remittances.

The general standard of living, measured as GDP per capita, has fluctuated between 1990 and 2011 (figure 9), remaining far below the EU-28 level (only approximately 10%, in 2011).[50] Also, Moldova has a medium human development index,[51] with a rank of 113 out of 187 countries worldwide (figure 8).

[50] Eurostat data (in PPS).

[51] The index measures the average achievement in three basic dimensions of human development - a long and healthy life, knowledge and a decent standard of living.

Montenegro (ME)

Montenegro (*Crna Gora*) is a small, mountainous state in the South West Balkans, with a coast on the Adriatic Sea (South West). It is bordered by Croatia to the West, Bosnia and Herzegovina to the North West, Serbia to the North East, Kosovo to the East and Albania to the South East. With a territory of 13.812 square kilometres, Montenegro has a mostly Mediterranean climate.

The population of 623 thousand[52] people is predominantly urban (about 61.46% of the entire population).[53] Montenegro is divided into 21 municipalities. The capital, Podgorica, is also the largest city. Montenegro has only 2 cities with populations exceeding 50,000 inhabitants.

The proportion between men and women is 49%/51%. Since 2002, the share of children under 15 has constantly decreased reaching 19%, whereas the proportion of people over the age of 65 years has slightly increased (13% of the country's population, in 2012, figure 5). The ageing tendency[54] is less accentuated than at the EU-28 level, but it is expected to increase in the future (up to 48.3% by 2020, according to the World Bank population projection).

The population growth rate has been positive since 2000 (at about 3.5‰ per year). According to the World Bank's population forecast, the population will increase to reach about 633 thousand by 2020, after which it will decline (figure 4).

[52] Data for 2012, Eurostat, downloaded on September 27, 2013. The country is inhabited mostly by Montenegrins (45%), Serbs (29%) Bosniaks (9%), Albanians (5%), Muslims by nationality (3) and other minorities (less than 1% each). The most common religious denomination is Orthodoxism (data from 2011 Census).

[53] Data for 2010, UNDESA (2012).

[54] With a median age of population of 36.8 years, comparable with the EU-28 average of 41.5 years. The age dependency ratio (proportion of persons aged 0-14 years and 65 or more to population aged 15-64 years) was 46.9% in Montenegro compared with 50.1% at the EU-28 level. Data at 1st January 2012, Eurostat.

In Montenegro, the total fertility rate remained stable between 2003 and 2011, with values higher than the EU-28 average: 1.65 compared with 1.56 average births per woman, in 2011.[55] Although the crude death rate has increased since 1990,[56] it has stayed below the other SEE analyzed countries as well as the European average: 9.29‰ compared to EU-28 average of 9.72‰, in 2009.

The general standard of living, measured as GDP per capita, has increased (figure 9), but it reached only 43% of the EU-28 level, in 2012.[57] Considering a multidimensional approach on well-being, Montenegro falls into the group of countries with high human development[58] (with a rank of 52 out of 187 countries worldwide, figure 8).

Romania (RO)

Romania is bordered by Hungary and Serbia to the West, Ukraine and Moldova to the North and East, Bulgaria to the South and the Black Sea to the South East. With a territory of 238,391 square kilometres, Romania has a temperate and continental climate, with four distinct seasons.

The population of 20.077 million[59] people is predominantly urban (about 57.5% of the entire population)[60]. Currently, Romania is divided in 41 counties and the capital Bucharest, which are grouped in 8 development regions. The development regions are territorial units, but not administrative units, being established by association agreements between 4-6 counties. Out of a total of 319 Romanian cities, 103 are municipalities. There are 41 cities with populations greater than 50,000 and 9 with populations exceeding 200,000. Bucharest, the capital, is the biggest municipality in the country (with 1.8 million inhabitants).

The proportion between men and women is 48%/52%. In the period 1977-1992, the population grew by about one million persons, whereas between 1992 and 2002 the population decreased by the same amount. So, in 2002 the population size was comparable to that in 1977. This trend has continued after 2002, with the total population decreasing by about 1.5 million inhabitants by 2012.

The population decline is the result of a cumulated effect of complex of demographic trends recorded after 1990, particularly in fertility, mortality and emigration. Social and economic crises associated with the post-communist transition are considered the most influential causes of the increase in mortality rates and of the growth of external migration. The previously unlikely high levels in fertility trends need a historical explanation. Fertility in Romania used to be unusually high under the impact of the forced pro-natalist policy promoted by the communist party, by far the most coercive policy in Europe. In 1990-1991 all restrictions concerning access to contraception and abortion were lifted. Nonetheless, the former communist policy still has had effects on the fertility dynamic after 1990 due to the size and structure of the fertile-age population. In addition, the context of transition, on the one hand bringing poverty, unemployment uncertainty and stress, and, on the other, higher availability of information about family planning and the diffusion of western cultural models, altered the demographic behaviour. Consequently, fertility drastically diminished (from 2.39 children per woman in

[55] The Eurostat data show that after 2002 the number of births was of about 7-8 thousands per year, registering in 2011 the lowest number. In the same time, the crude birth rate has declined from 14.4 ‰ to 11.6 ‰ in the same period. Nonetheless, the crude birth rate of Montenegro is higher than the EU-28 average (10.4 ‰, in 2012, table 1).

[56] The crude death rate increased from 6.11‰ (1990) to 9.29‰ (2009).

[57] Eurostat data (in PPS).

[58] The index measures the average achievement in three basic dimensions of human development - a long and healthy life, education and a decent standard of living.

[59] Data for 2012, Eurostat, downloaded on September 27, 2013. The country is inhabited mostly by Romanians (88.6%), Hungarians (6.5%), Roma (3.2%) and other minorities that account for the remaining 1.4% of the population. The most common religious denomination is Orthodoxy (data from 2011 Census).

[60] Data for 2010, UNDESA (2012).

1990 to 1.27 in 2011).[61] The fertility rate is much below the level required for generational replacement, so demographic ageing will be one of the most serious problems in about 20-25 years, when the large generation born after 1967 will retire.

Since 2000, the share of children under 15 has constantly decreased, reaching 15%, whereas the proportion of people over the age of 65 years has increased up to 16% of the country's population (figure 5). Thus, the ageing tendency[62] is rather accentuated. Furthermore, the World Bank's population forecast shows that this trend will continue and the population dependency ratio will reach 47.9% by 2020 (compared with 43.1% in 2010).

The population growth rate has been negative since 2000 (at about -2.1‰ per year). According to the World Bank's population projection, despite the negative growth rate, the population will increase to about 21 million by 2020, after which it will decline (figure 4).

Romania has had a high mortality rate, both total and premature. After 1974, when the lowest mortality rate in the country was recorded (9.1 ‰), the death rate has been steadily growing (table 2). The death rate in Romania is significantly higher than the EU-28 average (12.12‰ compared with 9.67 ‰, in 2011, table 2; see also figure 7). Also, rates of premature mortality[63] are considerably higher compared with the EU average (27% versus 19.3%, in 2010).

External migration represents the third demographic trend with a significant contribution to the population decline. Romania represents the second largest provider of the migrant labour force in Europe, after Turkey. In 2010, Eurostat data show that the number of Romanian migrant resident on EU territory was over 2 million i.e. almost 10% of Romania's population (Vasileva, 2011). However, it is estimated that the real number of Romanians in the EU is higher. Over 70% of the Romanians which work abroad have chosen as their destination countries either Spain or Italy (Stanculescu and Stoiciu, 2012). Labour migration, temporary or circular in nature, is the most prominent component of Romanian emigration. Certain surveys indicate that from 4 to 7.3% of the population has worked abroad at least once since 1990. (IOM, 2008) Correspondingly, remittances from abroad made an important contribution to GDP, which reached a peak in 2006 and started to decline steeply after 2008.[64]

The general standard of living, measured as GDP per capita, has constantly increased (figure 9), yet has remained well below the EU-28 level (only 49% in 2012).[65] Based on a broader definition of well-being, which measures the average achievement in three basic dimensions - a long and healthy life, education and a decent standard of living, Romania belongs to the group of countries with high human development, with a rank of 56 out of 187 countries worldwide (figure 8).

Serbia (SRB)

Serbia is located at the crossroads of Central and Southeast Europe. It is a landlocked country bordered by Hungary to the North, Romania and Bulgaria to the East, Macedonia to the South, Croatia, Bosnia and Montenegro to the West. With a territory of 88,361 square kilometres, Serbia has a diverse, mostly continental and Mediterranean climate.

[61] With about 196 thousand live births per year, Romania has had a birth rate below the EU-28 average (10 ‰ compared with 10.4 ‰, in 2012 (table 1)

[62] With a median age of the population of 39 years compared with the EU-28 average of 41.5 years. The age dependency ratio (proportion of persons aged 0-14 years and 65 or more to population aged 15-64 years) was 43% in Romania compared with 50.1% at the EU-28 level. Data as of the 1st of January 2012, Eurostat.

[63] Defined as the proportion of deaths of population younger than 65 in the total number of deaths. The rate of Romania decreased to 25.4% in 2012. More recent data are not available for the EU average (Eurostat data).

[64] Remittances grew from 0.3% of GDP in 2000 to 5.4% in 2006 and it dropped to 4.5% in 2008 (beginning of the global financial crisis), respectively to 1.9% of GDP in 2012. (World Bank Database)

[65] Eurostat data (in PPS).

The population of 7.217 million[66] people is predominantly urban (about 56.06% of the entire population).[67] Serbia is organized into 25 districts, including 138 municipalities and 23 cities, which form the basic units of local self-government. Out of the total, 17 cities register populations larger than 50,000. The capital and largest city is Belgrade, which constitutes a district of its own.

The proportion between men and women is 49% – 51%. The country's population, both domicile and refugees, is characterized by ageing, smaller families, and migration into cities. Since 2000, the share of children under 15 has constantly decreased, reaching 14%, whereas the proportion of people over the age of 65 years has remained constant between 2003 and 2012 at 17% of the country's population (figure 5). The ageing tendency[68] is less accentuated than the EU-28 level, but it is expected to increase in the future (up to 49.3% by 2020, according to the World Bank population forecast).

Serbia has experienced negative population growth rate since the 1990s. This trend was maintained after 2000 and deepened after 2007 when the country registered natural growth rates of - 4.8‰ per year on average. The World Bank's population projection indicates that the population is expected to decrease further to 7.172 million by 2020 (figure 4).

The negative natural population growth is mainly the result of a long-term decline in fertility[69] together with an increase in mortality. Serbia has had a high mortality rate, both total and premature. With about 110 thousands deaths per year, Serbia has constantly registered a death rate considerably higher than the EU-28 average (14.18‰ compared with 9.67 ‰, in 2011, table 2; see also figure 7). The premature mortality[70]rate is relatively high compared with the EU average (22.4% versus 19.3%, in 2010).

Serbia belongs to upper-middle-income countries. The poverty rate decreased between 2002 (10.6%) and 2008 (7.9%), but a large proportion of the population is at risk of falling into poverty. The impact of the economic crisis primarily affected employment – with the official national unemployment rate increasing to 23.6% in 2011.

The general standard of living, measured as GDP per capita, has constantly increased (figure 9), yet has remained well below EU-28 levels (only 35% in 2012).[71] According to the human development approach,[72] Serbia belongs to the group of countries with high human development, with a rank of 64 out of 187 countries worldwide (figure 8).

[66] Data for 2012, Eurostat, downloaded on September 27, 2013. The country is inhabited mostly by Serbs (83.3%), Hungarians (3.5%), Roma (2%), Bosniaks (2%) and other minorities (less than 1% each). The most common religious denomination is Orthodoxy (data from 2011 Census).

[67] Data for 2010, UNDESA (2012).

[68] With a median age of population of 41.6 years, comparable with the EU-28 average of 41.5 years. The age dependency ratio (proportion of persons aged 0-14 years and 65 or more to population aged 15-64 years) was 46.7% in Serbia compared with 50.1% at the EU-28 level. Data at 1st January 2012, Eurostat.

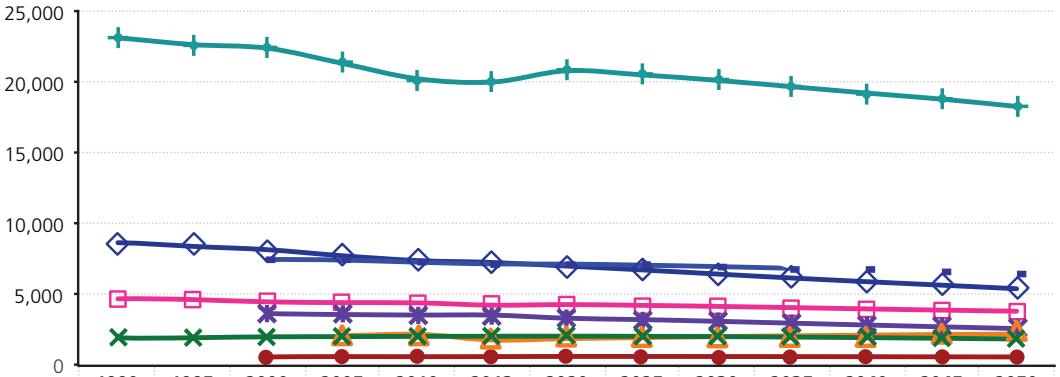
[69] With about 50 thousand live births per year, Serbia has had a crude birth rate below the EU-28 average (9.3 ‰ compared with 10.4 ‰, in 2012, table 1).

[70] Defined as the proportion of deaths of population younger than 65 in the total number of deaths. The rate of Serbia decreased to 22.1% in 2012. More recent data are not available for the EU average (Eurostat data).

[71] Eurostat data (in PPS).

[72] The index measures the average achievement in three basic dimensions of human development - a long and healthy life, knowledge and a decent standard of living.

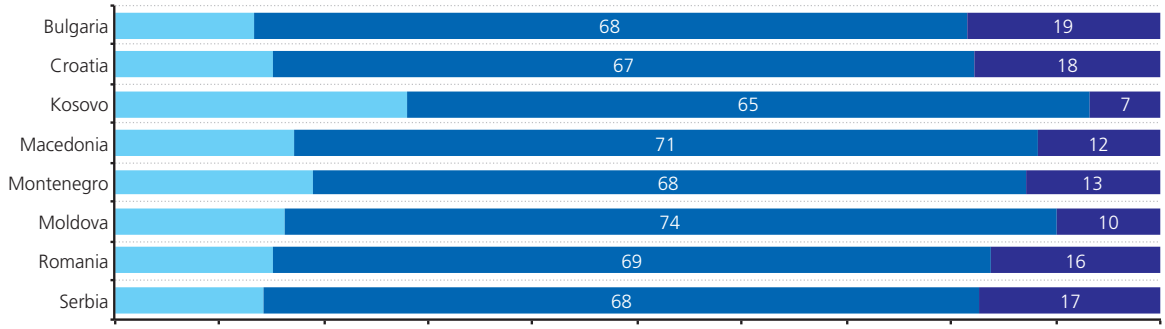
Figure 4. Population on 1 January by country (in 1,000 persons)



	1990	1995	2000	2005	2010	2013	2020	2025	2030	2035	2040	2045	2050
Bulgaria	8,767	8,427	8,191	7,761	7,422	7,285	7,030	6,760	6,468	6,186	5,926	5,679	5,428
Croatia	4,773	4,659	4,498	4,444	4,426	4,262	4,305	4,249	4,177	4,090	3,999	3,913	3,834
Kosovo				2,041	2,208	1,794	1,894	1,966	2,034	2,092	2,143	2,184	2,216
Macedonia	1,873	1,957	2,022	2,035	2,053	2,062	2,068	2,058	2,037	2,004	1,964	1,918	1,868
Moldova			3,644	3,600	3,564	3,559	3,338	3,242	3,121	2,989	2,858	2,731	2,605
Montenegro			612	623	616	623	633	632	628	623	615	606	597
Romania	23,211	22,712	22,455	21,382	20,295	20,057	20,860	20,564	20,180	19,731	19,276	18,848	18,332
Serbia			7,528	7,456	7,307	7,182	7,172	7,095	6,995	6,872	6,746	6,612	6,464

Data: For 1990-2013, Eurostat, September 2013. For 2015-2050, population growth projections of the World Bank.[73]

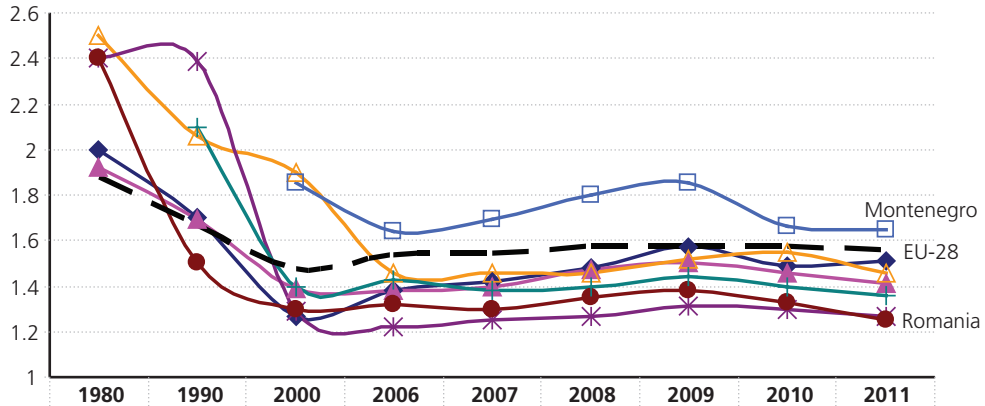
Figure 5. Population by broad age groups in 2012 (%)



Data: Eurostat, September 2013.

[73] The input data used for these projections include a base year (mid-2010) population estimate by age and sex, and five-year period assumptions of mortality, fertility, and migration through 2050.

Figure 6. Total fertility rate by country



	1980	1990	2000	2006	2007	2008	2009	2010	2011
Bulgaria	2	1.7	1.27	1.38	1.42	1.48	1.57	1.49	1.51
Croatia	1.92	1.69	1.39	1.38	1.4	1.47	1.5	1.46	1.41
Macedonia	2.5	2.06	1.9	1.46	1.46	1.46	1.52	1.55	1.46
Montenegro			1.85	1.64	1.69	1.8	1.85	1.66	1.65
Moldova	2.4	2.39	1.29	1.22	1.25	1.27	1.31	1.30	1.27
Romania	2.4	1.5	1.3	1.32	1.30	1.35	1.38	1.33	1.25
Serbia		2.1	1.4	1.43	1.38	1.40	1.44	1.40	1.36
EU-28	1.88	1.66	1.47	1.53	1.54	1.57	1.57	1.57	1.56

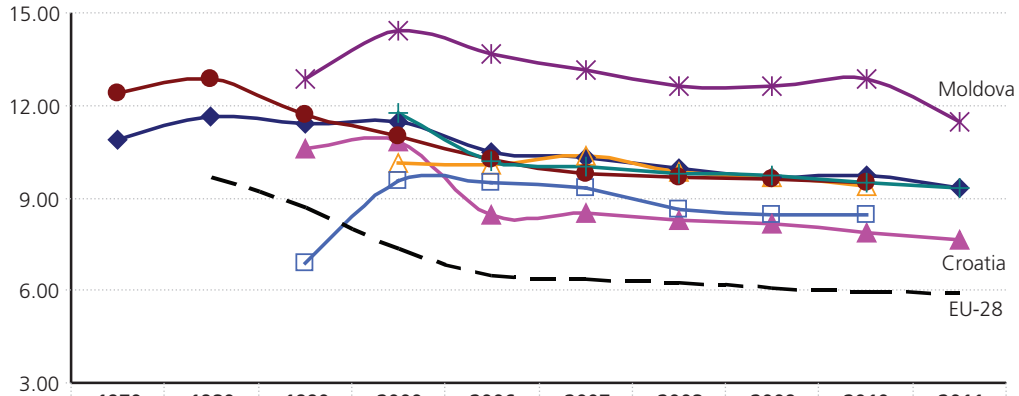
Data: WHO/Europe, European HFA Database, July 2013. Definition: The average number of children that would be born alive to a woman during her lifetime if she were to pass through her childbearing years conforming to the fertility rates by age of a given year. Comparable data for Kosovo not available.

Table 1. Crude birth rate (per 1,000 inhabitants)

Country	2001	2005	2006	2007	2008	2009	2010	2011	2012
Bulgaria	8.5	9.2	9.6	10	10.4	10.9	10.2	9.6	9.5
Croatia	9.2	9.6	9.3	9.4	9.9	10.1	9.8	9.4	9.8
Kosovo	...	18	16.2	15.5	15.9	15.7	...	15.4	15.4
Macedonia	13.3	11	11.1	11.1	11.2	11.5	11.8	11.1	11.4
Montenegro	14.4	11.8	12.1	12.5	13.1	13.7	12	11.6	12
Romania	10	10.4	10.4	10.3	10.8	10.9	10.5	9.7	10
Serbia	10.5	9.7	9.6	9.2	9.4	9.6	9.4	9.1	9.3
EU-28	10.4	10.4	10.6	10.6	10.9	10.7	10.7	10.4	10.4

Data: Eurostat, September 2013. Definition: The crude birth rate represents the ratio of the number of births during the year to the average population in that year. Note: Comparable data for Moldova is not available.

Figure 7. Age-standardized death rates, all causes, all ages, by country (per 1,000 inhabitants)



	1970	1980	1990	2000	2006	2007	2008	2009	2010	2011
Bulgaria	10.90	11.62	11.38	11.46	10.46	10.28	9.95	9.65	9.70	9.33
Croatia			10.60	10.84	8.42	8.52	8.30	8.13	7.90	7.61
Macedonia				10.15	10.08	10.39	9.82	9.65	9.40	
Montenegro			6.86	9.53	9.50	9.29	8.60	8.46	8.46	
Moldova			12.88	14.41	13.69	13.13	12.64	12.61	12.88	11.47
Romania	12.36	12.84	11.69	10.98	10.26	9.80	9.64	9.59	9.48	
Serbia				11.76	10.18	10.01	9.78	9.72	9.48	9.30
EU-28		9.65	8.66	7.36	6.45	6.35	6.24	6.10	5.96	5.87

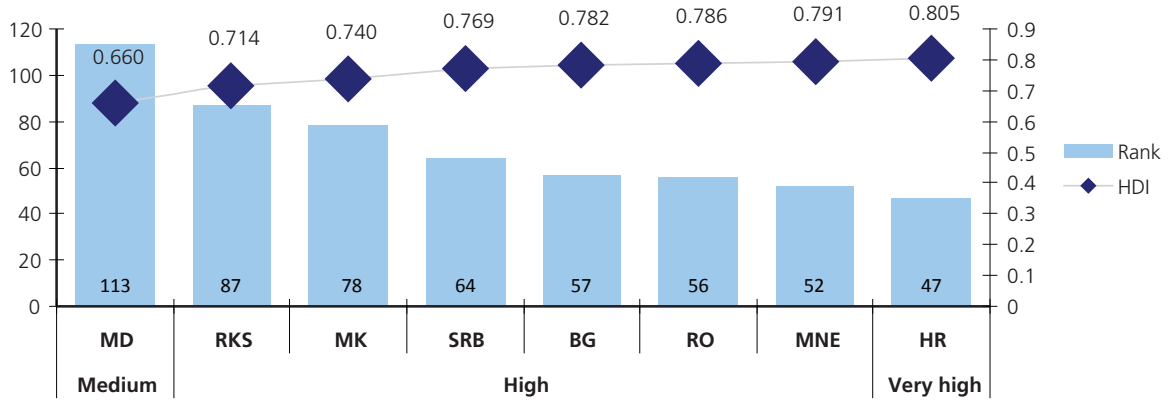
Data: WHO/Europe, European HFA Database, July 2013. Definition: The age-standardized death rate calculated using the direct method, i.e. represents what the crude rate would have been if the population had the same age distribution as the standard European population. Comparable data for Kosovo is not available.

Table 2. Crude death rate (per 1,000 inhabitants)

Country	1990	2000	2005	2006	2007	2008	2009	2010	2011	2012
Bulgaria	12.08	14.09	14.65	14.73	14.75	14.5	14.25	14.62	14.73	...
Croatia	10.92	11.47	11.66	11.35	11.81	11.76	11.83	11.79	11.59	...
Kosovo	...	8.51	9.04	9.13	9.59	9.27	9.29	9.3	...	...
Macedonia	6.11	8.74	9.37	9.56	9.55	9.08	9.29	...	...	...
Montenegro	9.73	11.33	12.43	12.03	12.04	11.75	11.82	12.25	11.03	11.11
Romania	10.65	11.4	12.12	11.96	11.7	11.77	11.98	12.12	...	...
Serbia	...	13.84	14.35	13.88	13.93	13.97	14.21	14.16	14.18	...
EU-28	10.4	10.03	9.83	9.64	9.7	9.74	9.72	9.7	9.67	...

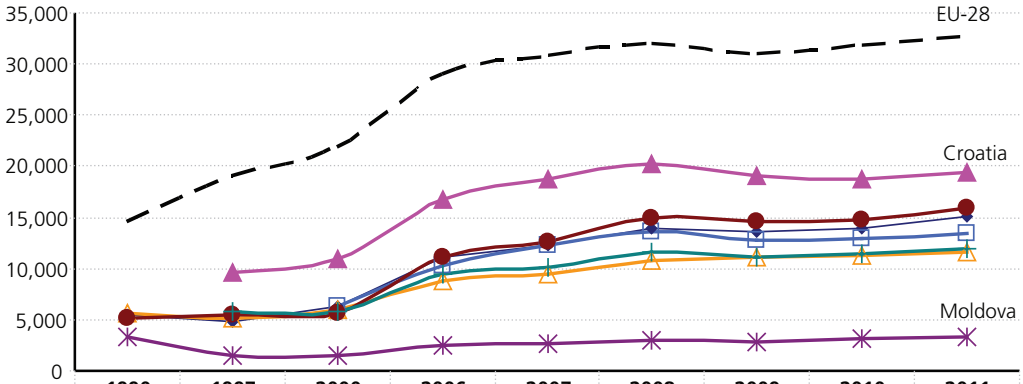
Data: WHO/Europe, European HFA Database, July 2013. Definition: The crude death rate represents the ratio of the number of deaths during the year to the average population in that year. Note: Comparable data for Kosovo is not available.

Figure 8. Human Development Index (HDI) by country in 2012



Data: UNDP (2013). HDI calculated based on the new method (2010 Report onwards), based on three dimensions: Life expectancy at birth, Mean years of schooling and Expected years of schooling, GNI per capita (PPP US$). Rank among the 187 countries included.

Figure 9. Real gross domestic product, PPP$ per capita



	1990	1997	2000	2006	2007	2008	2009	2010	2011
Bulgaria	5,402	4,855	6,225	11,063	12,344	13,916	13,617	13,892	15,083
Croatia		9,586	10,922	16,795	18,687	20,215	19,158	18,727	19,487
Macedonia	5,559	5,059	5,943	8,760	9,483	10,723	11,152	11,327	11,561
Montenegro			6,303	10,309	12,243	13,650	12,807	12,977	13,432
Moldova	3,310	1,508	1,470	2,562	2,723	3,005	2,866	3,094	3,369
Romania	5,186	5,500	5,662	11,119	12,665	14,983	14,643	14,778	15,983
Serbia		5,723	5,768	9,431	10,106	11,531	11,060	11,421	11,887
EU-28	14,645	18,998	21,916	29,050	30,772	32,000	31,035	31,774	32,724

Data: WHO/Europe, European HFA Database, July 2013. Note: Comparable data for Kosovo is not available.

2.2 HEALTH STATUS

Chapter 2.1 showed that the all eight countries selected for this study lag behind Western European States in terms of living conditions, but with marked differences between Croatia (with a level of GDP per head of 61% of the EU-28 average), Macedonia and Serbia (with rates 35%) and Moldova (with a level of GDP per head of only 10% of the EU-28 average).[74] After 1990, all SEE countries experienced tremendous social changes linked to the transition to democracy and market economy and/or to war. Changes in socioeconomic conditions have affected population health both directly and through psychosocial factors (Marmot and Wilkinson, 1999). In common with most countries from the former Soviet Union, all countries included in this study experienced a mortality crisis in the early 1990s. For example, in Bulgaria and Romania, after the fall of communism, men faced a steady deterioration in mortality, while women experienced no improvement (Nolte et al., 2005). The focus of this chapter is on investigating the differences in health status between the eight selected countries.

Economic growth is a major determinant of the average health status in poor and developing countries. Among poor countries, a small rise in gross national product leads to large gains in life expectancy, but as the gross national product increases, the relationship levels off (Mladovsky et al., 2009).[75] At the same time, there is a strong bidirectional relation between health and socioeconomic status. Socioeconomic inequalities in health status are persistent in all societies: people at the bottom of the social scale are more likely to report ill health than those near the top, both at individual and population levels. The inequalities in health status within and between countries are determined by the 'unequal distribution of power, income, goods and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives - their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns and cities - and their chances of leading a flourishing life' (WHO Commission on Social Determinants of Health, 2008).

Other determinants of socioeconomic inequality in health refer to individual genetic predispositions (which are out of the scope of this report) or are environment or lifestyle-related, such as diet, physical exercise, housing, smoking and alcohol consumption (Mackenbach at al., 2002). These latter determinants are not necessarily the result of free choice, but are influenced by the stratification of society (Mladovsky et al., 2009). Finally, the healthcare system may also play a role in explaining health inequalities, but this theme is addressed in chapter 2.3 of this report.

2.2.1 Trends in life expectancy

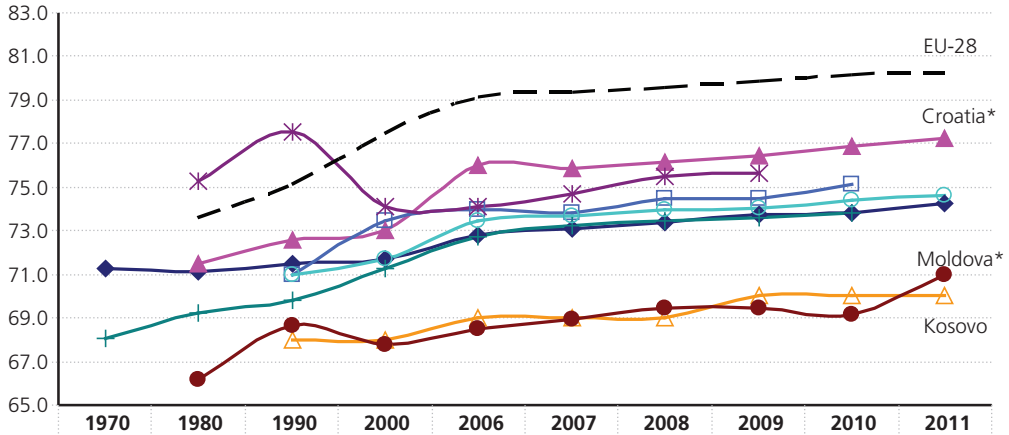
Life expectancy is one of the most widely used macro-level measures of population health. Life expectancy has increased in seven of the eight studied countries, which indicates that the population's health has improved since the 1970s (figure 10). During the 1990s, Montenegro experienced a decline in life expectancy both for men and women; the trend reversed only after 2006. In the other countries, in the last twenty years,[76] life expectancy at birth increased by values ranging from between less than one year in Moldova and almost four years in Romania. Nonetheless, the gap between the EU and these countries has remained significant. Thus, in 2011, the average life expectancy in EU-28 countries was 80.2 compared with values between 77.3 in Croatia and only 70 in Kosovo.

[74] Index of GDP per capita expressed in PPS. Data for 2011 from Eurostat and, for Moldova, from WHO/Europe, European HFA Database.

[75] In wealthy countries, absolute income has no significant effects on longevity.

[76] For most studied countries, reliable mortality data are only available from 1990 onwards.

Figure 10. Trends in life expectancy at birth, total population (years)



	1970	1980	1990	2000	2006	2007	2008	2009	2010	2011
Bulgaria	71.3	71.1	71.5	71.7	72.8	73.1	73.4	73.8	73.8	74.3
Croatia*		71.5	72.6	73.0	76.0	75.9	76.1	76.4	76.9	77.3
Kosovo			68	68	69	69	69	70	70	70
Macedonia			71.0	73.4	74.0	73.8	74.5	74.5	75.1	
Montenegro*		75.3	77.55	74.1	74.1	74.7	75.5	75.6		
Moldova*		66.1	68.6	67.8	68.5	69.0	69.4	69.4	69.1	71.0
Romania	68.0	69.2	69.8	71.3	72.7	73.3	73.5	73.6	73.8	
Serbia			71.0	71.7	73.5	73.7	74.0	74.1	74.4	74.6
EU-28		73.6	75.2	77.5	79.2	79.4	79.6	79.9	80.1	80.2

Data: WHO/Europe, European HFA Database, July 2013. Data for Kosovo from the World Bank, September 2013. Definition: Life expectancy at birth indicates the mean number of years a newborn infant would live, if subjected throughout the rest of his or her life to the current mortality conditions (age-specific probabilities of dying).
Note: * Data for 1985.

As in the other European countries, women on average live longer than men. In 2011, the gap was as large as eight years, in Moldova, or seven years, in Bulgaria and Romania, compared with four years in Kosovo and Macedonia (table 3).

In most countries, men have not only a shorter life expectancy, but also a shorter expected lifespan in good health than women. The available estimates of healthy[77] life expectancy at birth for women and men are higher for Bulgaria (65.9 years for women and 62.1 for men, in 2011) than for Croatia (61.8 for

[77] Eurostat data for 2011. Data is not available for the other five countries included in the study. Definition: The number of years that a person can expect to live in a good health, without any severe or moderate health problems. Indicator calculated based on EU-SILC and mortality data.

Table 3. Female-male differences in life expectancy at birth, 2011 (years)

	BG	HR	RKS	MK	MNE	MD	RO	SRB	EU-28
Female	78	80	72	77	77	73	78	77	83.02
Male	71	74	68	73	72	65	71	72	77.4
Female-male	**7**	**6**	**4**	**4**	**5**	**8**	**7**	**5**	**5.62**

Data: World Bank, September 2013. Data for EU-28 from Eurostat, September 2013. Notes: Bulgaria (BG), Croatia (HR), Kosovo (RKS), Macedonia (MK), Moldova (MD), Montenegro (MNE), Romania (RO) and Serbia (SRB).

women and 59.9 for men). So, Croatian people live longer than Bulgarians, but the Bulgarians live more healthy years compared with the Croatians. For Romania, the situation is different. Firstly, men have a slightly higher healthy life expectancy at birth than women (57.4 for men and 57 for women). Secondly, the average number of healthy life years is considerably lower compared to Bulgaria and Croatia, both for men and women. Finally, in all selected countries the average number of years spent in good health is far below the EU-15 average of more than 70 years.

Micro-level health indicators provide, however, a different mapping of health status in the region. Data on self-reported health status is available only for Moldova (NBS, 2011) and the EU member states - Bulgaria, Croatia and Romania, and only from 2010 onwards. In 2010-2011, the percentage of people reporting either 'poor' or 'very poor' health was approximately 10% in Romania (similar to the EU-28 average), 12% in Bulgaria and Moldova, and 28% in Croatia (Eurostat data). Thus, the self-reported health status results do not correspond to life expectancy, indicating instead a reverse tendency across countries. Although many studies have demonstrated that self-assessed indicators are better predictors of mortality than medical records, the differences in self-reported health should be carefully considered since it is sensitive to variations in environmental conditions as well as individual perceptions and expectations of their conditions. For example, the report for Moldova (NBS, 2011) shows that self-assessed health is more critical as age increases, for women compared to men, for rural residents compared with the urban ones (with much better access to health-care services), and for poor compared to the better-off people.

2.2.2 Trends in child and maternal health

Infant mortality, although on a descendent trend since the 1970s, is still higher than the EU average. Figure 11 shows that, in 2011, the infant mortality rate was comparable with the EU-28 average (3.9 per 100) in only two countries - Montenegro and Croatia (with rates of 4.4, respectively 4.7 per 1000), whereas in the other six countries was much greater, particularly in Kosovo (13.1 per 1000) and Moldova (11 per 1000).

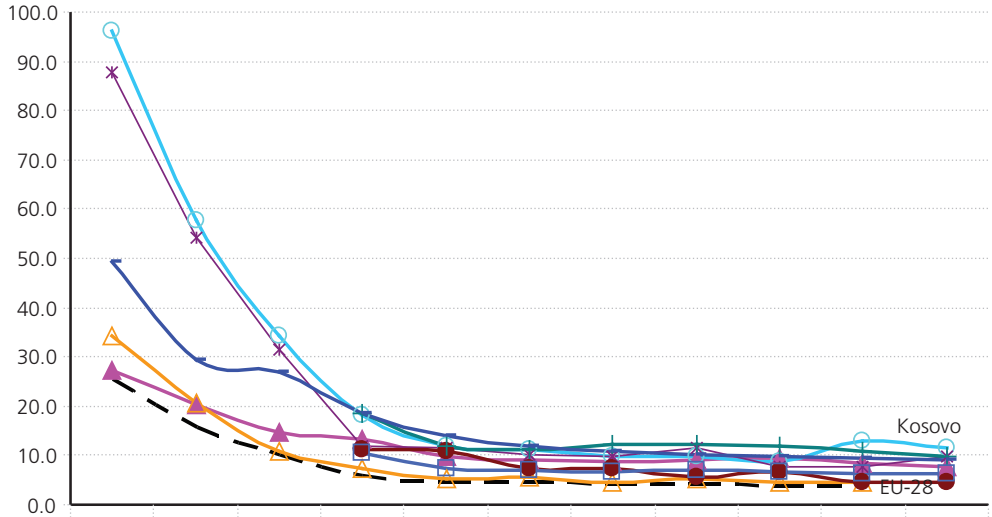
In all studied countries, the infant mortality is higher in rural compared to urban areas. For example, in Romania, the infant mortality rate was 6.6‰ in urban areas and as high as 11.8‰ in the rural environment, compared to the 2012 national average of 9% (Ministry of Health of Romania, 2013). Monitoring reports on progress towards the Millennium Development Goals in Moldova (e.g. PAS and UNICEF, 2009) show that a child from a rural area has 1.5 times higher chances of dying before the age of five compared to a child from an urban settlement. Also, children from a poor household have two times higher chances of dying before the age of five compared to children from well-off households.

According to the UNICEF's Country Programme Document 2013-2017 for Bulgaria (UNICEF, 2012a), an increasing number of children whose parents do not have health insurance cannot access health services and 12% of children aged 0-3 years are not registered with a doctor, although the right to free access to health is guaranteed under law. The infant mortality rate in some parts of the country reached 33 per 1000 live births, in 2011. The situation is even worse in Roma settlements due to difficult access to health services, low levels of education of parents and caregivers, poor nutrition and sanitary conditions well below standards.

In Croatia, the positive outcomes have been supported by the determined commitment of the government to accelerate progress on maternal, newborn and child survival (the pledge 'A Promise Renewed'). The network of maternity wards achieving baby friendly status expanded and reached 84% of all maternity wards. This was followed by an increase in exclusive breastfeeding practices (UNICEF, 2012b).

In Kosovo, infant and under-five mortality rates are among the highest in Europe and are

Figure 11. Trends in infant mortality (per 1000 live births)



	1970	1980	1990	2000	2006	2007	2008	2009	2010	2011	2012
EU-28	25.5	15.8	10.3	5.9	4.6	4.5	4.3	4.2	4.0	3.9	
Bulgaria	27.3	20.2	14.8	13.3	9.7	9.2	8.6	9.0	9.4	8.5	7.8
Croatia	34.2	20.6	10.7	7.4	5.2	5.6	4.5	5.3	4.4	4.7	
Kosovo	96.3	57.7	34.4	18.2	12.0	11.1	9.7	9.9	8.8	13.1	11.4
Macedonia	87.9	54.2	31.6	11.8	11.5	10.3	9.7	11.7	7.6	7.6	9.8
Montenegro				11.1	11.0	7.4	7.5	5.7	6.7	4.4	4.4
Moldova				18.4	11.8	11.3	12.1	12.1	11.8	11.0	9.8
Romania	49.4	29.3	26.9	18.6	13.9	12.0	11.0	10.1	9.8	9.4	9.0
Serbia				10.6	7.4	7.1	6.7	7.0	6.7	6.3	6.2

Data: Eurostat, September 2013. Definition: Infant mortality rate represents the ratio of the number of deaths of children under one year of age during the year to the number of live births in that year.

accompanied by significant levels of stunted growth, malnourishment and malnutrition in young children (Stubbs and Nestic, 2010). 'On paper, poor families and repatriated families are entitled to free health care, including medication. In reality, access to health-care across Kosovo depends on cash payments - thus excluding the most vulnerable' (Knaus, 2011, p. 29)

In Macedonia, the key child health indicators have improved since the 1990s. Thus, infant mortality and stunted growth rates in children under-five have followed a declining trend. Nonetheless, disparities persist among different ethnic communities. Roma and Albanian children have 25% higher infant mortality. Roma children have 4.5 times higher stunting prevalence than the national average. Disparities in child indicators are also significant among geographical regions, with some of them being up to 30% higher than the national average. (UNICEF, 2012c)

In Moldova, most infant deaths are related to perinatal conditions; reflecting poor maternal health care. The maternal mortality rates due to pregnancy-related pathologies and complications have also remained high (41 per 100000 live births in 2010, WHO data). In rural areas, maternal mortality is 1.8 times higher than in urban areas. Social determinants, particularly poverty and migration play an important role in half of the maternal mortality

cases (UNICEF, 2012d). The UNICEF's Country Programme Document 2013-2017 for Moldova (UNICEF, 2012e) shows that in rural areas and the south, the under-five mortality rate is 33 to 50% higher than the national average. Rural and poor children and pregnant women, including Roma, miss out on medical care due to; long distances required to travel to reach health-care providers; informal payments; costs of treatments not covered by health insurance. 60% of children in rural schools face water and sanitation associated health risks.

In Montenegro, infant and maternal mortality are low, at levels comparable with the European average. However, refugees and unregistered Roma remain among the most vulnerable. Almost 40% of Roma, of whom two thirds are children, lack either birth or citizenship documentation. While for the nation in general the under-five mortality rate is 8 per 1,000 live births (in 2010), it is estimated to be three times higher for Roma. (UNICEF, 2010a)

In Romania, most infant deaths are related to perinatal conditions and malformations but also due to diseases of the respiratory system. The maternal mortality rate in Romania has declined noticeably since the 1990s. Despite this positive trend however, the current estimated maternal mortality rate is still rather high in the European context (27 per 100000 live births in 2010, WHO data). Disparities (including in health) particularly affect the Roma population: children with disabilities and children living in rural areas (UNICEF, 2012f). The infant mortality rate is 60 per cent higher in rural areas than in urban areas, according to Ministry of Health data. The infant mortality rate in the northeast region, the poorest part of the country, is 87 per cent higher than in Bucharest.

Serbia reports a situation similar to Montenegro, with good results on child health indicators for the general population, but with persistent inequalities between ethnic groups. Roma face disproportionate risks from poverty, unemployment, low education[78] as well as ill health and thus, under-five mortality rate is three times higher for Roma than for the general population. (UNICEF, 2010b)

2.2.3 Major causes of morbidity and mortality

Communicable Diseases

Communicable diseases account for 9% of the disease burden in the WHO European Region, of which over half is related to HIV and Tuberculosis (TB). Although with stable low prevalence, communicable diseases remain high on the public health agenda, mainly due to high rates of TB (particularly its drug-resistant forms) and growing rates of HIV infection in several Member States and bordering countries. (WHO, 2013) Socially conditioned diseases such as HIV/AIDS and TB have the highest impact on life quality and duration, and are the main causes of poverty, discrimination and marginalization. (UN, 2008)

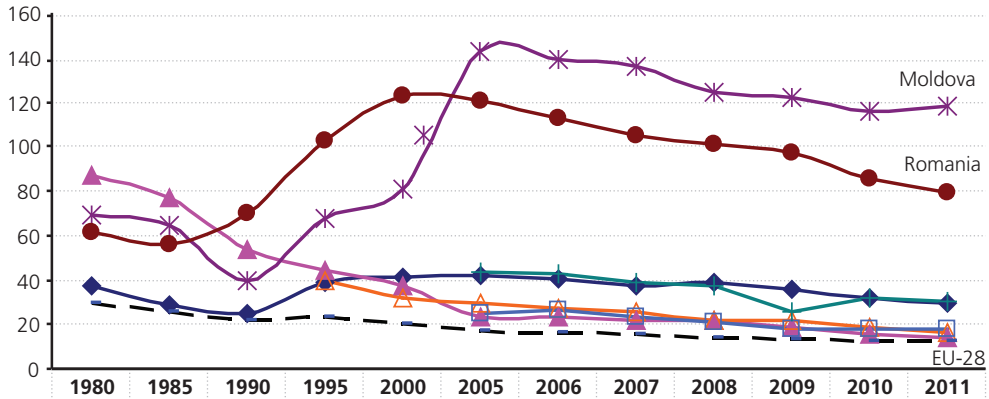
Similarly, in the countries under study, communicable diseases have a low prevalence due to the constantly improving surveillance system immunization coverage. Only in of Moldova, communicable diseases still represent major causes of morbidity and mortality due to the system's insufficient capacity to detect and respond to outbreaks (WHO, 2006).

Tackling Tuberculosis is still challenging in the region. Nevertheless, only Romania and Moldova are high-burden countries for TB prevention and control, due to their high TB incidences, which have only started to decrease since 2000, in Romania and 2005, in Moldova (figure 12).

Sexually transmitted infections and HIV/AIDS also represent a challenge. However, the rate of HIV infection among adults aged 15 to 49

[78] Education coverage remains high at 94.8 percent, but the (gross) completion rates are much lower for Roma (28%), poor (77%), and rural (89%) children. (UNICEF, 2010b)

Figure 12. Tuberculosis incidence per 100 000, in 2011



	1980	1985	1990	1995	2000	2005	2006	2007	2008	2009	2010	2011
Bulgaria	37.01	28.52	25.09	38.6	40.99	41.67	40.73	37.18	38.62	35.37	32.01	29.56
Croatia	87.23	76.67	53.91	44.26	37.2	23.64	23.18	21.44	22.1	18.78	15.57	14.06
Macedonia				39.98	31.63	29.36	27.5	25.74	21.98	21.94	18.69	16.23
Montenegro						25.03	26.75	23.48	20.83	17.89	17.82	17.73
Moldova	69.33	64.83	39.62	67.42	80.64	143	139.18	135.79	124.42	121.91	115.72	118.2
Romania	61.05	55.78	70.05	102.6	122.44	120.72	112.56	104.89	101.02	97.2	85.76	79.23
Serbia						43.11	42.45	39.17	36.92	25.67	31.9	29.91
EU-28	29.78	25.26	21.6	23.23	20.23	17.16	16.58	15.47	14.11	13.5	12.31	12.14

Data: WHO/Europe, European HFA Database, July 2013. Data not available for Kosovo. Definition: Number of newly diagnosed tuberculosis cases, all forms (ICD-9:010-018; ICD-10: A15-A19) during the given calendar year; relapses are included.

is still below 0.1% in all studied countries, with the exception of Moldova which has a high and increasing prevalence of HIV (0.5% in 2011).[79] At the same time, in 2011, HIV incidence in Moldova (with 20.25 new HIV-positive persons were found per 100 000) was almost 14 times larger than in Montenegro, 11-12 times higher compared to Croatia, Romania and Serbia, and more than 7.4 times larger than in Bulgaria. Also, the syphilis incidence is considerable higher in Moldova than in the other countries (63.54 per 100000, in 2011).[80]

Viral hepatitis B, C and Delta account for a significant morbidity and mortality burden in Moldova (WHO, 2006). Within the European Union, intermediate to high prevalence rates are found only in Bulgaria, Latvia, Romania and Turkey (Rechel at al., 2011).

[79] WHO, Global Health Observatory Data Repository, September 2013.

[80] WHO/Europe, European HFA Database, July 2013. For comparison, the EU average of HIV incidence was 5.65, in 2011.

Non-communicable diseases (NCDs) and risk factors

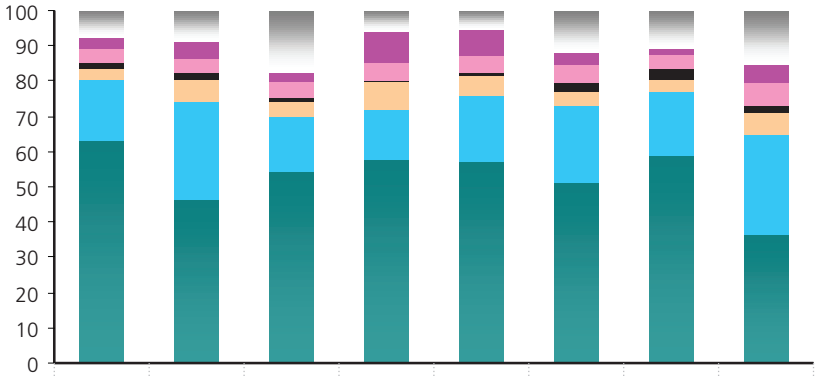
Non-communicable diseases represent one of the biggest burdens on the health system and also on the daily life of patients and their families. Because most are treatable but not always curable, these health conditions generate an enormous financial burden due to costs of treatment and care and loss of productivity (European Chronic Disease Alliance, 2010).

At the global level, non-communicable diseases (NCDs) - particularly cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases and diabetes - account for the largest share of mortality: about 80% of deaths. In Europe, in 2009, diseases of the circulatory system accounted for nearly 50% of all deaths, with higher rates among men than women, followed in frequency by cancer (neoplasm), with 20% of deaths, and external causes of injury and poisoning, representing 8% of all deaths. (WHO, 2013a)

The eight SEE countries under study (no data for Kosovo) follow the European pattern. Figure 13 shows that the circulatory diseases and neoplasm represent the first two major causes of death in all eight countries. The third major cause of death varies across countries: external causes of injury and poisoning, in Bulgaria and Croatia, diseases of the respiratory system in Bulgaria, Montenegro and Serbia and diseases of the digestive system in Moldova and Romania. In all eight countries, the burden of noncommunicable diseases (NCDs) is increasing.

The high burden of NCDs is directly related to a high prevalence of risk-factors. All over the world, tobacco use, physical inactivity,

Figure 13. Mortality profile by cause of death in 7 selected SEE countries, last reported data, 2009-2011 (% of total deaths)



	BG	HR	MNE	MD	RO	SRB	MK	EU-28
Other causes of death	8	9	18	6	5	12	11	15
Diseases of the digestive system	3	5	2	9	7	3	2	5
Diseases of the respiratory system	4	4	5	5	5	5	4	7
Diabetes	1	2	1	1	1	3	4	2
External causes of injury and poisoning	4	6	4	7	6	4	3	6
Neoplasms	17	28	15	14	19	22	18	28
Diseases of circulatory system	63	46	55	58	57	51	59	36

Data: WHO/Europe, European HFA Database, July 2013. Data not available for Kosovo. Notes: Percentages in total deaths calculated based on age-standardized mortality rates per 100000 population, all ages. Countries: Bulgaria (BG), Croatia (HR), Macedonia (MK), Moldova (MD), Montenegro (MNE), Romania (RO) and Serbia (SRB). Last reported data: 2009 - Montenegro, 2010 - Romania and Macedonia, 2011 - the other countries, including EU-28.

unhealthy diet and the harmful use of alcohol increase the risk of, or cause, most NCDs. 'For the major groups of diseases causing high mortality, morbidity and disability (...), two main risk factors contribute to multiple disease outcomes and thus remain a priority to tackle: tobacco smoking and harmful alcohol consumption. From a European perspective, their prevalence and levels remain high across all populations, in spite of the knowledge and technology available to address both.' (WHO, 2013a, p. 40-41)

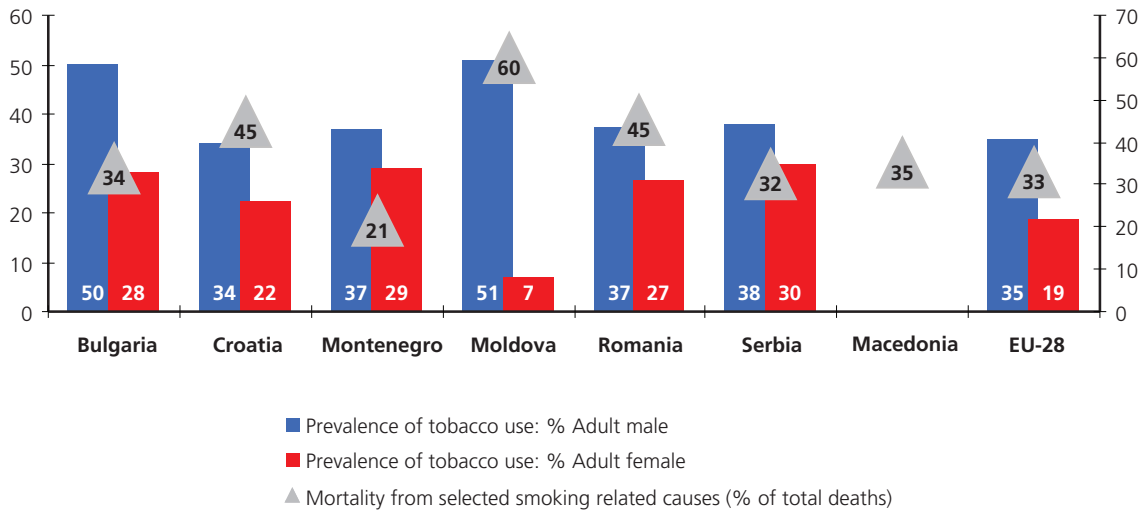
Tobacco use is also one of the largest causes of avoidable death and disease in all eight selected SEE countries (no data for Kosovo). Prevalence of current tobacco use in persons aged 15 years and older is higher than the European average, both for men and women (except in Moldova). Also, mortality from smoking related causes is considerable higher compared with the EU-28 average for Croatia, Romania and especially Republic of Moldova. Thus, tobacco use represents one of the critical elements of effective NCD control and prevention in the region.

In all countries, with the exception of Kosovo, the *WHO Framework Convention on Tobacco Control* is in force. Serbia established a Council for Tobacco Control (in April 2006), at the initiative of the Ministry of Health, as a multisectoral body composed of representatives from a large number of ministries relevant to tobacco control, health professional organizations and international organizations with the status of observer (WHO, UNICEF). This intergovernmental body is unique in the region. Health promotion and intensive national campaigns against tobacco smoking and exposure to secondhand smoke resulted in a moderate but steady decrease of prevalence of smoking: on average by 1% annually. (Mauer-Stender, 2012)

Heavy alcohol consumption is reported only in Moldova.[81] Actually, the *Global Status Report on Alcohol and Health 2011* (WHO, 2011) states that Moldova has the highest adult per capita alcohol consumption in the world. Mortality from alcohol-related causes

[81] Pure alcohol consumption among the population aged 15 years and over declined until 2003 to 11.17 liters per capita, after which it has sharply increased to 20.61 in 2008 (versus 11.02 EU-28 average). WHO/Europe, European HFA Database, July 2013.

Figure 14. Tobacco use: prevalence of regular smokers among adults and mortality from smoking related causes, last reported data to WHO as at 31 December 2012



Data: WHO (2013b) and WHO/Europe, European HFA Database, July 2013. Data not available for Kosovo. Notes: Percentages in total deaths calculated based on age-standardized mortality rates per 100000 population, all ages.

represents more than 15% of total deaths[82] in Moldova compared to the EU-28 average figure of 10% (which is the rate for Croatia and Romania) and 6% which is the average figure Bulgaria, Macedonia, Montenegro and Serbia.

Iodine and iron nutrient deficiency are common in Moldova (WHO, 2006) while unhealthy diet and obesity are reported as a growing health problems among both adults and children, (at least in Bulgaria, Croatia, Moldova, Montenegro, Romania, and Serbia (WHO, 2006, 2007 and 2009). As an example, the National Health Survey in Serbia 2006 revealed that 54.5% of adult population was overweight and 18% of children aged 7–18 were moderately obese or obese. Only 23% of the adult population reported taking daily physical activity, with 67% of adults reported being physically inactive (Ministry of Health of the Republic of Serbia, 2007). For Romania, the WHO reported in 2006 percentages of total deaths 13.9% were attributable to high body mass index, 7.1% to low fruit and vegetable intake and 6.6% to physical inactivity (WHO, 2007).

The prevalence of high-risk behaviours is not equally distributed by gender. For example, studies show that in Croatia men have a higher smoking prevalence, higher obesity prevalence, higher consumption of fat, salt, meat and alcohol as well as lower consumption of fruit and vegetables compared to women. However, a lower percentage of active working women perform daily physical activity. (WHO, 2007)

Research on avoidable mortality in Europe showed that Romania and Bulgaria (along with some Baltic states) have the highest levels of mortality due to disease groups that could be considered effectively treatable or preventable by health-care services.[83] A similar situation was recorded in relation to treatable mortality,[84] which accounted for large shares of under-75 mortality in women (Romania) and men (Bulgaria); the largest shares in Europe (Mladovsky et al., 2009). Patterns of preventable mortality call for strengthening of policies and their implementation (particularly for women) especially the continued development of both tobacco and alcohol policies (Figueras and McKee, 2012). By doing so considerable progress could be made in reducing mortality further in these countries by targeting health-care services. By targeting we mean not only better financing of the health system but also modernizing and enhancing the quality of health-care services.

2.2.4 Socioeconomic inequalities in health and health care

The achievement of high levels of health, health risk prevention, and equitable access to health-care services for the population are key priorities of any health system. Access to health-care services is regarded as an essential right in EU Member States as reflected in Article 35 of the Charter of Fundamental Rights of the European Union, which states: 'Everyone has the right of access to preventive health-care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of Human health protection shall be ensured in the definition and implementation of all Union policies and activities.'

There is growing recognition of the importance of cross-country comparative research based on commonly agreed indicators in order to monitor the progress towards these goals. Evidence from national and international studies demonstrate significant inequalities in mortality, health and health-care use, in favour of groups with socioeconomic advantages, in all countries and over time. The research on socioeconomic inequalities in health and access to care shows that factors such as income, education and job status have a high influence on health status, mortality and risk factors among EU countries (e.g. Mladovsky et al., 2009)

[82] In 2010, 18.8% of male mortality and 13.7% of female mortality could be attributed to alcohol consumption.

[83] Treatable conditions, such as cancer for colon, skin, cervix, and breast, diabetes mellitus, epilepsy, pneumonia, measles, are responsive to medical intervention through secondary prevention and treatment. Preventable conditions (i.e. lung cancer, motor vehicle and traffic accidents, and cirrhosis) are responsive to interventions that are usually outside the control of the health services through intersectoral health policies. (Mladovsky et al., 2009, p. 23)

[84] Treatable mortality refers to three main causes of death, namely infant mortality, cerebrovascular disease and testicular cancer.

The major inequities in health in the eight studied countries relate to poverty, ethnicity (Roma), financial barriers, geographical barriers (in particular rural areas but also some regions) and migration.

Poverty

Although a gradient in health is present all along the socioeconomic strata, *poverty* and *unemployment* represent important contributors to inequalities. Marked inequalities in self-reported health by income and education were documented in Bulgaria and Croatia. People with only primary education are more likely to be in poor/rather poor health than those with secondary or higher education. Rates of illness vary with income, with highest rates among the poor. However, self-reported health is particularly associated with self-assessed financial status, a proxy for material deprivation that is sensitive to informal economic exchanges, with the relationship especially strong among women. (e.g. Balabanova and McKee, 2002a and 2002b; Babic-Banaszak et al., 2002) Furthermore, health inequalities are more marked in Croatia than in EU countries: a higher proportion of Croatian citizens who are in the lowest income quartile report poor health (27.8%) than their counterparts in the EU-15 (9.2%) (Sucur and Zrinscak, 2007).

The strong relation between poverty and low health status (and low levels of education) is also well documented for Romania and Moldova. Already in the 1990s, the World Bank's Poverty Assessment reported that poor households had lower health status, lower levels of education, and their children were less likely to be enrolled in school, particularly in secondary and higher education, and had worse nutritional outcomes. A recent UNICEF report provides evidence that in Romania children from severely poor households have higher risk of low birth weight, are liable to have an impaired immune system, have lower share of exclusive breast-feeding and are consequently more vulnerable to infections and diseases. These children are also more prone to high incidence of chronic illnesses and disabilities in later life, specifically because during childhood, for a few times each month, a large percentage of them suffer from improper heating, insufficient food or even hunger, and are less protected through an appropriate diet or preventive health and hygiene practices. The households from this group typically have three children or more and/or are single-mother families, both Romanian and Roma and usually have parents who are poorly educated. These children also tend to live in dwellings with deficient hygiene conditions, limited access to information, and have substantially lower food, health and school expenses per child. Roma children who belong to this group are in the worst situation. (Stanculescu, coord., 2012)

UNICEF studies for Moldova found a strong association between poverty and food deprivation (below the minimum caloric intake). Also, children from households within the lowest quintile have disproportionately high rates of infant and under-five mortality (Stanculescu and Marin, 2011). The national statistical data of Moldova shows that the proportion of the population outside the health insurance system was 23% at national level, in 2011, but 32% among people in absolute poverty and as high as 47% of people living in extreme poverty, mainly because health insurance is too costly compared to their incomes. The lack of a health insurance is a major barrier in access to health care. Accordingly, the poor use two times less health services, are less informed about the available services (e.g. compensated medicines), and invest four times less of their income compared with the better-off people. (Ministry of Economy of Moldova, 2012)

Ethnicity - Roma population

Inequities in health related to socioeconomic determinants are especially strong for the Roma population in Bulgaria, Macedonia, Moldova, Romania and Serbia. The health of the Roma is worse than the health of the general population. Their life expectancy is many years shorter than the life expectancy of the majority. Their children have a higher infant mortality rate and higher rates of vitamin deficiency, malnutrition, anaemia, dystrophy and Rickets than their non-Roma peers. The rates

of tuberculosis notified from the Roma population in Romania are considerably higher than those from the non-Roma population (Berger et al. 2010). In all five countries, only a small proportion of Roma are covered by health insurance and so access to health-care is ensured only for those who receive social support benefits or are otherwise in need. However, many Roma do not receive the medical treatment they need due to direct and indirect discrimination. Some health-care professionals and facilities discriminate directly against the Roma. They may decline to accept Roma patients and may subject them to verbal abuse and degrading treatment. Emergency centre operators often refuse to send an ambulance to poor Roma communities. There are a variety of additional barriers for Roma in accessing health-care services, including 'lack of information in the Romani community, unlawful practices of the local authorities that lead to loss of health insurance or the impossibility of obtaining health insurance without payment of a contribution, and abuse of power by social workers'. (Zoon, 2001)

Out-of-pocket and informal payments for health care

Financial barriers in the form of out-of-pocket payments reduce considerable access to health services for lower income individuals and people who cannot afford to pay. Patient cost sharing for public services (co-payment for publicly insured services) in general constitutes a relatively small component of financing for health-care, but out-of-pocket payments[85] are substantial in four of the eight selected countries. Out-of-pocket payments for health services represent an average of 16% of total spending on health-care in the EU-28 (in 2011). Heavy reliance on household payments for health is registered in five countries: Bulgaria, Kosovo, Macedonia, Moldova and Serbia (see also figure 15). In Moldova, Bulgaria and Kosovo, out-of-pocket payments sharply increased in the late 1990s, reaching share of total spending on health-care almost three times higher than the European average in 2011 (45%, 43% and 40% respectively). In Serbia, out-of-pocket payments increased after 2003, while in Macedonia they stayed at levels more than two times greater than the European average (36% and 38% respectively). Thus, in these countries, patients bear the responsibility for a large part of costs of health services; a fact which continues to have deleterious effects on the accessibility of health services for people with lower incomes and health overall outcomes.

Figures for out-of-pocket payments are underestimated in those countries where patients also pay informally for health-care services (voluntary or not), in all eight studied countries. A clear policy response to informal payments is, however, lacking in the region. Studies on informal payments[86] for health-care in Bulgaria and Romania reach rather similar conclusions (e.g. Balabanova and McKee, 2002c; Spridon, 2011; IRES,[87] 2011).

Informal payments are relatively common. For example, in Romania, 11% of the adult population reported informal payments for public services, mostly for health-care services (5% for the medic and 2.5% at hospital), in 2011. Most reported informal payments were given in gratitude, as only 1.2% patients declared that payments were solicited by the staff (IRES, 2011). Most informal payments are in the form of gifts. A national representative survey carried out in 2012 showed that in Romania gifts (such as coffee, chocolate, meat, flowers, cigarettes) accounted for 88% of informal payments, while informal cash payments represented approximately 37% (Spridon, 2011).

Informal payments occur at almost all levels of the health system also in Moldova, accord-

[85] WHO definition: Includes non-reimbursable cost sharing, deductibles, co-payments and fee-for service. Excludes payments made by enterprises which deliver medical and paramedical benefits, mandated by law or not, to their employees. Excludes payments for overseas treatment.

[86] Informal payments are defined as a monetary or in-kind transaction between a patient and a staff member for health services that are officially free of charge in the public sector.

[87] Romanian Institute of Evaluation and Strategy, Cluj-Napoca, Romania.

ing to the WHO 2012 Health System Review (Turcanu et al., 2012). They are much more widespread for inpatient care; the seriousness of the illness being reflected in the amount patients pay informally for care. Similarly, in Romania, according to a survey done in 2013 in the capital city Bucharest the same relations between informal payments and treatments exist in the inpatient and emergency/ severe health-care sectors. Thus, in 2013, on average, the informal payment for a GP was around 34 lei (about € 8), while in hospitals for a problem that did not require surgery it increased to approximately 360 lei (or € 80)[88] and reached 1,130 lei (or € 250)[89] in cases involving surgery (Stoica, 2013).

Informal cash payments are universal for operations and childbirth, clear-cut and life-threatening procedures, in both hospitals and/ or elite urban facilities and for well-known physicians, especially surgeons, and nurses. Most gifts were given at the end of treatment and most cash payments-before or during treatment. Wealthier, better educated and younger patients tend to pay more often, as a means of obtaining better-quality treatment. In all countries the principle of comprehensive free coverage (existing until 1989) has been significantly eroded. After 1990, informal payments had become more frequent, explicit, increasingly in cash, and less affordable. Informal payments stem from patients desiring better treatment, the low wages of staff, acute funding shortages, and tradition. Attitudes to informal payments range from strongly negative (if solicited) to tolerant (if patient-initiated), depending on the circumstances. However, generally speaking tolerant attitudes towards such practices are prevalent both among patients and medical staff.

Geographical barriers - Rural areas are at disadvantage

Countries included in the study have large shares of rural population ranging between about 62% in Kosovo, 53% in Moldova and 39-44% in Montenegro, Macedonia, Croatia, Romania, and Serbia. The most urbanized country in the region is Bulgaria with a proportion of rural population comparable with the EU-28 average (29% versus 26%).[90] In Bulgaria and Romania, migration for work abroad – notably of young people and women – is acute and risks deepening the general impoverishment of rural areas.

The rural-urban gap is more marked in the region than in the Western countries (Bertolini et al., 2008). The rural areas are characterized by higher degrees of income poverty in relation to urban areas in all countries. For example, World Bank data indicates that in Montenegro rural poverty is more than four times higher than urban poverty (18.4% compared with 4.4% in 2011). Similarly, in Serbia the rural poverty headcount is 13.6% compared to 5.7% in urban settings (in 2010). In Macedonia, two thirds of the poor live in rural areas (at least this was the situation in 1996-1998 (World Bank, 1999).[91] In Kosovo, the rural-urban gap exists but is smaller: 31.5% rural poverty versus 26.7% urban poverty (in 2011).

In Moldova the absolute poverty headcount was 25% of the population in rural areas and 7.4% in urban ones (Ministry of Economy of Moldova, 2012). The overall quality of infrastructure is lower in rural regions; traditional public transport services are difficult and very expensive and access to water and sanitation is limited. In Romania, besides the poor connections to water and sewerage systems, a big issue is the poor quality of water, which significantly diminishes the quality of life and exposes the population to risk of disease; especially following natural disasters such as floods. Accordingly, infant and under-five mortality rates are considerably higher among children from rural areas in countries such as Moldova or Romania[92]

[88] On average, 76% went to doctor and 24% to nurses.

[89] On average, 60% went to surgeon, 24% to anesthetist and 16% to nurses.

[90] Data for 2011 from WHO/Europe, European HFA Database, July 2013. Data for Kosovo from the World Bank, September 2013.

[91] More recent data on rural poverty are not available.

[92] For example, in 2012, the infant mortality rate was 11.8‰ in rural areas compared with 6.6‰ in urban areas.

(PAS and UNICEF, 2009; Ministry of Health of Romania, 2013).

Access to health-care and social services is much more limited in rural areas. The rural population is on average much further from a major hospital than urban residents. The longest travel times in Europe are found in the regions of the Northern Norway, Northern Scotland, Southern Italy, the Greek Islands, Eastern Poland, and Romania (Bertolini et al., 2008). In general, basic health-care services are underdeveloped in rural settlements. For instance, in Moldova, the 2009 *Annual Report on Health* (Ministry of Health, 2010) identifies 200 rural localities where a doctor comes only two or three times a week, and identified 25 villages there is no doctor at all. About 8.5% of rural households encounter problems with access to medical services due to the long distances and lack of transportation to clinics, hospitals and health centres. Furthermore, 29% of households do not access health-care services because of lack of money, out of which the majority are from villages (36%) or towns (30%). Also, 28% of rural residents have reduced access to health-care due to lack of health insurance, compared to 16% in urban areas, in 2011 (Ministry of Economy of Moldova, 2012). The most disadvantaged groups include single parents, the elderly living alone, elderly couples without children, households with disabled persons and households with three or more children (UNDP, 2011).

Sucur and Zrinscak (2007) showed that health inequalities in Croatia are more accentuated than the in EU-15 countries. The rural-urban proportion ratio of individuals who reported poor health was about 80% higher in Croatia than in EU-15. The proportion of people[93] who perceived the distance to the nearest medical facility as a very serious problem was 26% in Croatia compared with 5.4% in the EU-15 and the rural-urban proportion ratio of individuals who reported the cost of seeing the doctor as a very serious problem was almost two times larger than in the developed EU countries.

[93] Persons in the lowest quartile of income.

Besides the rural-urban gap, significant inequalities are also apparent between different regions, counties and districts. Yakimovo, Bulgaria's rural northwest, is officially the poorest region in the European Union. In Croatia, the Central and Eastern regions account for 43% of population but for over 70% of all poor individuals (Nestic and Vecchi, 2005). In Macedonia, the Eastern region lags behind in its development. In Moldova, the Southern area is at disadvantaged as compared with the other regions, especially the capital Chisinau (PAS and UNICEF, 2009). The isolated northern regions are the poorer in Montenegro. In Romania, all socioeconomic indicators look worse for the Northeast and Southern regions of the country. In Serbia, the South is substantially poorer than the rest of the country.

Migration

In Moldova, migration is strongly linked to health inequalities in the treatment of certain diseases and in access to health-care (IOM, 2012). Utilization of health services is two times less frequent among migrants compared to the population not involved in migration. The main barriers that migrants face in access to health care, both in the country and abroad, include: high cost of medical services; lack of health insurance; the need to obtain a referral from a family doctor; illegal status abroad; restrictions from leaving their job during workdays; and fear of job loss.

Parents' migration also influences children's access to medical services. Thus, almost 23% of children whose mothers are overseas did not visit a doctor due to lack of accompaniment as compared to 6% of children whose fathers working abroad, and 4% in cases when both parents are abroad.

Migration is highly relevant for health inequalities in maternal mortality and for HIV/AIDS. The IOM 2012 study shows that 40% of maternal deaths can be attributed to adoption of a migrating lifestyle and women's work abroad, which entails occasional or seasonal work, and harmful and extremely dangerous conditions for reproductive health. Additionally, 7% of maternal deaths are caused by

delay or absence in the utilization of health-care services, which mainly occur due to: lack of available transportation; lack of adequate equipment in medical institutions; acute lack of medical personnel in rural areas, where pregnancy supervision is usually carried out only by a midwife or family doctor. These conditions also explain the fact that about 58% of maternal deaths originate in rural areas. Regarding HIV/AIDS, some studies (e.g. Bivol et al., 2010) indicate a higher probability of engaging in sexual relations with occasional and commercial partners as well as lower rates of consequent use of condoms among migrants. At the same time, adolescents with migrant parents (especially mother) are exposed to higher risk of HIV infection due to a general low knowledge about prevention methods (IOM, 2012).

2.3 HEALTH-CARE PROVISION

This chapter shifts the focus from the population to the health-care system itself and compares the eight selected countries based on a common set of indicators related to financing and resources available for provision of health-care services.

2.3.1 Financing the health system

Expenditure in health does not merely represent a cost, but also an investment with long-term impact on socioeconomic development (EC, 2007).

The health financing systems across the former communist countries of central and southeast Europe experienced a myriad of problems of growing intensity in the initial transition period and by the early 1990s it was clear that the inherited systems required radical reform. During the early transition, all these countries experienced an unprecedented decline in economic production, which reduced the capacity of governments to spend on health and led to the growth of both legal and informal charges for health-care services and a reduction in subsidies for prescription medicines, at the same time their being a substantial increase in poverty at population level. These factors caused deterioration in protection for the population against the financial risk of health-care costs and deepened the already existing inequities in health spending and access to health-care services (Davis, 2010). Among the CE/EECCA countries, most of the divergence in government health spending occurred in the early transition period and there has been little change in ranking since the end of the 1990s. (Kutzin and Jakab, 2010)

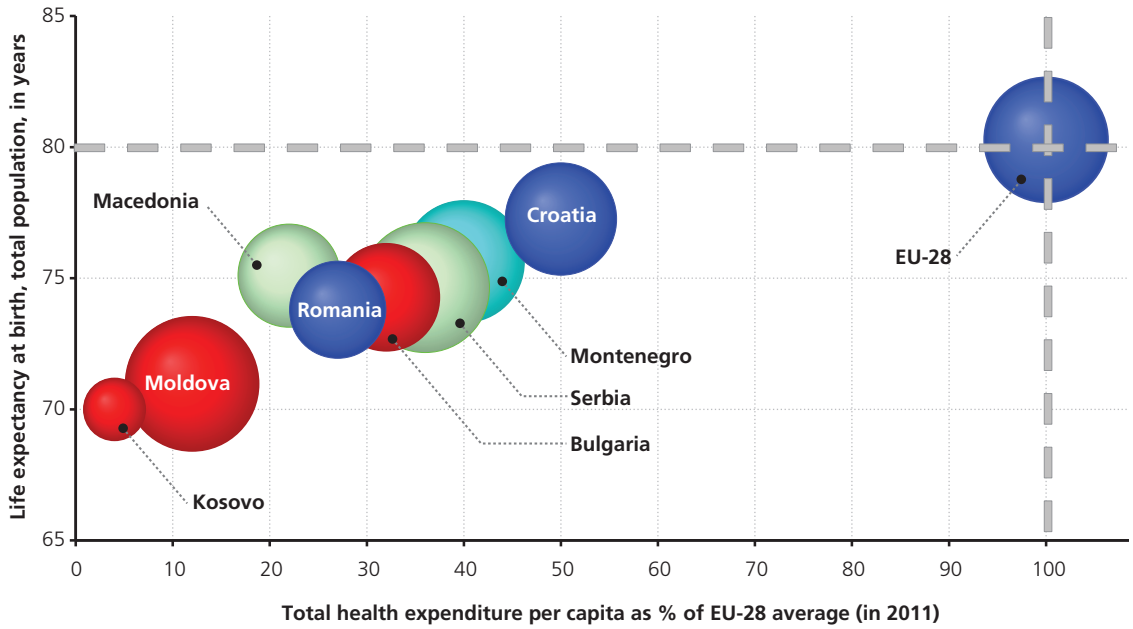
Figure 15 (A and B) illustrates the significant variation in the SEE region among the health spending patterns still persistent in 2011. Total health spending ranges between 3% of GDP in Kosovo and 5.8% in Romania[94] to 10.4% in Serbia and as much as 11.4% in Moldova

[94] Romania decreased its health spending to only 4% of GDP in 2012, hence registering one of the lowest health expenditure in Europe.

(against the EU-28 average of 9.6% of GDP). Thus, Moldova appears to be the highest spender. However, due to the level of GDP, in absolute terms, total health expenditure per capita in Moldova is the lowest (no data for Kosovo), almost two times lower than in Macedonia and Romania, about three times smaller than in Bulgaria, Montenegro and Serbia, approximately four times less compared to Croatia (the highest spender) and representing only 12% of the EU-28 average. This substantial variation in health spending translates into great variation in the coverage which the population benefits and, as a result, into great variation in health outcomes. Figure 15A shows the positive relation which exists between health spending per capita and life expectancy at birth.

(A)

Figure 15. (A) Relation between health-care spending and health outcome and (B) Relation between health-care spending, fiscal context and priority of health sector, 2011



(B)

Dimension	Indicator	BG	HR	RKS	MK	MD	MNE	RO	SRB	EU-28
	Bubble chart									
Vertical axis	Life expectancy at birth, total population, in years	74.3	77.3	70.0	75.1	71.0	75.6	73.8	74.6	80.2
Horizontal axis	Total health expenditure per capita (in PPP) as % EU-28 average	33	49	...	24	12	39	28	37	100
Bubble size	Total health expenditure as % of GDP	7.3	7.8	3	6.6	11.4	9.3	5.8	10.4	9.6
Bubble color	Out-of-pocket health expenditure (% of total expenditure on health)	43.3	14.6	40	38.3	45	30	19.4	36.2	16.2
	Government health spending, fiscal context and prioritization									
Fiscal context	Total government spending as % of GDP	35.7	37.3	…	34.6	39.1	45.9	39.4	46.0	47.9
Priority of Health	Government health spending as % of Government spending	20.4	21.0	8.0	19.0	29.1	20.3	14.8	22.7	20.0

Data: WHO/Europe, European HFA Database, July 2013. Data for Kosovo: life expectancy from the World Bank, September 2013, and financial indicators from Stubbs and Haxhikadrija (2008) and FES (2012). Definition: Out-of-pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. Notes: Data on life expectancy last reported to WHO 2009-2011 (see figure 10). All health expenditure related indicators refer to 2011. Data not available.

The amount that a government spends on health depends partly on its overall fiscal constraints and partly on priorities of public resource allocation accorded to the health sector (Kutzin and Jakab, 2010). In this sense, figure 15B shows that fiscal context[95] represents the main driver of relatively low health spending, since most countries studied have overall government spending levels lower than 40% of GDP as against an EU-28 average of 47.9% of GDP (exceptions are Montenegro and Serbia; no data for Kosovo). Nonetheless, the priorities that governments accord to the health sector are an influential factor, since government health spending accounts for only 8% of total government expenditure in Kosovo and less than 15% in Romania compared with 19-21% in Bulgaria, Croatia, Macedonia and Montenegro (a figure which also represents

[95] The fiscal context refers to the current and expected capacity to spend of a government. Richer countries tend to be more effective at mobilizing tax revenues and so to have higher levels of public spending as a share of GDP, whereas more limited fiscal space is associated with low government spending, including on health.

the EU-28 average), and 23% in Serbia and as much as 29% in Moldova.

Protection against the financial risk of ill-health (or financial protection) is one of the major European health financing policy objectives, which can be summarized as follows: 'people should not become poor as a result of using health care, nor should they be forced to choose between their physical (and mental) health and their economic well-being' (Kutzin, 2010, p. 6). Another related objective is equity in funding, which is closely linked to the concept of solidarity and means that, 'relative to their capacity to pay, the poor should not pay more than the rich (the distribution should be progressive or at least proportionate to income)' (ibid, p. 8). Financial protection and equity analysis should consider all sources of health spending, however, with a special focus on out-of-pocket payments which tend to be the least equitable. In most studied countries, the majority of expenditure on health (as a proportion of GDP) is generated publicly. Nonetheless, out-of-pocket payments for health services exceed 40% of total health expenditure in Moldova, Bulgaria and Kosovo. More details on this subject can be found in a dedicated section of the subchapter 2.2.4.: Socioeconomic Inequalities in Health and Health-care.

A WHO study in the CEE and NIS[96] countries showed that health system reform efforts prior to 2004 focused on the key theme of health financing (Figueras et al., ed., 2004). Several reform areas were critical in the entire region. On the funding side, three areas central to financing reform were problematic: (a) the implementation of effective health insurance systems, (b) defining a more realistic benefits package for ensuring financial sustainability and (c) addressing informal payments, which appeared to be widespread in both ambulatory and hospital care. On the purchasing side, two areas were of particular importance: (a) enhancing the cost-effective purchasing of services and (b) the introduction of performance-related payment systems for providers for enhancing efficiency.

[96] Newly Independent States of the former Soviet Union.

Most studied countries during the 1990s introduced social health insurance arrangements; usually payroll tax funded and contribution-based entitlement. The successor states to Yugoslavia inherited a highly decentralized system of social health insurance that was actually introduced in 1948 (Davis, 2010). Most of these countries shifted to a centralized single insurance fund approach early in the 1990s (Macedonia in 1991, Serbia and Montenegro – each with its own fund – in 1992, and Croatia and Slovenia in 1993). Bulgaria and Romania (along with the CE countries) introduced social health insurance in 1999 based on models of the systems in place in the pre-Communist era (at least symbolically). Moldova, in 2004, implemented nationwide compulsory health insurance managed by a single national pool of funds. The new health insurance systems improved equity in government spending but have brought about new challenges, particularly related to weak collection systems. For example, in Romania difficulties enforcing collections led to a shift in responsibility for collecting revenue from the insurance fund (for the employed but not self-employed people) to the central government tax agency in 2002.

In the entire region, achievement of universal coverage for marginalized poor populations, Roma, internally displaced persons or persons returned through the re-admission process from EU countries has remained a major challenge. In some countries, such as Bulgaria, Macedonia, Romania and Serbia, difficulties in obtaining identity documents and registering with the insurance scheme have systematically discriminated against the already severely disadvantaged Roma population. (e.g. Zoon, 2001; Figueras and McKee, 2012) Long-term care and home-care are funded from EU funds (such as in Bulgaria) or from donations (as in Romania) and remain a challenge not yet consistently addressed in the studied countries. (Genet et al., ed., 2012)

For ensuring financial sustainability under the pressure of fiscal constraints, most countries have sought to shift the burden from collective financing to the individual, whether through encouragement of private, voluntary

insurance (though the private market remains limited) and/or through increased co-payments and deductibles and no-claim bonuses. The case studies presented in sections below describe the situation from Kosovo, Macedonia, Moldova and Montenegro.

On the purchasing side, most studied countries introduced performance-related payment systems for providers in order to enhance efficiency. Across Europe, the main approaches for paying providers are salary, capitation and fee-for-service. In the public sector, most primary and outpatient care doctors are paid on a salaried or capitation basis, or a combination of the two. In primary care, capitation payments are predominantly used in Croatia and Romania and are being piloted in Serbia and Montenegro. Fee-for-service payments are the norm for privately delivered primary and outpatient care. For hospital doctors, salaries are the most common method. (Figueras and McKee, 2012)

Regarding access to medicines, reference pricing[97] linked to reimbursement listing is widely used in the studied countries as it is in the CEE countries. Data on pharmaceutical expenditure is scarce. Available information (WHO) shows that total pharmaceutical expenditure measured as share of total health expenditure has notably increased in Serbia from 12% in 2000 to 31% in 2011, whereas in Moldova it jumped from 11% in 2000 to 46% in 2005 after which it dropped to 35% in 2011. Noteworthy is the fact that in Moldova, 73% of all out-of-pocket payments in 2010 were for pharmaceuticals, as the list of medicines that can be reimbursed through mandatory health insurance has been extremely limited in order to maintain the financial sustainability of the system (Turcanu et al., 2012).

[97] Reference pricing, a form of indirect price control, refers to setting a maximum reimbursement level that the third-party payer, whether government or insurance fund, pays. (Figueras and McKee, 2012)

Financing the Health System in Kosovo

(by Ilir Hoxha)

Kosovo's circumstances differ from those of some other countries of former Yugoslavia, such as Macedonia, Montenegro or Croatia, where a continuation of the social insurance system after the dissolution of Yugoslavia was maintained (WB, 2008; Hoxha and Shaipi, 2009). For these countries continuity was possible because the Yugoslav system that was inherited was preserved without an extended interruption between changes in the political system. Due to various circumstances in Kosovo, such continuity has been more difficult. Kosovo, not only endured a devastating war in 1998 and 1999, but for a decade prior to that, medical structures, including the medical education system functioned in a parallel existence to the social insurance system that had existed in Yugoslavia, thus leaving health personnel completely isolated.

Immediately after the war in 1999 the focus was on emergency assistance and basic organization of the health-care system. This process was led by WHO and resulted in a centralized health-care system. In this system, the Ministry of Health manages the funds allotted for health care. These funds are raised from taxes and then distributed among line Ministries.

Government health spending is about 3% of the GDP and 8% of general government expenditure (Hoxha, 2011). Only 60% of overall health spending is covered by the government budget. The other 40% is private spending, resulting in significant inequalities in access, and out-of-pocket payments which themselves contribute to increased poverty (Stubbs and Haxhikadrija, 2008). In 2004, it was estimated that each person paid an additional 81 Euros out-of-pocket beyond what the government spent on health, for the services they used (WB, 2008). According to the WB survey, the average (six member) household expenditure was 716 Euros per year. Most of these additional services and expenditures have been taking place in the private sector and focused on payment for medications.

Health sector transition has been hampered by numerous shortfalls in areas such as financing and management. Such gaps in the health-care system are now being tackled by a comprehensive reform undertaken by the Government of Kosovo (SDC and SECO, 2012). The Government of Kosovo has been exploring alternative ways to structure the health financing system. Both in public and behind closed doors, there has been much discussion and expressed intent to learn from other countries' experiences in health insurance (WB, 2008; Hoxha and Shaipi, 2009; National Democratic Institute, 2011) In the past three years, the issue of health insurance has become a key topic in health sector discussions among representatives of the government, civil society and the media. Aside from the passage of the Health Law by the parliament and the government, and the approval of the draft law on health insurance - all of which set the stage for further developing a health insurance plan - no other concrete policy results have materialized until now.

Financing the Health System in Macedonia

(by Elisaveta Stikova and Lolita Mitevska)

According to the Health-care Law,[98] the individual is responsible for his or her own health, the company is responsible for providing a healthy working environment, and the state is responsible for providing a healthy living environment. The State is also responsible for the provision of preventive care for the population through the activities of the Institutes for Public Health and for ensuring that health services are available to all citizens all over the country. Equity, solidarity and reciprocity, as well as the provision of universal health coverage for the population, have been defined as its core values.

The reform processes in Republic of Macedonia didn't ignore the health sector. The goal of health sector reform in Republic of Macedonia is the creation of a system that is both aligned to the needs of the population and which can operate efficiently within the resources available.

What was implemented as a result of these reforms was an insurance-based health system where the Government and the Ministry of Health provides the legal framework for operation and stewardship, and the Health Insurance Fund (HIF) is responsible for the collection of contributions, allocation of funds and the supervision and contracting of providers. Macedonia has a compulsory health insurance system that provides universal health coverage for the whole population. In 2002 the HIF started contracting with private primary health-care facilities (family doctors or General practitioners-GPs), introducing a capitation-based payment system.

Medical examinations by the GPs are free of charge for all citizens. The population participates in covering national health expenditures by paying some amount of money which is calculated from HIF special scales and is generally 20% of the total costs of health services. Co-payment was introduced in 1992 by ministerial decree and was revised in 2000, when it was changed to a co-insurance model with a system of fixed tariffs. If the patient pays the maximum amount of money as participation, according to the scale from HIF, after that all other health services are free of charge during the end of that calendar year. This practice was changed and even improved in the year 2012, by introduction of the Law for health protection.[99] All patients that have a monthly salary below the average official salary for the previous year announced by State Statistical Office (for example, the official average salary was 10,800 dinars for the year 2012 and all patients with a salary or pension below this amount received free of charge medical services in 2013) receive free of charge services. There are small groups of the population that are excluded from co-payment and receive health services free of charge such are: blood donors, children with special needs, persons under permanent social care, patients in a

[98] Official Gazette No. 10, January, 2013, www.moh.gov.mk, assessed at 30.03.2013.

[99] Official Gazette No. 26/2012, www.moh.gov.mk, assessed at 30.03.2013.

mental institution and mentally disabled abandoned persons. The extent to which informal payments are levied by health-care providers in hospitals is difficult to assess.

Compulsory health insurance is the main source of the health-care revenue. This model of insurance covers those employed in the public or private sectors, the retired, students, the disabled and their dependents. Certain citizens, who are not covered by health insurance, for example stateless persons and social care recipients, are subsidized by the state budget, as is child and maternal care for the uninsured. For the year 2013,[100] by special program for uninsured persons, the Government provided 2,127,355,000 dinars to cover the health-care for 213,500 uninsured citizens, which is around 9,964 dinars or 210$/ per uninsured person.

Certain occupational groups are required to contribute with additional funds to cover the risks of occupational disease or injury. This additional amount applies to all employees and to farmers. There are two rates of contribution: Non-profit companies contribute at a rate of 0.5% of total salary cost whereas for-profit entities contribute 1.8% of their total profits. These contributions are paid directly to the health insurance fund and are used for health-care of those groups of population in case of occupational diseases or injuries at work. Preventive occupational safety and health activities are additionally paid for by companies.

GPs have been paid by the capitation model since the year 2002. Insured citizens are obliged to select a GP, who guides them, as a gatekeeper, through the system.

In the year 2004 a new payment system for hospital care was introduced, based on budget calculations from the needs of the three preceding years as well as the projected types and volume of services for a given period of time. This model was changed in the 2009 when the model of Diagnostic Related Groups (DRG) was implemented in hospitals.[101] Health-care professionals are paid by monthly salary, with scales decided through collective bargaining between the Ministry of Health and the health-care workers union. According to the Law for health protection, employees at public health organizations can receive additional payments as an reward for achievements in their work.[102]

Financing the Health System in of Moldova

Since 2004, health financing in Moldova has been organized as mandatory health insurance. The National Health Insurance Company is the pooling agency for prepaid health-care funding and the sole purchaser of health services. Voluntary health insurance accounted for less than 0.1% of total health expenditure in 2010. Contributions from the working population come predominantly through payroll contributions of a fixed percentage of salary (to be paid by the employee and by the employer). The self-employed are expected to purchase their insurance for the year at a fixed price. The non-working population (14 categories including pensioners, students, children, registered unemployed, etc.) is covered through transfers from the central budget.

Access to emergency and primary care is universal regardless of insurance status and so are services connected to key public health issues such as HIV infection and AIDS, TB and immunization. The benefits package covered under mandatory health insurance includes specialized outpatient and hospital care and a very limited range of pharmaceuticals. For those without insurance cover, these services are paid in full as out-of-pocket payments. In 2009 and 2010 the automatic coverage of mandatory health insurance was extended to

[100] Official Gazette No.4/2013 page 84, www.moh.gov.mk, assessed at 30.03.2013.

[101] Macedonian DRG model is based on the Australian Refined Diagnosis Related Groups (AR-DRG version 5.2).

[102] Law for health protection, Official gazette No. 102/2012 article 219 al.5, www.moh.gov.mk, assessed at 30.03.2013.

families registered as living below the poverty line even if they are formally known as "self-employed". (Turcanu et al., 2012)

Even so, 26% of the resident population was uninsured in 2010 (17% of the urban population and 32% of the rural). Those without health insurance are most often self-employed agricultural workers or informal workers in urban areas who cannot afford to pay the monthly contribution for a mandatory health insurance. In actual fact, the population participation through contributions to the health insurance system is rather low: only about 20% of the population from rural areas and 40% from urban ones. Consequently, most insured persons are insured by the State free of charge (data for 2010, National Bureau of Statistics of Moldova, 2011)

Financing the Health System in Montenegro

(by Agima Ljaljevic)

All citizens of Montenegro are entitled to exercise their rights to health-care, additionally they have the right to health insurance, including the right to compensation during any temporary inability to work and the right to reimbursement of travel expenses related to health care.

The health insurance system is based on the adopted Law on Health Insurance, as well as (as was the case in the previous period) the principle of mandatory social health insurance as per the Bismarck model. The Health Insurance Fund is the financing body of health insurance. According to the Law, all employees, retired persons, owners (founders of companies), unemployed persons, farmers and others as family members by Law have the right to health insurance. Mandatory health insurance is financed by contributions paid by employers for their employees, the Pension Fund for retired persons, and the Bureau for Employment for self-employed, farmers, legal and naturalized persons. According to new laws, the scope of the right to health-care and the standards of these rights include health-care services at primary, secondary and tertiary levels as well as medications and medical supplies. However, the system is not capable of providing health-care service to the extent defined by law.

2.3.2 Health-care delivery

Regarding governance and organization, in all studied countries with the exception of Kosovo, the health systems are organized according to the principles of universal access to basic health services, equity and solidarity in health-care financing. The health systems include a mix of public and private medical facilities, as well as public agencies and authorities involved in the provision, financing, regulation and administration of health services.

The health-care provision system is organized on three levels: primary, secondary and tertiary. The primary care system is a network of family medicine facilities. Public medical facilities at secondary levels provide specialized care to the community and belong to local public authorities. Medical facilities at the tertiary level include research and teaching institutions that also provide specialized and highly specialized medical care for the whole population. Both public and private health-care providers may be directly contracted by the National Health Insurance bodies for the provision of medical services under mandatory health insurance. A large number of parallel health care services are also provided through public medical institutions belonging to other branches of government, which are financed from the state budget through the respective ministries but can also contract with the National Health Insurance bodies.

Regulatory functions are centralized in the Ministries of Health, which also, collects and analyses data and generates relevant information to contribute to the development of evidence-based policies. Nearly all selected countries promote the principle of Health in All Policies through multi- and inter-sectoral collaboration, with the Ministry of Health en-

suring the coordination of public health activities within the sector and beyond it.

With respect to physical and human resources, most selected countries inherited numerous facilities and health-care personnel from the communist era. Infrastructure has been significantly reduced but in some countries there is still an oversupply of beds (see table 4). Thus, the rationalization of hospital stock and introduction of new management structures in hospitals have been on the reform agenda in Bulgaria, Croatia, Kosovo, Moldova and Romania. Croatia[103] has been most successful in this respect; during 2002, health centres began a merging process, which led to a reduction from 120 units in 2001 down to 49 units in 2011. Correspondingly, the number of hospital beds in Croatia has reduced, yet has remained higher than the EU-28 average (579 acute hospital beds per 100 000 inhabitants compared with 540, in 2011, WHO data). Romania started the rationalization of hospital stock in 2011 with a planned reduction of 182 out of a total of 435 units.[104] After 67 hospitals were closed, a media and political scandal occurred and the reform stopped.

In the entire region, hospital services are concentrated in particular areas, especially in the larger cities and in capitals. There is also significant variation[105] in the provision of hospital beds across regions within countries, as well as between urban and rural areas. For example, in Bulgaria, 51% of hospital beds are concentrated in just seven districts with 20% being in the capital. In Moldova, inpatient care is provided at the municipal and district (secondary care) as well as republican (tertiary care) levels, but highly specialized tertiary services are concentrated in Chisinau. In Romania, the capital region has over 10 hospital beds per 1,000 inhabitants compared with less than 5 in the poor North-East region. At the same time, the ratio between urban and rural areas in terms of the number of hospital beds per 100,000 inhabitants is 8.5. In Serbia, the number of beds per 1,000 people ranges between 3.2 (in Srem) and 11.1 (in Zajecar), with the capital Belgrade above the country average (6.9). Besides the large regional disparities, the problem comes from the inadequate structuring of hospital's capacities that are not adjusted to the needs of the population in particular territories.

The capital investment in secondary and tertiary care provision varies from one country to another, but generally has been lower compared to the investment in primary care. As a general rule, high-technology equipment is available only in larger centres, whereas everyday low-technology medical equipment is missing or outdated in many areas, particularly in smaller medical facilities. Information technology is developing, but it is fragmented and uncoordinated in most studied countries.

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[103] The network of health care providers is decentralized, and the public providers are owned by the state, cities and counties, accessible to all citizens. By the end of 2010, there were 6,223 private practice units (doctors' offices, laboratories, private pharmacies, private physical therapy practices and home care services) registered. The private health care providers offer mostly diagnostic and outpatient care, and increase their share yearly. (Country study)

[104] Ministry of Health of Romania, Press Release 01.02.2011, *Ministerul Sănătății a început procesul de reorganizare a sistemului spitalicesc*, http://www.ms.ro/?pag=62&id=8806&pg=1

[105] Data presented in this paragraph come from country studies, based on diverse national sources, for 2007-2011.

Box 1. Health-care delivery system (by Elisaveta Stikova and Lolita Mitevska)

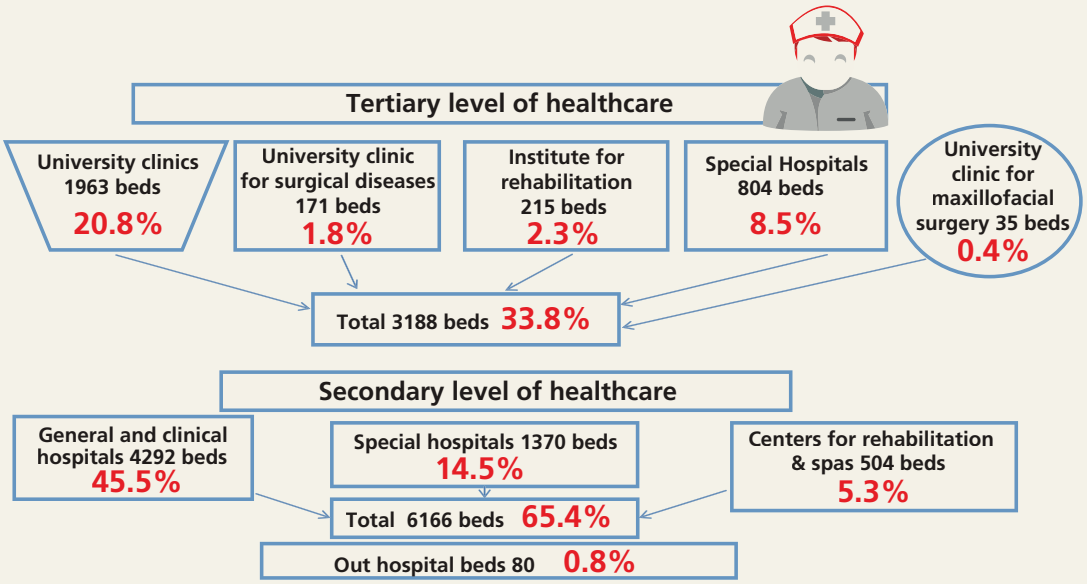
In the Republic of Macedonia there are three levels of health care: primary, secondary and tertiary. Most of the institutions in Macedonia provide both primary and secondary outpatient health-care without a clear distinction. Tertiary care institutions also provide out-patient services which, in other countries would be considered secondary care or even primary care. Inpatient health-care is provided by general hospitals at secondary level and by clinical hospitals and university clinics at tertiary health-care level. The general practitioners, at primary level, decide where to send the patient for diagnostic and treatment procedures by using a strictly recommended referral system.

According data from the year 2010, there are 3375 private health-care practices that have contracts with the Health Insurance Fund and provide primary levels of care and 386 practices for secondary level care. The hospital care facilities are organized in 29 university clinics, one university clinic for maxillofacial surgery, 4 clinical hospitals, 14 general hospitals, 13 special hospitals, 6 rehabilitation centres and spas and 9 birth delivery hospitals units (Kosevska et al., 2011).

As part of the health-care reform, all dental offices and pharmacies have been privatized. However, an emergency medical and dental care service, emergency home treatment, preventive check-ups of pre-school and school children as well as some patronage services should remain in the public domain.

The total number of hospital beds in 2010 was 9434 or 4.6 beds per 1000 inhabitants. Their distribution according to the level of health-care is shown in the figure above.

Number of beds in the healthcare institutions in Macedonia



The first private hospital in Macedonia, specialized in gynaecology and obstetrics, was opened in the year 2001. Throughout the following years were opened more private health facilities, specializing in cardio surgery, ophthalmic surgery, gynaecology and obstetrics. They are registered as private general or specialized hospitals/clinics and provide health services with full payment.

The health-care in these facilities that is covered by the Health Insurance Fund is cardio surgery and infertility treatment. Regarding the medical equipment and modern sophisticated devices, according to the data from public health organizations, in March 2010 there were an estimated 3863 types of devices, such as: 986 ECG devices, 318 EHO, 37 EEG, 10 EMG, 138 Rtg devices, 26 bronchoscopes, 19 colonoscopies, 29 gastro scopes, 83 respiration machines, 23 devices for computer tomography, 4 devices for magnetic resonance, 366 dialyzers, 2 devices for in-vitro treatment, 1 Gama camera, 32 mammography devices, 6 lithotripters 2 coronary angiography units, 5 devices for radiographic diagnostic and another 1773 different types of devices. Besides that, the aforementioned equipment wasn't satisfactory for the current needs of modern treatment of patients. The Ministry of Health has started a project for public procurement of new equipment. With a budget of 70 million Euros, in the year 2011 over 609 new sophisticated medical devices such as: magnetic resonances, computerized tomography, angiographs, lithotripters, linear accelerator, Rtg devices, PET (positron therapy) centre, autoclaves etc. were procured They were distributed through public hospitals, according to the number of population in the regions.

In the Republic of Macedonia, according to data from the National Public Health Institute in 2011, the total number of patients that have been treated in hospital was 253.906, for cancer 33.836 (13.3%), for diseases connected with the endocrinology system 6.422 (2.5%) patients, for diseases of the musculoskeletal system 11.150 (4.4%) for cardio-vascular diseases 38.133 (15.0%) and for injuries 12.955 (5.1%) (Ckaleska et al., 2011).

Table 4. Resources in health-care services in 2011 (number)

	GPs per 100 000 inhabitants	Active physicians per 100 000 inhabitants	Specialist medical practitioners per 100 000 inhabitants	Pharmacists per 100 000 inhabitants	Nurses per 100 000 inhabitants	Hospital beds per 100 000 inhabitants	Hospitals or stationary health care
Bulgaria	64	386	128	...	475	645	315
Croatia	51	284	97	68	579	579	49
Kosovo	...	119	...	9	382	240	17
Macedonia	...	274	77	38	421	450	76
Montenegro	30	202	73	15	535	397	14
Moldova	53	283	84	53	647	619	84
Romania	68	239	70	68	551	611	368
Serbia	73	309	72	32	632	557	139
EU-28	**79**	**346**	**92**	**...**	**836**	**540**	**-**

Data: WHO/Europe, European HFA Database, July 2013. Data for Kosovo from the National Institute of Public Health of Kosovo (2012). Data on hospitals from country studies, based on diverse national sources for 2009-2011. Note: ... Data not available.

Table 4 shows that in 2011 the availability of all types of medical professionals was well below the European average in nearly all studied countries. In most studied countries, planning of human resources has become a priority only in recent years, particularly in relation to the mass migration of medical professionals. Many doctors and nurses have left medicine, and often the country, in search of better pay, working conditions and/or social recognition.

For example, Romanians represent the largest group of foreign medical doctors in Italy. Health professionals from Croatia, Bosnia and Herzegovina and Serbia represented in 2008 about a quarter of all active medical doctors in Slovenia. Croatia and Turkey are the main source countries for foreign nurses in Germany. Health professionals (especially nurses) from the former Yugoslavia account for a significant part of the foreign workforce in Austria. (Wismar et al., eds., 2011)

During 2000–2005, about 10% (5,180) of the total number of medical doctors and 5% (4,440) of nurses trained in Romania worked in any of the OECD countries (Simoens and Hurst 2006). These percentages were higher for Romanians than for citizens of any other former communist country. For instance, percentages for Bulgarians were 6.2% of medical doctors and 2.6% of nurses. The EU enlargement and the economic downturn considerably increased existing flows towards the western EU. In 2007, 1,421 medical doctors (around 3% of all practicing medical doctors in Romania) left in that year alone. In 2009, under conditions of economic downturn, the new staffing regulations in the public sector and a 25% cut in the salary of health professionals contributed to higher outflow numbers. Intention-to-leave data from Romania indicates continuing high outflows of medical doctors; more than 300 certificates per month were issued to Romanian medical doctors in 2010. The health professional mobility is a matter of concern, particularly because the most economically deprived North-East region was most affected by outflow. An effective health workforce strategy has been lacking and some of the retention measures in rural areas have not proved effective. (Galan et al., 2011)

Health professional mobility has a long tradition in Serbia. It is estimated that a total of 10,000 Serbian health professionals have moved to work abroad since 1960, particularly in Germany and Switzerland, and more recently, Slovenia. Aside from the country's political and economic situation, health professional outflows are due to higher salaries abroad and domestic oversupply of medical doctors, but also to working conditions and limited career development opportunities in domestic health sectors. (Jekić et al., 2011)

Service delivery contributes to health improvement by providing individual and collective services and ensuring access to, and quality of, health services. The quantity, appropriateness and quality of services delivered will depend on the geographical distribution, skill mix and size of the health-care workforce. Thus, health professional mobility results in reduced quality of services by causing shortages and misdistribution of specialists and/or by affecting the skill mix (Wismar et al., eds., 2011). For example, in Moldova, over 9,000 doctors and nurses left the system between 1996 and 1999 and another 10,000 medical staff did the same in the period 2000-2008 (UNDP, 2011). In Romania, the rural areas with the lowest coverage of medical doctors report some of the highest emigration rates among medical doctors and nurses under the conditions in which the number of doctors per 1,000 people is 5.8 times lower in rural than in urban areas (Galan et al., 2011).

However, the problem of shortages is not just related to the absolute number of doctors, but also their profile. In deprived rural areas, the departure of even a few specialist doctors can produce a substantial effect on service delivery. Given that family medicine is one of the most demanded specialties in some EU countries, it is most likely that access inequalities to primary care services will increase even further if the emigration of family doctors continues and/or increases. Also, some specialties and skills at hospital level might be adversely affected. This is the case in Romania, where increasing emigration of medical doctors and nurses in 2010 has jeopardized the proper running of many facilities, especially small municipal hospitals. Even when the Ministry of Health advertises job vacancies for missing specialties, many of them continue to remain unoccupied (Galan et al., 2011).

Shortages of some specialties and skills are reported in the following studied countries - Croatia, Macedonia, Kosovo, Moldova, but not necessarily in relation to health professional mobility.

Health professional mobility impacts health system performance not only in service delivery but also on resource creation, financing and stewardship. According to estimates, Serbia and Montenegro have spent US$ 9–12 billion educating and training medical specialists who have left the country. (Jekic et al., 2011) In all countries with significant outflows, health workforce planning is hampered by the lack of solid evidence, particularly related to nurses.

With regard to provision of services, in all studied countries family doctors or general practitioners act as gatekeepers to specialist and inpatient services for insured patients, by the use of a strictly recommended referral system. Despite the efforts to develop primary care, access to adequate and holistic community health-care remains a challenge for certain segments of the population (low-income groups, residents of rural areas and small towns, Roma etc.). The community nursing system remains largely unutilized as the most powerful "equalizer" in the health system (UNICEF reports). None of the studied health systems has the capacity to provide the comprehensive packages defined by the national laws.

Most hospital beds are for acute care. Palliative, long-term and rehabilitation care are not sufficiently developed as parts of the health systems in the region. Most long-term care is provided in the family, and there are few resources available for informal carers.

In most studied countries, the pharmaceutical supply network was almost entirely privatized. There is an oversupply of pharmacies in urban areas, whereas in rural areas shortages are still a problem although the situation has gradually improved. For example, in Romania, there are 7 times more pharmacists per 1,000 people in urban localities than in rural ones. This has implications for access of rural populations to essential medicines.

The limited access of some segments to health services leads to significantly larger proportions of the population reporting unmet needs for medical examination (due to them being too expensive, too far away to travel to or too long a waiting list): 5.1% in Croatia, 9.8% in Bulgaria and 11.9% in Romania compared with the EU-27 average of 3.4% (data for 2011, Eurostat). At the same time, surveys such as Eurobarometer or European Quality of Life Survey (EQLS) indicate Romanians and Bulgarians as the most dissatisfied with health-care provision in their country. In 2008, a Eurobarometer[106] showed that the proportion of individuals who assessed as "very good" or "rather good" the health-care provision in their country was only 17% in Bulgaria, 20% in Romania, but this figure reached 42% in Croatia, and rising to 52% in Macedonia as against a European average of 55%. In 2011, the perceived quality of health services was only 4.5 in Bulgaria and 4.7 in Romania compared to 6.3 which was the average rate of EU-27 (Eurofound, 2013, 3rd EQLS). Low levels of perceived quality of heath-care and lack of trust in doctors' professionalism was also reported for Moldova (e.g. IOM, WHO, UNAIDS and Ministry of Health, 2010).

From a consumer and patient perspective, the Euro Health Consumer Index 2013 (figure 16) indicates that all SEE countries need to improve the performance of their health systems in all considered areas: patients rights and information, accessibility (waiting times for treatment), outcomes, range and reach of services provided, prevention, as well as pharmaceuticals deployment. Among the five countries included, Croatia appears to be the best performer (ranked 19th). The other four countries fall at the bottom of the hierarchy. Of the 35 European countries covered, Serbia finishes the last (ranked 34th),[107] Romania obtains the second worst score (ranked 33rd), Bulgaria is ranked 30th, and Macedonia is ranked 27th. Furthermore, during the global financial crisis (in the period 2006-2013), while countries at the top (e.g. Netherlands, Denmark) have kept improving, most countries in the bottom, including our countries, have experienced a decline in performance (Health Consumer Powerhouse, 2013).

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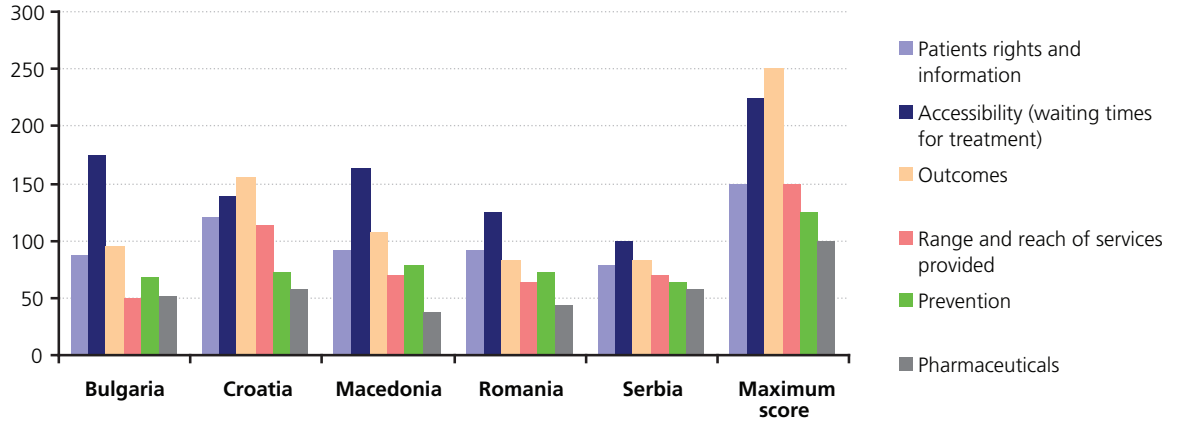
[106] http://ec.europa.eu/public_opinion/cf/showtable.cfm?keyID=3232&nationID=27,28,16,32,29,&startdate=2008.10&enddate=2008.10

[107] Serbia had rank 34 although was the last in hierarchy, because England and Scotland finished both on rank 13.

Figure 16. Euro Health Consumer Index in 2013 in selected countries



Data: Health Consumer Powerhouse (2013). Note: The graph presents the scores per country and the maximum possible score by sub-discipline. For each sub-discipline is calculated an index based on 6 to 12 indicators, overall 48 indicators. EHCI methodology combines statistics from WHO, OECD with soft data obtained from interviews with patients, expert reference panel discussions and survey to Patient Organisations regarding waiting times and other 10 indicators.

In Kosovo, considerable investments have been made since 1999 for rehabilitating primary health-care centres and hospitals. This has contributed to improvement in human resources, better conditions for provision of services, and management of health-care facilities. Nonetheless, the current Kosovo health sector is characterized by a low quality of health services, a lack of pharmaceuticals, related supplies, and consumable materials. Inpatient treatment at public hospitals necessitates that patients' families bring their own supplies, such as drugs and their meals before undergoing surgical interventions. Low salaries and poor working conditions in the public sector leave staff highly discouraged. There is a rapidly growing private sector but considering the high level of poverty in Kosovo, it is not surprising that there are not many such patients in Kosovo who can afford to pay cash up-front, immediately following treatment.

3. PERFORMANCE OF THE PUBLIC HEALTH SYSTEM:

A MICRO-PERSPECTIVE

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3.1 SETTING THE SCENE

This chapter presents both the analysis of data collected within this study and the main findings. The first subchapter focuses on the analytical framework understood as the lens through which we analyzed the interviews. This is followed by sections dedicated to each of the five health problems considered in the study, each section follows a common pattern: a short presentation of the general situation (incidence, prevalence and death rates), an analysis of the accessibility of state-of-the-art treatment in the specific disease and a list of major barriers to access. The major areas for intervention are then identified and discussed in the final chapter 4.

3.1.1 Analytical framework

The performance of the public health care system is understood in this study based on the concept of accessibility as defined by the WHO: 'a measure of the proportion of the population that reaches appropriate health services' (WHO, 1998, p. 2). Article 35 of the Charter of Fundamental Rights of the European Union[108] affirms access to health-care services as an essential right in EU Member States: 'Everyone has the right of access to preventive health-care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of Human health protection shall be ensured in the definition and implementation of all Union policies and activities.'

The analysis presented in the next subchapters was structured in line with the model used to analyze actual access of the population to health-care services developed by Wismar et al. (2011, p. 49-50), which identifies seven steps, each representing a potential access barrier that needs to be surmounted if universal access is to be achieved. The first two steps are fundamental and refer to: (1) health-care coverage of the population (both public and voluntary health insurance), in particular if it extends to the whole population and (2) benefits covered under the system of primary coverage: some services may not be covered in the benefits basket, or are covered but not available. The other five steps refer to: (3) cost-sharing policies as these can threaten equity of access; (4) geographical distribution of services that may pose a threat to accessibility in spite of equal entitlement; (5) a lack of accreditation of health-care providers that may block access to these providers; (6) the organization of the system that can result in barriers to access, mainly through waiting lists; and (7) the preference and ability of patients to actually utilize a health-care service, which is influenced by gender-related, socioeconomic and cultural factors.

The topic of health insurance coverage of the population has been discussed in previous sections so we will not address it during the analysis of health problems. Generally, in all eight countries, employers must register their employees with the health insurance fund when a new employee starts work. Employees and employers pay monthly contributions in an amount which varies from one country to another. Dependent family members are covered by the contributions paid by employed family members. The unemployed, old age pensioners and people on long-term sickness benefit or maternity leave do not have to pay healthcare contributions. Social aid covers the

[108] Official Journal of the European Communities 2000/C 364/01, 18 December 2000, available at: http://www.europarl.europa.eu/charter/pdf/text_en.pdf

health insurance for poor people. Self-employed persons and farmers must pay a contribution varying across countries, which is calculated according to the taxable revenue from self-employment, but the base rate cannot be lower than the average or minimal wage in the country for the month that the contribution is paid. Emergency care is available free for everyone including those without state health insurance. However, once your condition has stabilized providers will want proof of insurance status and may expect payment in cash.

The data obtained through interviews with knowledgeable observers and individual witnesses, for each of the five selected health problems, was organized and analyzed in relation to an adjusted 6-access-steps model based on the following sequence of themes:

(A) The extent to which the national benefits packages cover diagnostics, treatment, monitoring and rehabilitation in the specific health problem. At a general level, in all eight countries, the state fund covers most medical services including treatment by specialists, hospitalization, prescriptions, pregnancy and childbirth and rehabilitation;

(B) The extent to which payments, co-payments, and out-of-pocket money are involved and threaten equity of access in the diagnosis, treatment, monitoring and rehabilitation in the specific health problem;

(C) Geographical access and availability of services in the diagnosis, treatment, monitoring and rehabilitation in the specific health problem;

(D) Public and private health-care providers available in the diagnosis, treatment, monitoring and rehabilitation in the specific health problem;

(E) Waiting lists and other aspects of system organization that can result in barriers to access in the diagnosis, treatment, monitoring and rehabilitation in the specific health problem;

(F) Groups with limited access and risk factors related to the specific health problem.

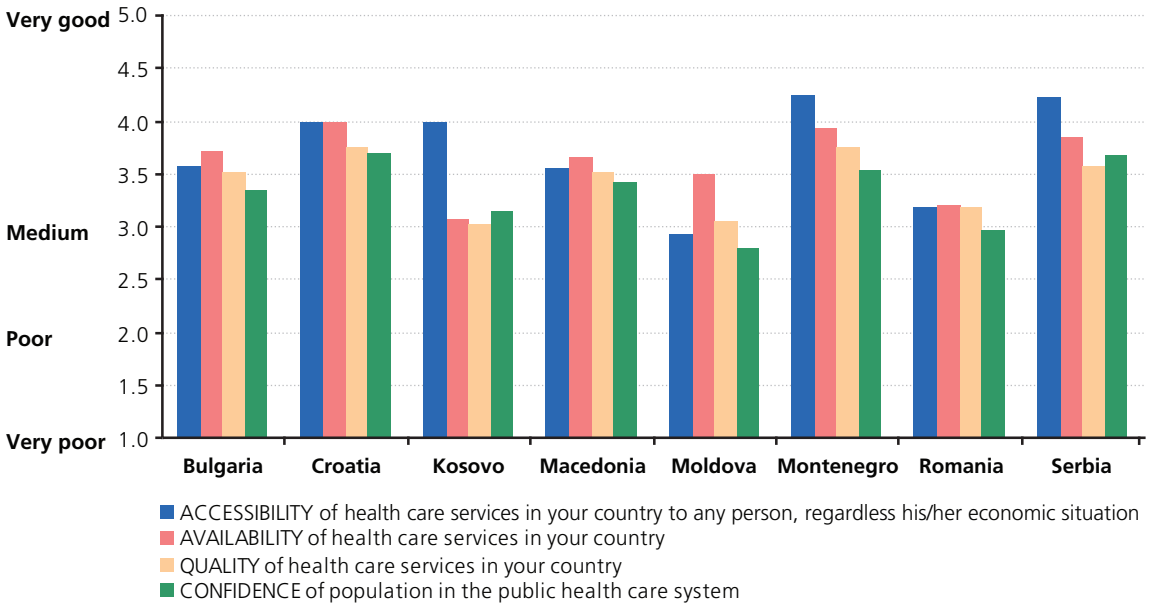
Within the study *The Performance of Health-Care Systems in SEE*, the data collection process was based on structured interviews that followed ten interview guides (see Research instruments) common to all countries. The interviews began with few opening questions about general perceptions on the public health-care services, followed by tailored questions depending on the particular therapeutic scheme of each health problem.

3.1.2 General assessment of the public health-care services

This section presents the opinions of the interviewed knowledgeable observers both about the accessibility, availability and quality of health-care services in their country and the population's confidence in the public health system. These results should be interpreted with caution since neither the overall sample nor the national samples of knowledgeable observers are statistically representative.

Opinions of knowledgeable observers vary significantly across countries with respect to all dimensions (figure 17). At one extreme, the knowledgeable observers from Croatia, Montenegro and Serbia tend to assess their health systems in positive terms. At the other extreme, representatives of Romania, Moldova and Kosovo are rather critical in evaluating their health systems (except accessibility that is assessed as being 'good' in Kosovo). Bulgarians and Macedonians consider their health systems as being medium-good in all respects, be it accessibility, availability, quality of health-care services, or the population's confidence in the public health system.

Figure 17. Knowledgeable observers' assessment on accessibility, availability, quality of and confidence in the health-care services

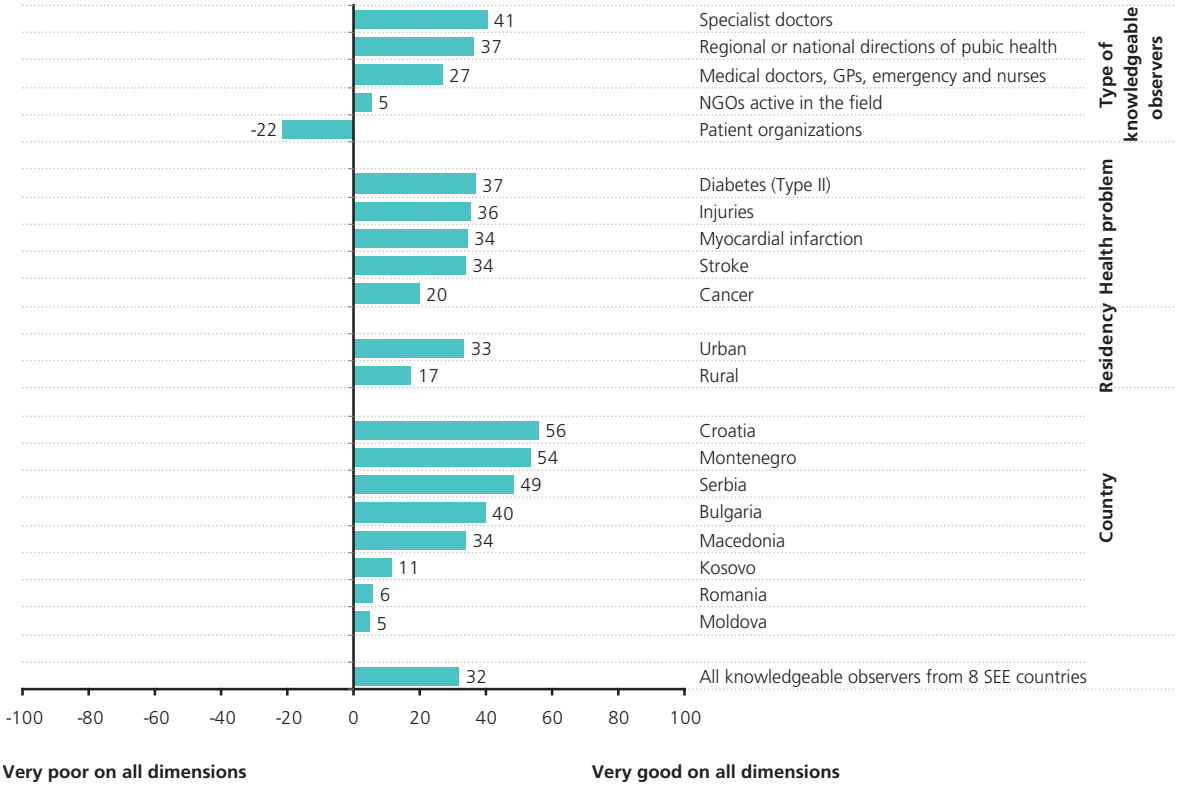


Data: FES (2012-2013) *Performance of the Public Health-Care Systems in SEE countries*. N=125 knowledgeable observers by country, except for Kosovo N=113 (18 missing cases). Note: Assessment for each dimension on a scale from 1 - 'very poor' to 5 - 'very good'. The graph presents the average values. On all dimensions, differences between countries are statistically significant according to a univariate analysis of variance (at p=.000).

For measuring the general assessment of the health system we aggregated the opinions on the four dimensions in a dominant opinion index.[109] The results are shown in figure 18. At the level of the overall sample, the dominant opinion about the health-care services has an average value of 32 (and a standard deviation of 46), which shows that the performance of the health systems in the SEE region is rather a matter of controversy among health professionals.

[109] Method developed by Hofstede (1980) based on the formula: (P-N) * (T-NR)*100/T*T, where P – positive answers ('very good' or 'good'), N – negative ('very poor' or 'poor'), NR – neutral or non-response, and T – total number of variables. This type of index varies between -100 (generalized negative attitude) and 100 (generalized positive attitude toward the issue).

Figure 18. General assessment of the health systems from 8 SEE countries according to knowledgeable observers



Data: FES (2012-2013) *Performance of the Public Health-Care Systems in SEE countries*. N=125 by country, except for Kosovo N=113 (18 missing cases), a total of 988 knowledgeable observers. Note: Assessment on a scale from 1 - 'very poor' to 5 - 'very good'. The graph presents the average values of the dominant opinion index determined based on the four dimensions shown in figure 17. Differences between categories are statistically significant according to a univariate analysis of variance (at p=.000).

Firstly, the dominant opinion varies widely from a country to another. In Croatia and Montenegro, most health professionals tend to consider that the national health systems perform well in terms of accessibility, availability and quality of services and are invested with trust by population. By contrast, in Kosovo, Moldova and Romania, health professionals are divided almost equally between positive and negative assessments.

Secondly, in the entire region, health professionals from rural areas tend to assess the system's performance as being much weaker than in urban areas. This opinion reflects the urban - rural gap which (as we have shown in the previous chapters) is also highly visible in the statistics and indicators on health status and health-care provision.

Thirdly, the performance of health systems in the SEE region is significantly lower in relation to certain groups of diseases, such as cancer.

Fourthly, the assessment depends also on the profile of the evaluator. Thus, patient organizations tend to be very critical, NGOs are rather neutral (or almost equally split between positive and negative attitudes), whereas specialist doctors and management representatives (from regional and national departments of public health) are the most positive regarding the system's performance. This gap between the patient organizations and the system's representatives is particularly accentuated in the case of terminal diseases (such as cancer). The patient organizations mainly focus on 'desperate cases' such as the poor, Roma or other vulnerable people who need help and support

in order to access appropriate health services. By contrast, the system representatives tend to focus on success stories, on health professionals who strive to provide state-of-the-art services under severe constraints of all kind or on the efforts to provide minimal conditions in a context of significant cuts and budgetary shortages.

3.2 MYOCARDIAL INFARCTION

3.2.1 General situation

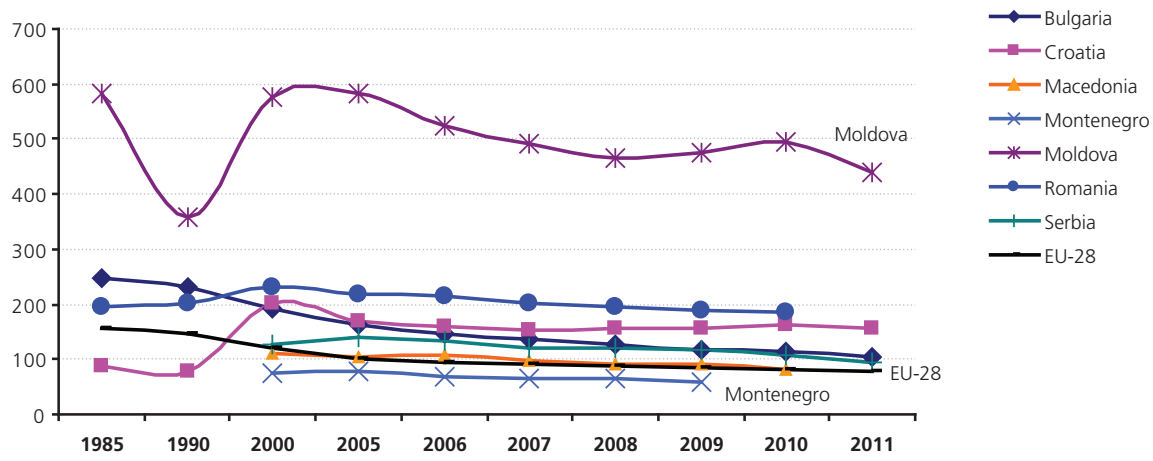
Cardiovascular diseases are the leading cause of morbidity and mortality worldwide. Statistical data (WHO) shows that circulatory diseases, especially coronary disease are leading causes of morbidity and mortality in all eight studied countries; the share of cardiovascular diseases (CVD) in overall mortality is higher than 50% (figure 13). Ischemic heart disease (IHD), along with cerebrovascular diseases, is leading causes of death in this group of diseases. Thus, the share of deaths attributable to IHD ranges between a low 13% of CVD deaths and 7% of all deaths in Montenegro (2009), and a high 66% of CVD deaths and 38% of all deaths in Moldova (2011).[110] The age-standardized death rates from IHD have registered a decline in recent years, yet have remained higher than the European average in Croatia, Romania and especially in Moldova.

Acute myocardial infarction (including subsequent myocardial infarction) is the leading cause of deaths in the group of ischemic heart diseases.

There are significant regional, gender and age gaps in age-standardized death rates from acute myocardial infarction. Figure 20 shows that, in 2010, 177 per 100,000 deaths among Macedonian men were attributable to myocardial infarction in comparison to only 96 deaths per 100,000 among Macedonian women of all ages. In Romania, the rate for men aged 0-64 years was 62 per 100,000, while for women was only 16 per 100,000. The figure also illustrates the 'east-west gap' in mortality rates,

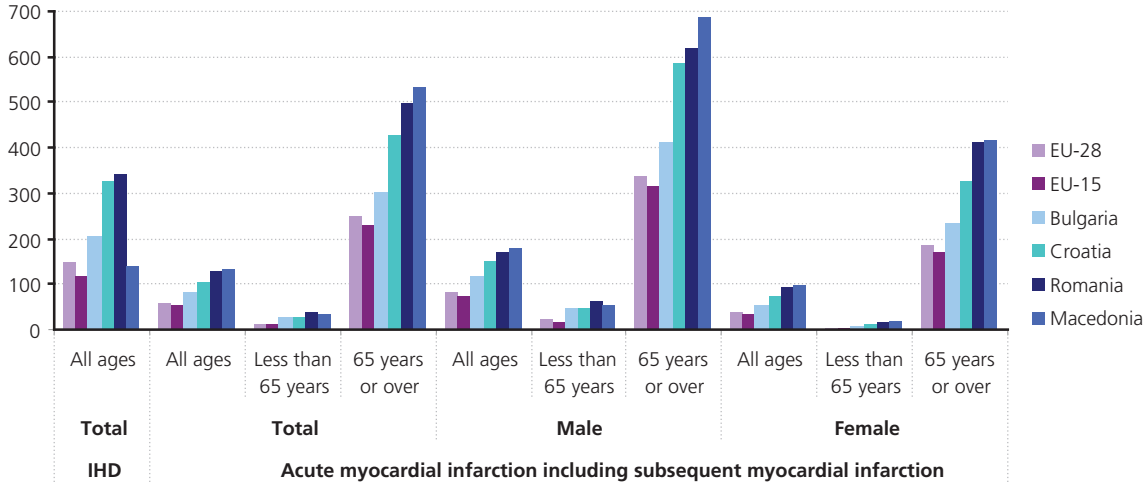
[110] Shares of IHD deaths in the other countries were the following: Bulgaria (2011) - 18% of CVD deaths and 11% of all deaths; Croatia (2011) - 44% of CVD deaths and 20% of all deaths; Macedonia (2010) - 15% of CVD deaths and 9% of all deaths; Romania (2010) - 35% of CVD deaths and 20% of all deaths; Serbia (2011) - 20% of CVD deaths and 10% of all deaths. For comparison, the European averages in 2011 were 37% of CVD deaths and 13% of all deaths. Note: Percentages in total deaths calculated based on age-standardized mortality rates per 100,000 of all ages of the population. Data: WHO/Europe, European HFA Database, July 2013, last reported data.

Figure 19. Trends in age-standardized death rates from IHD: all ages per 100 000 population



Data: WHO (2013b) and WHO/Europe, European HFA Database, July 2013. Data not available for Kosovo.

Figure 20. Standardized death rates due to acute myocardial infarction (including subsequent myocardial infarction) per 100,000 population, by gender, broad age groups and country, in 2010



Data: Eurostat, September 2013. Notes: Annual data. Data not available for the other countries included in the study.

which is evident for men as well as women, for the young as well as the elderly.

Although statistics are not available, myocardial infarction is also considered to be one of the leading causes of death also in Kosovo, with an increasing incidence among younger people.

In Montenegro, there are no precise figures on the number of patients suffering heart attacks, or the percentage of mortality, as the registry is in process of development. However, the analysis of national data shows that the overall mortality rate from myocardial infarction is higher in the male population (62%) than in females (38%). Out of the total number

of people who died of myocardial infarction, 62.3% died before the age of 75 years, and 28.4% before the age of 65, suggesting that death by myocardial infarction is a more significant factor in older age groups. However, by comparing the mortality profile of myocardial infarction and cerebrovascular disease it becomes apparent that myocardial infarction is more significant among younger persons compared to cerebrovascular disease.[111]

[111] Out of the total number of people who died from cerebrovascular disease, 45.1% died before the age of 75 years and 14.7% before 65 years.

The main risk factors for myocardial infarction (and CVD) in the region are almost the same as in other EU countries, including obesity, smoking, high blood pressure, diabetes, hyperlipidemia, stress, physical inactivity and genetic factors. The national studies report a rather high incidence in population of risk factors in most countries.

The cardiovascular diseases represent an urgent public health problem due to increasing number of patients with cardiovascular diseases and their impact on the loss of the work capacity of the young-aged persons.

Box 2. An analysis of national data on acute coronary syndrome in Serbia (by Milos Bjelovic)

There is National Registry of people affected by acute coronary syndrome. Some of the data are extrapolated from the main registry and published yearly by the Institute of Public Health of Serbia, as a part of the Health Statistic Yearbook.

In 2011, in Serbia, 55,514 people (25,454 males and 30,060 females) died from cardiovascular diseases (ICD 10: I00-I99). Cardiovascular diseases account for 53.9% of all causes of death and are the leading cause of death in Serbia. Females were dying from cardiovascular diseases more often (54.1%) than males (45.9%).

Ischemic heart diseases and cerebrovascular diseases are leading causes of death in this group of diseases. In the observed ten-year period death rates for cardiovascular diseases in Serbia increased from 756.9 per 100.000 to 764.8 per 100.000 populations. In the period between 2002 and 2011 mortality rates in females increase by 2.1%, compared to a 0.1 decrease in males. In the period between 2002 and 2011 death rates form hypertensive diseases (ICD 10: I10-I15) increase by 75.3% and from ischemic heart diseases (ICD 10: I20-I25) by 9.5%. The reason for this evolution in death rates for the above mentioned diseases lies largely in better coding of the primary cause of death.

As the most severe form of ischemic heart diseases, acute coronary syndrome (ACS) has been leading health issue in the developed countries. For many years, it has been the leading problem in the developing countries, too. Acute coronary syndrome includes acute myocardial infarction and non-stabile angina. In Serbia, in 2011, 55.0% of all deaths from ischemic heart diseases were caused by ACS. Myocardial infarction was diagnosed in 95.2% of patients, and non-stabile angina was diagnosed in 4.8% of patients.

- According to the data from the population-based Registry of Acute Coronary Syndrome in Serbia, in 2010, acute coronary syndrome was diagnosed in 22,078 cases. Incidence rate was 302.8 per 100,000 population. In the 2011, 5,839 people in Serbia died from this disease. Mortality rate was 80.4 per 100,000 populations. Additional data extrapolated from the Acute Coronary Syndrome Registry from 2010 were the following:
- Demographic data suggested that an average age of the patients with myocardial infarction was 65 years, with age range of 22 to 110 years and standard deviation of 12 years.
- The most common risk factors for acute coronary syndrome included high blood pressure (10,049 patients), a family history of chest pain, heart disease or stroke (7,178 patients), high blood cholesterol (6,878 patients), physical inactivity, smoking, diabetes and obesity.

- Medical history of the patients treated in the acute coronary units in Serbia included previously diagnosed angina pectoris (4,178 patients) and acute myocardial infarction (3,051 patients). The 1,517 patients underwent percutaneous invasive coronary intervention, 618 patients had coronary artery by-pass graft. A total number of 632 patients had peripheral artery disease and 870 patients had cerebrovascular accident.
- Average time span from developing disease symptoms until acute coronary unit admission was 855 minutes, including all acute coronary units in Serbia. Median was 180 minutes and mode was 120 minutes. The majority of patients, 10,714 had typical disease symptoms, 1,542 patients (10.4%) had atypical symptoms and 149 patients were symptoms free.
- A large number of the patients (6,713) was initially examined by emergency physician, 2,631 patients by attending GPs, 2,440 patients by attending physician in emergency admission units, 1,315 patients were transferred from other hospital departments, 371 patients was transferred from other health-care institutions. In 1,428 patients this data was not recorded.
- The vast majority of patients admitted to acute coronary units in Serbia had previously administered therapy which included: acetylsalicylic acid (12,827 patients), clopidogrel (11,831 patient), nitroglycerin (7,537 patients), heparin (1,976 patients), low molecular weight heparin (10,199 patients), beta blockers (9,951 patient), ACE inhibitors (10,348 patients), diuretic (5,013 patients), calcium channel blockers (1,602 patients) and statins (11,861 patient).
- Urgent percutaneous trans-luminal coronary angioplasty was performed in 1,861 patients. A total number of 1,996 patients were treated with thrombolytic therapy.

All the above mentioned data represented quality indicators for clinical care.

The collected data included complications of acute myocardial infarction, which had large social and economic importance, including lowered work productivity. The most common complications of acute myocardial infarction included: rhythm and conduction disorders (3,010 patients), heart failure (499 patients), and post-acute myocardial infarction angina (983 patients). Myocardial re-infarction occurred in 281 patients, mechanic complications in 291 patient, 869 patients underwent cardiopulmonary resuscitation. Average length of hospitalization in acute coronary units was 9 days, with a mode of 8 days.

National institutional arrangements and policies

In Croatia, health-care policies and institutions involved in prevention are mainly family doctors and primary health-care. High attention is also directed toward secondary prevention.

In Kosovo, a patient with myocardial infarction will usually end up in emergency centre. From there, patients are referred and treated in regional hospitals and University Clinical Centre of Kosovo. There is a lot of human capacity (medical professionals) for dealing with cardiovascular disease. There are protocols in place that are used by physicians in hospitals and there is a lot of training that has equipped medical staff for performing high quality care.

In Macedonia, according to the recommendations from the WHO, the Ministry of Health prepared a second National strategy for prevention and control of non-communicable diseases for the period 2007-2012, as well as Strategy for health, environment and safety work places, Strategy for diabetes etc. Each year the Ministry of Health announces a national program for prevention of cardiovascular diseases (CVD). There are integrative activities for GPs, Public Health Services, Government and local communities by which is expected to decrease the risks for CVD and protect the health of the population.

The patient with acute myocardial infarction is usually accepted by the teams from Emergency Units. They are responsible to give first aid and to transfer patients to hospital. All bigger cit-

ies in Macedonia have general hospitals where exist a Department for internal diseases. The patient receives a treatment and if the prognoses are not well, the patient is transferred to Clinic for cardiovascular diseases in Skopje by organized transport. As a most specialized institution for the tertiary level of healthcare, this Clinic provides health-care services for all patients regardless of their residential place.

Couple of years ago, there was a lack of equipment for early diagnosis of acute myocardial infarction within the Emergency units; the transport was performed by old and unsafe transport vehicles. The situation is much better now, due to the efforts of the Ministry of Health to provide new fully equipped vehicles for emergency units. Coronography and early antifibrinolotic therapy are present only in some health-care facilities, generally in Skopje (private hospitals and at the Clinic for cardiovascular diseases).

In Moldova there is a lack of coherent and financially sustainable policies on prevention, detection, diagnosis and treatment of CVD. Since 2002, Moldova hasn't approved and implemented National Programs for control of cardiovascular diseases.

In Montenegro, the network of reformed primary health care centers, through organizational unit of prevention centers, provides conditions for the implementation of measures of prevention and health promotion, early detection of diseases, monitoring and control of situation, while the Coronary unit at the Clinical centre of Montenegro monitors and treats cardiovascular diseases.

As part of improving the health-care system in Montenegro, financed by the World Bank, the Ministry of Health of Montenegro has developed a National Guide of Cardiology, 2012. Implementation of this guide in the field of cardiology aims at realizing the benefits for beneficiaries and health-care providers in this area, and therefore the health-care system as a whole.

The Government of Montenegro has developed a National Strategy for the prevention of chronic diseases, which covers, among others, cerebrovascular and coronary heart disease. This strategy provides the basic guidelines for a comprehensive and coordinated response to the growing presence of these diseases, and the aim of the Strategy is to avoid premature mortality, reduce morbidity and integrated multi-sectoral activity, directed towards the elimination and reduction of risk factors. In the period June-August 2012 in collaboration between the Institute of Public Health and the bakery sector a study on the amount of salt in bread and bakery products were conducted, including 107 samples of bakery products from 6 municipalities, of 18 manufacturers which supply the majority of the market in Montenegro. The results showed that more than half of samples contain a higher concentration of salt than recommended 1.5%. The long-term goal of this initiative is to contribute to reduce the prevalence, i.e. the extent of chronic mass diseases associated with diet in Montenegro, i.e. decrease in mean arterial blood pressure and improving its control in the general population (bearing in mind that arterial hypertension is a major risk factor for cardiovascular disease).

Given the importance of the program and its relationship with the EU integration process of Montenegro, it is essential to receive support of administrative and management bodies (Ministry of Health, Health Insurance Fund, Ministry of Finance, Ministry of Economy, Ministry of Agriculture, Chamber of Commerce of Montenegro, the Centre for Consumer Protection, the National Council for the assessment of food safety, etc.).

In Romania, one of the most important steps made in the direction of reducing mortality due to myocardial infarction was the introduction, in 2010, of the National Invasive Program for Acute Myocardial Infarction Treatment. The aim of the program was to correctly treat myocardial infarction according to the European guidelines. In 2011 the program already exceeded the target of 3,500 patients treated each year. According to official data,[112] in the

[112] http://www.ms.ro/?pag=62&id=9183.

first year, 4,052 patients received free, specialized treatment within the program. The success of the program was positively evaluated at the end of the first year of implementation as it led to a decrease by 15% of hospital mortality in acute myocardial infarction patients. However the program functions only in nine hospitals from capital Bucharest and few large cities: Iasi, Timisoara, Targu Mures and Cluj-Napoca.

In the Republic of Serbia, cardiology service is organized on several levels, including departments of cardiology, acute coronary units and post coronary care units within tertiary level health-care institutions (Clinical Center of Serbia –Belgrade, Institute of Cardiovascular Diseases in Sremska Kamenica, Clinical Centre Niš, Clinical Centre Kragujevac). The following facilities are all performing invasive cardiology procedures. On the secondary healthcare level, all Clinical Centers are equipped with acute coronary units, post coronary units, departments of cardiology and angiogram units, while only few of the regional health-care institutions are performing diagnostic and therapeutic invasive cardiology procedures. The management of acute coronary syndromes also includes GPs within the primary health-care level and emergency physicians who are often first in providing medical care to the patients.

3.2.2 Interviewees on myocardial infarction

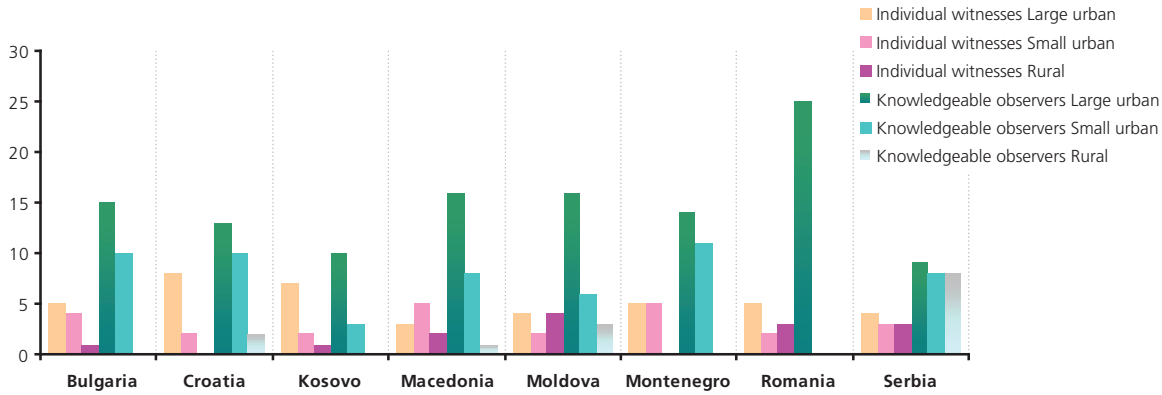
In all 8 countries a total number of 268 interviews on myocardial infarction were realized, of which 80 individual witnesses and 188 knowledgeable observers.

The study covered in each country various regions including metropolitan (159 interviews), urban (81) as well as rural (28) areas. Out of the total sample, the knowledgeable observers interviewed for myocardial infarction from large urban areas represent the largest group of interviewees on the topic (44% of the total interviewees on myocardial infarction).

Interviews were carried out both with women and men. At sample level, 56% of total individual witnesses are men. Due to the fact that in the majority of health-care systems there are more women employees than men, female knowledgeable observers represent 55% of the total medical representatives that participated in the project on the myocardial infarction topic.

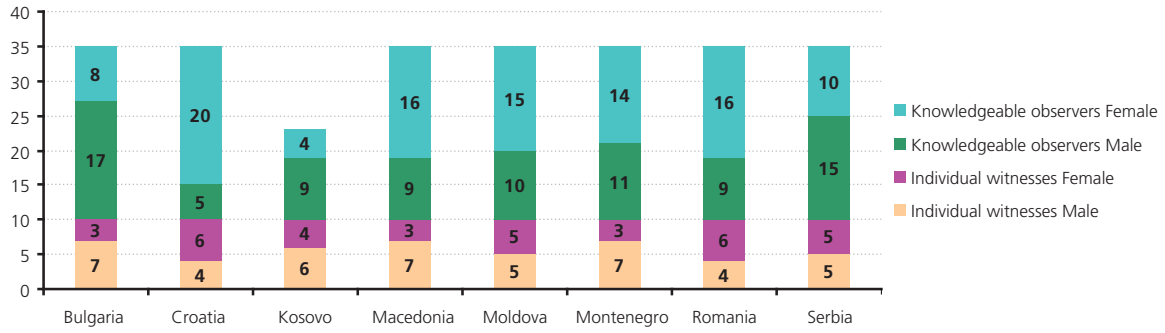
Individual witnesses who participated in the study were mainly patients diagnosed during the period 1st January 2010 - 31st December

Figure 21. Myocardial infarction: Distribution of the sample by interviewee's type by area and by country (number of interviews)



Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Note: Types of areas (rural or urban) according to the national administrative definitions.

Figure 22. Myocardial infarction: Distribution of the sample by interviewee's type, gender and country (number of interviews)



Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*.

2011, aged between 19 and 88 years old (and an average age of 54 years old), from a range of ethnic groups,[113] with various levels of education[114] and a broad range of occupations.[115]

Knowledgeable observers are medical representatives, aged between 24 and 67 years old (with an average of 44 years old). The interviewees include specialists (86 interviews), general practitioners (46), public health representatives (17), hospital representatives (14), emergency centres representatives (14), patients' organizations (5), NGOs (3), and others (3).

The main characteristics of the sample on myocardial infarction, regarding both individual witnesses and knowledgeable observers, are presented in tables A.3 and A.4 in Annex.

3.2.3 Accessibility to the state-of-the-art treatment in myocardial infarction

This section analyzes the actual access of patients with myocardial infarction to state-of-the-art diagnostic, treatment, monitoring and rehabilitation based on the interviews with knowledgeable observers and individual witnesses from the eight selected SEE countries. The analysis is organized according to the adjusted 6-access-steps model presented in subchapter 3.1.1.

[113] Bulgarians, Croatians, Kosovars, Albanians, Macedonians, Montenegrins, Romanians, Moldovans, Roma, Ukrainians, Russians, etc.

[114] Were interviewed 10 with elementary education, 28 with high school, 32 with college or more. For Kosovo data regarding the level of education of the interviewees is not available.

[115] Employed (45 interviews), pensioners (27) or other economically inactive persons (7).

(A) Content of the national benefits baskets

In all studied countries, acute myocardial infarction is included in the list of major medical-surgical emergencies covered by emergency medical assistance at the pre-hospital stage, including medical-assisted transportation to the hospital institution. For insured persons, these are covered by mandatory health insurance, whereas uninsured persons, in the event of acute myocardial infarction, receive free medical care, including hospital care until his/her health condition is stabilized and the life-threatening danger is excluded.

(B) Formal and informal out-of-pocket money

In Bulgaria, the medicines to be taken after acute myocardial infarction are only partially covered by the National Health Insurance Fund. The amount that patients pay for medication is about € 15-25 per month.[116] In addition, patients may choose to pay for a stent of better quality. No other out-of-pocket payments were reported. Bulgarian medical specialists evaluated the total cost of tests and examinations for acute myocardial infarction treated with angioplasty in the range of between € 200 and € 4,000.

In Croatia, treatment and medicines are totally free of charge for people covered by health insurance. However, the costs assigned to treatment in acute myocardial infarction covered by the health insurance (clinic/hospital budget) are so high that doctors need to consider it before they apply it; a fact which is considered to hamper the work of health professionals. In rare cases (usually including surgical intervention), informal payments are requested (up to € 1,500). A patient without health insurance who cannot pay the demanded amount would receive the same treatment and would get the bill afterwards, according to the price list.

In Kosovo, people do not have to pay for services they get in the public sector, but for services not available in the public health-care system, such as angioplasty or various tests, patients have to pay out-of-pocket. However, in reality, out-of-pocket payments are needed due to many unexpected circumstances surrounding acute myocardial infarction and the fact that in many cases the emergency centre or other department to where patients are referred from emergency centre will most likely lack medical supplies and medications. In public facilities, informal payments or payments for supplies or medication that are missing amount to less than € 100 in mild cases, up to several hundred euro for cases of surgical intervention and the case of private health institutions the out-of-pocket payment may reach € 4,200 in more complicated cases. In addition, the payments for medication range between € 100 (most commonly) and a few hundred Euros. Transport services are provided by family members on most occasions. Transport is costly by Kosovo standards although journey distances are usually not that long. In case a patient cannot pay there are other options. In the best-case scenario, the patient would be treated and relieved of any charge. In the worst-case scenario, their lack of money may lead to their fatality.

In Macedonia, most patients have to pay a participation fee for tests (about 2-20% of the national gross monthly wage, in February 2013), the amount of which depends on the type and number of analyses, for treatment (an additional 2-20%) and for medicines that have to be taken on regular basis (another 1-16%). The patient's treatment is declared the primary objective and so the payment is regulated after the crisis situation passes. Thus, a hospitalized patients does not pay for any services during the treatment, including laboratory tests, food, nursing care or medication. The model of payment depends on organizational issues, because some health facilities provide payment options (paying in installments, late payment and/or through the involvement of social care service). The last (and least popular) payment method is administrative regulation via the courts. N.B. Co-payments are declared by some health professionals as being barriers to access stat-of-the-art treatment for patients with modest means.

[116] At an exchange rate of 1.95583 BGN= 1 EURO.

Box 3. Informal payments in acute myocardial infarction in Moldova (by Andrei Mecineanu)

Acute myocardial infarction (AMI) patients face a number of financial barriers to accessing health services, especially at the stage of hospital and outpatient post-hospitalization treatment. Among identified barriers are the payments for diagnostic and treatment services that must be made to medical personnel and the high cost of drugs. These are perceived as a financial burden for patients because such payments exceed their financial capabilities.

The phenomenon of direct payments was reported by all stakeholders – patients and their relatives, health practitioners and officials. According to them, direct payments are more widespread at the stage of hospital care, and have not been reported at the stages of pre-hospital emergency care, prevention and/or rehabilitation. The absence at these stages of this phenomenon is determined by factors that reflect the principles and certain realities of the organization of the health-system.

AMI patients and their relatives reported that hospital treatment is partially free of charge and but there is the need for direct formal and informal payments. Direct payments cover the entire chain of hospital services – medical investigations, treatment (surgical), payments made to doctors, nurses and caregivers with a view to being delivered proper care.

Thus, for hospital-level diagnostic services, doctors reported the need for making formal payments amounting to 200-3,000 MDL and informal payments in the amount of 50-1,000 MDL.[117] For some types of investigations (for example, coronary radiography), formal payments are reported to reach 7,000 MDL, whereas for medical treatment the amount is 500-2,000 MDL. Regarding surgical treatment, doctors and patients reported the existence of formal payments amounting to 30,000 MDL, to which are added payments for the procurement of necessary medical devices (for example, coronary stents). Informal payments made to health-care personnel are reported to amount to 100-3,000 MDL. In some hospital institutions, such as the Institute of Cardiology (republican-level institution), patients and their relatives reported the existence of 'admission fees' of around 250 MDL.

Also, according to patients and doctors, the absence of additional payments will result in the delivery of inadequate and lower quality treatment (including the attitude and care from medical personnel).

Patients reported making payments at the post-hospital phase for prescribed medication, which in the majority of cases is partially compensated. Thus, there is the need for making additional payments amounting to 100-1,400 MDL/monthly.

In the context of direct payments for AMI treatment, some critical aspects for the public health-care system are worth noting. If it is widely known of the existence of informal payments (as a general phenomenon) for access to health-care, then the operability of formal payments for diagnosis and non-surgical treatment of AMI comes under question. These are determined by the fact that, from the point of view of the normative framework in force, the need for formal payments for health services and medication stipulated by the standard of care is not justified.

In Montenegro, the state-of-the-art treatment of myocardial infarction is free of charge, but high costs of medicines that patients receive as part of their regular therapy outside of hospitals was reported as a major access barrier. In this regard, it is necessary to initiate changes in the national health policy.

In Romania the situation is similar to Bulgaria. Patients do not have to pay for tests or medication during the diagnostic, stabilization or treatment phases. Nonetheless, medication

[117] At an exchange rate of 15.9967 MDL = 1 EURO, as at December 2012, http://www.curs.md/.

is only partly compensated hence poorer patients may find it rather expensive. The access to state-of-the-art treatment depends on payments: for a quality stent implant a patient has to pay up to € 1,000 euro in the absence of which the patient will receive a fibrinolytic treatment or a stent of lower quality. According to our interviews, no medical staff required informal payments, but most patients admitted giving small amounts of money as gratitude payments.

In Serbia all treatment costs are officially covered by the Health Insurance Fund. Patients have to provide funds for medications that are not covered by the Health Insurance Fund and for non-standard services, which include apartment accommodation, control laboratory work and diagnostic procedures for which there are waiting lists. These services are mainly performed in private practice facilities. In rare cases, informal payments are requested by the hospital staff (approximately €200) to precipitate performing surgical interventions (such as percutaneous coronary intervention).

In conclusion, in the case of acute myocardial infarction, out-of-pocket payments are critical in Kosovo, Macedonia and Moldova, as well as in Montenegro with respect to medication. In the other countries, out-of-pocket payments limit access to state-of-the-art treatment based on high quality medical technologies.

(C) Availability of services and geographical access for myocardial infarction patients

The majority of health professionals and officials (83%) interviewed within our study appreciate that state-of-the-art treatment in acute myocardial infarction is available in their country.[118] The negative answers are more numerous among representatives from Kosovo, Moldova and Serbia as well as among general practitioners from rural areas and specialist doctors.

The interviewed medical specialists claim that state-of-the-art treatment of acute myocardial infarction is available in Bulgaria. The

[118] A total of 183 valid answers.

Table 5. The critical out-of-pocket payments (formal and informal) for patients with acute myocardial infarction in SEE region

	Diagnostic (tests)	Treatment	Monitoring, rehabilitation	Medication	Transport to doctor or health facility
Bulgaria		Quality stent			
Croatia		Rarely for surgery			
Kosovo					
Macedonia	Co-payments	Co-payments		Co-payments	
Montenegro					
Moldova					
Romania		Quality stent			
Serbia		Rarely for surgery			

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries.*

process of opening of cardiac catheterization laboratories for coronary angioplasty is still very dynamic – in 2012 at least 3 new ones were opened. At the end of 2012 Bulgaria had 31 'cath labs' and 5,298 coronary angioplasty procedures were performed. In the opinion of health professionals, the number of catheterization laboratories is sufficient, they are easily accessed and their equipment is new and modern and the specialists there are well trained. Medical staff calls this kind of treatment of acute myocardial infarction 'the golden standard'. In contrast to the treatment available for cancer and stroke patients, the treatment of acute myocardial infarction shows no staff shortages yet. Nevertheless, geographic access has remained a problem due to a lack of doctors in certain areas and insufficient rehabilitation units.

In Croatia, all interviewed health professionals consider that state-of-the-art treatment for acute myocardial infarction is available to everyone. There are national guides both for treatment and for prevention of myocardial infarction. Clinic/hospitals offer the following state-of-the-art care in the case of myocardial infarction: 12 hours of primarily PCI and a stay in a coronary unit until stabilization - 5-7 days. The most frequent rehabilitation is thalassotherapy. Doctors, medical services, emergency services and medicines at the local pharmacy are available in most areas of the country, but people from remote areas (especially islands) are at a disadvantage.

In Kosovo, state-of-the-art treatment of acute myocardial infarction is available in the private sector. In the public health-care system this is only partly true; the University Clinical Centre in Kosovo (UCCK), as a tertiary academic centre, may regarded as being be close to that, since a lot of invasive and non-invasive procedures are provided there. The UCCK staff tries to keep up with international standards and protocols in treating patients. The health-care facilities, particularly the private institutions, try to keep up with the European standards. However, there is no official national guide for treatment of acute myocardial infarction, but rather different doctors try to keep up with good practices. There have been attempts to align Kosovo practice with EU standards and the interviewed professionals were aware of these initiatives and have been part of trainings or conferences that shared this knowledge. However, there is no support from the Ministry of Health for these actions.

Doctor or medical services are available in most localities, but most of the mountainous remote areas are at disadvantage. Emergency services are available but the efficiency of emergency network is questionable: sometimes emergency ambulances are not available, sometimes the working conditions are hard, sometimes there is a lack of supplies and sometimes organization of the network suffers. Pharmacies are available throughout Kosovo with the exception of remote rural zones. Rehabilitation units are very limited and do not fulfil either the needs of patients or due standards of care.

In Macedonia, there are national guidelines for treatment of acute myocardial infarction, which are followed in most of the cases. Doctors and medical services, including emergency services, are available, but most health professionals consider that geographical inequities are quite serious across the country, especially in relation to access to state-of-the-art treatment.

In Moldova, patients' experiences and perceptions, on the one hand, and doctors' accounts, on the other, highlight the lack of universal access to state-of-the-art treatment for acute myocardial infarction. Such treatment is available only in specialized tertiary level institutions from Chisinau municipality and in some private hospitals. Rayonal and municipal hospitals are limited in delivering state-of-art treatment due to poor funding and the unavailability of the entire spectrum of medicines established by the standard of treatment, etc. These factors determine that state-of-art treatment is available only to certain groups of patients – patients from Chisinau municipality, patients with financial resources or those for whom 'lobbying' was undertaken. Post-infarction management does not include the entire spectrum of measures established according to standards in the field;

it only includes monitoring conducted by the family physician and cardiologist, as well as the administration of long-term medication treatment. Rehabilitation services related to this health condition are unavailable. Box 4 presents more information about the quality of medical services in acute myocardial infarction in Moldova.

In Montenegro, nearly all interviewed health professionals believe that high-quality treatment of acute myocardial infarction is available and accessible to all citizens. The registry of cardiovascular diseases and the national guides for treatment as well as the various prevention policies are considered to be the guarantee of complete coverage of the population suffering from acute myocardial infarction, as well as monitoring their condition and overall provision of health-care delivery.

In Romania, state-of-the-art treatment in acute myocardial infarction is available, but tends to be concentrated in the University hospitals. At county and municipal level hospitals, a patient is most likely to receive only a diagnosis of certainty. For example a patient living in Botosani county (North East region) can be tested at the county hospital, but for receiving a stent implant he or she has to travel 150 km to the closest University hospital in Iasi county. Emergency services are available, but their effectiveness depends on distance as the quality of road infrastructure is rather poor, especially in rural areas. For patients living in rural areas the time between the occurrence of myocardial infarction and the first aid may take about 40 minutes. For patients living in the same city with the hospital the period for receiving care reduces consistently. In Romania, the most deficient part in the therapeutic scheme for myocardial infarction is rehabilitation. Most patients with myocardial infarction who suffer consequences such as movement control deficiencies, emotional instability, sensory disorders do not benefit of a rehabilitation programme. Some of them receive home visits from the general practitioner and all are under medication therapy. Medication is available, but some of the respondents consider it too expensive, although is partially compensated.

In Serbia, most interviewed health professionals do not think that state-of-the-art treatment in acute myocardial infarction is available in the country. Only the cardiology and internal medicine specialists from large medical centres consider that the best diagnostic and therapeutic options are available to everyone. On the other hand, among patients, only those hospitalized in apartments (private facilities) evaluate the received treatment as the best possible care, whereas the individual witnesses treated in public facilities tend to complain about the quality of medical services. This discrepancy in opinions reflects the existent large geographic inequities across the country as well as the lack of uniform prevention, diagnostic and therapeutic protocols for acute myocardial patients in primary care settings and in smaller public facilities. Thus, according to the dominant opinion, state-of-the-art treatment in acute myocardial infarction is not available due to the large distances from medical centres that are performing invasive diagnostic and therapeutic procedures.

Mobile cardiology teams are available, but their number is too small. Rehabilitation services and special rehabilitation programmes are available both in specialized centres and in local daily clinics in Primary Health-care Centres (outpatient rehabilitation units). Medication is available, but pharmacies are not available in some areas and many existing rural pharmacies suffer of shortage in supply, which results in irregular use of medications in some cases.

(D) Health-care providers in myocardial infarction

State-of-the-art treatment in acute myocardial infarction is provided both in public and private facilities. In many cases, the private providers are better endowed than the public ones. However, private services are not free of charge and are concentrated in larger cities, so they are accessible only to the wealthiest groups of population.

(E) Waiting lists and other aspects of system organization that can result in barriers to access

Long waiting times to be received by a specialist was declared a major hampering factor in six of the eight studied countries (except for Croatia and Montenegro). This refers to the regular checkups that need to be done after hospital discharge, in the period of recovery and monitoring. In most cases, the long waiting time is a consequence of the fact that usually patients want to be seen by the doctor who had provided the procedure and is not always available as s/he works in hospital, in outpatient care or in the catheterization laboratory (in Bulgaria).

In Croatia, long waiting times for getting treatment or rehabilitation were also mentioned. Until stabilization everything is done on time and promptly, but afterwards patients complain that they have to wait for everything else, both inside the clinic/hospital and after the discharge. They consider that the biggest problem inside hospitals is the lack of or insufficient medical staff. Because of the large number of patients and the small number of staff, medical workers are perceived as being cold and unreachable. If a patient doesn't go to rehabilitation straight from the hospital, s/he usually has to wait for a long time to start. Most patients with milder consequences have to wait longer for rehabilitation. Some of the patients had to seek additional help or acquaintances, so that they could receive rehabilitation processes faster.

In Kosovo, long waiting time for rehabilitation services was also reported. The waiting time for being received in a rehabilitation centre can be very long due to limited capacity for provision of rehabilitation services. There are good practices though. Also, the waiting time length for getting the medication depends on where the patient receives the services.

In addition, the need to extend coverage of the existing network of recovery units, cardiology departments and/or mobile cardiology teams was declared in five countries: Bulgaria, Kosovo, Moldova, Romania and Serbia.

Table 6. Waiting times for treatment in acute myocardial infarction

	Direct access to specialist	Treatment	Rehabilitation services	Getting medication
Bulgaria	After discarge			
Croatia			Less severe condition	
Kosovo				
Macedonia	After discarge			
Montenegro				
Moldova				
Romania	After discarge			
Serbia	After discarge			

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Notes: Red cells indicate long or very long waiting times, light orange cells show a intermediate situation, and green cells indicate the areas with no problems in terms of waiting times.

Besides waiting times, other organizational aspects that reduce the quality of services have been mentioned in Croatia, Kosovo, Romania, Moldova (see box 4) and Serbia, including poor hospital conditions (e.g. cold, hygiene, food, medical supplies), poor equipment associated with laboratories (at times they don't work and sometimes there is lack of particular equipment), overcrowding of cardiology departments and insufficient medical staff. Most health professionals consider that the lack of medical staff is the main factor responsible for lower quality indicators of clinical care.

In spite of all the problems, most interviewed patients across the eight countries declared satisfaction with diagnostic and treatment in acute myocardial infarction.

(F) Groups with limited access to health-care services in myocardial infarction

In defining the groups with limited access to health-care in acute myocardial infarction, most interviewed medical professionals referred to the geographic factor. In Bulgaria, the main group with limited access includes people living in remote rural areas. In Croatia, groups with limited access to health-care people come from remote areas, particularly islands. In Kosovo, people from rural areas, especially mountain zones have most limited access. In Macedonia, people living far away from hospitals, particularly those with difficult socio-economic circumstances have the most limited access. In Moldova, mostly people from rural populations have limited access to services but generally those at large distances from Chisinau are disadvantaged. In Serbia, older male individuals and individuals of lower socio-economic status residing in rural areas are under greater risk of having fatal acute myocardial infarction and more serious disease complications following a non-fatal acute myocardial infarction, due to their greater distance from medical centres where adequate medical care could be provided.

Box 4. Quality of medical services in acute myocardial infarction in Moldova (by Andrei Mecineanu)

At the onset of symptoms, patients with acute myocardial infarction (AMI) most often resort to their family members or other relatives, who, in their turn, call for emergency medical assistance. Also, some patients reported their decision to directly visit the hospital institution.

Patients reported a number of problems regarding the delivery of emergency medical care, namely: the long ambulance response time (20 min - 3h), refusal of the request, refusal of transportation to the hospital and recommendation of visiting the family doctor, lack of medical investigations or inadequate investigations conducted by emergency medical teams (lack of ECG examination, non-evaluation of blood pressure, failure to establish presumptive diagnosis of AMI, etc.), and the withholding of treatment while transporting the patient to hospital. These deficiencies have also confirmed by hospital doctors, who also highlight the inadequate equipment in emergency medical transport units, non-observance of AMI patient management standards and limited availability of specialized emergency medical crews.

The process of establishing the diagnosis of AMI in hospital institutions highlights a series of shortcomings, which are less significant in tertiary level institutions. Thus, patients and their relatives reported long waiting times for diagnosis ranging from 3 hours to 2 days, although the standard stipulates a maximum period of 60 minutes for conducting investigations and establishing the diagnosis for patients with uncertain diagnosis for AMI. A similar situation is also reported by patients whose AMI diagnosis was established during hospitalization for another health condition. In this context, one patient highlighted the absence of diagnostic measures within 24 hours after the onset of symptoms, with only the symptomatic treatment being administered in this case. These deficiencies reported by patients and their relatives lead to the conclusion of reduced performance of the hospital system and low capacity for ensuring effective the management of an AMI patient.

Stabilization treatment is initiated in the hospital institution, a situation which is dependent upon the period of time necessary for the patient to be admitted to the hospital and have the AMI diagnosis established. Patients and their relatives reported a waiting time of up to 1h from diagnosis; however the time from onset of symptoms to initiation of treatment is much too long, which is contrary to AMI patient management standards.

Access to surgical treatment and to medication treatment according to the latest standards is lacking, due to the fact that cardio surgical services are delivered only in tertiary level hospitals from Chisinau municipality and in a few private hospitals, as well as due to insufficient equipment and financial provision of the cardio surgical service.

3.2.4 Main access barriers in myocardial infarction

Poor knowledge, low levels of information and the lack of preventive health-related behaviours are considered to be the main factors that hamper access to quality health-care in seven of the eight studied countries (except for Montenegro). The national studies report a higher than average incidence of their populations experiencing risk factors. Due to the low level of information many patients do not recognize their symptoms on time. Thus, a large number of patients remain undiagnosed until the fatal life-threatening situation occurs, when the possibility to give proper medical treatment does not yield positive results and patients die as a result of acute myocardial infarction.

In most countries, there has been work in preventive health related behaviour, but there is much room for improvement. The capacity of the health systems in the region to ensure the implementation of policies on the control of cardiovascular diseases is still reduced. In these circumstances, patients report the absence or inadequate quantitative and qualitative delivery of information and prevention services. The participation of family doctors and cardiologists in the provision of these services consists of the administration of treatment for associated risk conditions, which is not complemented by patient education, although the existing National Protocols provide guidelines in this respect. As a high-level decision-maker declared during one interview many general practitioners are like boutique salesmen. They open at 9 and close at 5, have no time or interest for prevention activities and know nothing else about the patient, other than what is recorded in the medical record'.

Consequently, the main sources of information for patients about cardiovascular diseases, (including acute myocardial infarction) are relatives and acquaintances, TV, the Internet and to a lesser extent medical representatives. This situation, which is associated with lack of information and educational programmes, causes a poor knowledge of symptoms or a distorted perception of symptoms by the patient and his or her relatives. The interviews show that patients under treatment or being monitored for another health problem (as well as those from families with myocardial infarction history) are more likely to be informed or to take preventive actions. For previous healthy persons, the myocardial infarction usually comes as a shock: until the event, they do not pay any attention to the risk factors, nor consider that smoking or lack of physical activity could result in such incidents. The recognition of symptoms and the emergency access to care was simpler for patients with previous interaction with the medical system.

Other major barriers to state-of-the-art treatment in acute myocardial infarction in the region refer to long waiting times for being received by a specialist, low quality of medical services and the high cost of medication. The first obstacle relates to general experience of patients, as described in the previous chapter. The latter two barriers indicate the need for better financing of the health services: for more medical staff, for extending of (and better equipment in the existing) network of public facilities, as well as for including more medication under health insurance coverage.

Table 7. Main access barriers in public health-care to state-of-the-art treatment in myocardial infarction

Access barriers	BG		HR		RKS		MK		MD		ME		RO		SRB	
Delayed first contact with a doctor								x						x		x
Poor knowledge and level of information of the population. Preventive health related behaviour is uncommon		x		x		x		x		x				x		x
Doctor or medical services are not available in some areas		x				x		x	x	x			x	x		x
Cardiology services are available only in some areas						x				x			x	x		x
Rehabilitation units/ services are not available/enough in some areas		x				x				x			x	x		
Pharmacies are not available in some areas								x							x	x
Emergency services are not available in some areas or are underdeveloped		x				x		x	x	x						x
Transport services are underdeveloped or too costly						x										x
The waiting time for being received by a specialist is very long	x					x		x	x	x			x		x	x
The waiting time for getting treatment or medication is very long			x						x	x						
The waiting time for rehabilitation services is very long			x	x		x										
Lack of interest or unprofessionalism of the doctor or medical staff										x						
Lack of trust in doctors, nurses or medical staff																x
Lack of humanity of the staff	x		x													
Lack of money to pay the doctor								x	x							
Lack of money for out-of-pocket payments		x				x			x	x				x		
Low quality and effectiveness of medical services				x	x		x		x	x			x	x	x	x
High costs of medication					x		x	x	x		x	x	x		x	
Poor equipment of public clinics/ hospitals						x		x		x						x
Lack of accessibility and continuity of care							x								x	
Specialists of certain subspecialties are missing or insufficient										x						

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Notes: Lack of humanness of the staff: not treated well, disrespectful, not provided with explanations about disease and treatment. Low quality and effectiveness of services: inappropriate waiting time, laboratory tests not reported promptly and correctly, poor working equipment, unclean and untidy hospital/clinic. Lack of accessibility and continuity of care: inappropriate number of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

3.3 STROKES

3.3.1 General situation

Cardiovascular diseases are the main cause of mortality in almost all EU member states. They cover both diseases related to the circulatory system, including ischemic heart disease (known as IHD, or myocardial infarction, see chapter 3.2) and cerebrovascular disease (or stroke). Together, ischemic heart diseases and strokes comprise about 60% of all cardiovascular deaths, and caused more than one-fifth of all deaths in EU member states in 2010 (OECD, 2012).

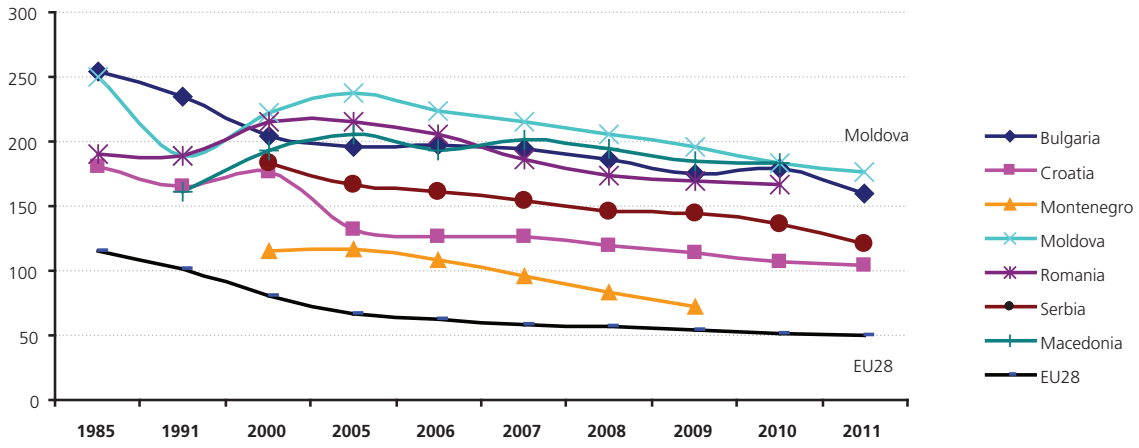
Cerebrovascular diseases, along with ischemic heart disease, are the leading cause of death in the group of circulatory system diseases. Thus, the share of deaths attributable to cerebrovascular diseases ranges between a low of 16% of cardiovascular diseases (CVD) deaths and 9% of all deaths, in Montenegro (2009), and a high 33% of CVD deaths and 20% of all deaths, in Macedonia (2010).[119] The age-standardized death rates from cerebrovascular diseases have registered a decline in recent years, yet have remained higher than the European average in all eight studied countries.

Moldova has not only the highest death rate from cerebrovascular diseases (although declining since 2005), but it reports a maintained high risk of invalidity caused and a high incidence of post-stroke disability.

There is an enormous age gap in age-standardized death rates from cerebrovascular diseases. Figure 24 shows that, in 2010, 40 per 100,000 deaths among Bulgarian people aged 0-64 years were attributable to cerebrovascular diseases in comparison to over 1,600 deaths per 100,000 among the elderly of 65 years or more. The figure also illustrates

[119] Shares of cerebrovascular diseases deaths in the other countries were the following: Bulgaria (2011) - 27% of CVD deaths and 17% of all deaths; Croatia (2011) - 30% of CVD deaths and 14% of all deaths; Moldova (2011) - 27% of CVD deaths and 15% of all deaths; Romania (2010) - 31% of CVD deaths and 18% of all deaths; Serbia (2011) - 25% of CVD deaths and 13% of all deaths. For comparison, the European averages in 2011 were 24% of CVD deaths and 9% of all deaths. Note: Percentages in total deaths calculated based on age-standardized mortality rates per 100,000 population, all ages. Data: WHO/Europe, European HFA Database, July 2013, last reported data.

Figure 23. Trends in age-standardized death rates from cerebrovascular diseases, all ages per 100 000 population



Data: WHO (2013b) and WHO/Europe, European HFA Database, July 2013. Data not available for Kosovo.

the 'east-west gap' in mortality rates, which is evident for men as well as for women, for the younger as well as for the elderly.

Although statistics are not available, strokes are also considered one of the leading causes of death in Kosovo. The main groups with a disproportionate risk of strokes in Kosovo include women, people with low economic status, people suffering from chronic diseases and people over 50 years old.

In Montenegro, the analysis of national data collected by the National Institute of Public Health shows that the overall mortality cerebrovascular diseases is higher in women than in men. Out of the total number of people who died of cerebrovascular diseases, 45% of people died before the age of 75 years, and 15% before 65 years, suggesting that deaths from cerebrovascular diseases is more significant in older age groups; similar to the other countries in the region.

Cerebrovascular disease is part of the cardiovascular and non-communicable diseases group that is highly preventable. The risk factors that lead to stroke are very similar to those for acute myocardial infarction, such as: hypertension, cigarette smoking, diabetes, high levels of triglycerides, genetic predisposition, etc. Potential risk factors include obesity, physical inactivity, stress, nutrition habits, alcohol abuse and the use of oral contraceptives.

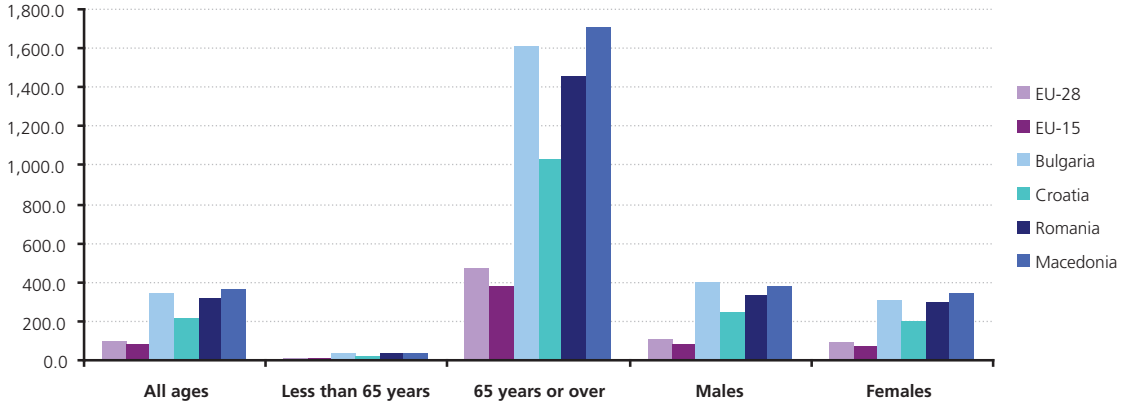
Besides the high mortality rate, strokes are a disease with the highest level of disability in relation to all other neurological diseases. It is estimated that approximately half of all survivors recover completely, while approximately 20-30% remain unfit for independent life. In addition to the fact that this disease dramatically disrupts the life of patients, it causes big financial burdens for the community, and therefore it is not only a medical but also a socio-economic problem.

National institutional arrangements and policies

In Bulgaria, thrombolytic therapy treatment of acute ischemic strokes with the application of recombinant tissue plasminogen activator was introduced in 2005. The treatment is covered by the National Health Insurance Fund (NHIF) and is performed in neurological clinics/wards within intensive-care units with the capacity for respiratory resuscitation according to the current medical standards on Neurological diseases. According to the Bulgarian Society of Neurosonology and Cerebral Hemodynamics,[120] at the end of 2009, there were only 34 hospitals in Bulgaria accredited for this treatment, which had contracts with the NHIF. This figure represents about 10%

[120] http://www.neurosonology-bg.com/en/publications/journal/50-lechenie-na-ostria-ishemichen-mozachen-insult-s-tromboliza-v-bulgaria.html

Figure 24. Standardized death rates due to cerebrovascular diseases per 100,000 population, by gender, broad age groups and country, in 2010



Data: Eurostat, September 2013. Notes: Annual data. Data not available for the other countries included in the study

of the hospital care establishments in the country (mainly university, regional and some major municipal hospitals) and 27.6% of the multi-profile hospitals for active treatment. However, only in one third of them venous thrombolysis was provided, namely: Sofia, Varna, Plovdiv, Stara Zagora, Shoumen, Lom, and Gabrovo Kyustendil.

In Kosovo, the treatment of strokes starts with emergency services that are available throughout the country. After initial treatment and triage, patients end up either in regional hospitals or in the University Clinical Centre of Kosovo. Although national policies in treatment of strokes have not been aligned, there is an increasing trend in use of treatment protocols.

In Macedonia there are neurological departments in almost all larger cities and one Neurology Clinic within the Clinical Centre in Skopje where patients with strokes are treated. The ischemic forms of stroke are mostly treated at the secondary level of care, except those with more severe clinical forms, which are transported to the Neurology Clinic-Skopje or the Clinic for Neurosurgery.

The health system in Montenegro, through reforming the primary health-care level (in 18 primary health-care centres) provides conditions for the implementation of prevention and health promotion measures, early detection of diseases and monitoring and control of health conditions, while hospitals provide conditions necessary for the technical support for diagnosis and treatment of strokes. Thrombolytic therapy is applied to stroke patients in the Clinic of Neurology, Clinical Centre of Montenegro. The Ministry of Health supported the initiative to incorporate the drug to the list of those medications covered by Fund, so that the therapy is available to all patients who meet the conditions for its application. They also made national guidelines for good clinical practice for acute ischemic strokes.

The Government of Montenegro adopted (in 2008) the *Strategy for Prevention and Control of Chronic Non-Communicable Diseases* (CNCD) and also appointed a Commission to support the implementation of this Strategy. In order to monitor the implementation of the Strategy and evaluate impact, the National Office for Prevention and Control of HNCD was established at the Institute of Public Health. The principles of the Strategy are aligned with the principles of the European Strategy for the Prevention and Control of CNCD and the strategy 'Health for All' from the European Region of the World Health Organization. This strategy covers all chronic diseases (cardiovascular and cerebrovascular diseases, malignant neoplasm, diabetes mellitus and chronic obstructive airways disease) linked to common risk factors, and their socio-economic and environmental determinants that have the potential for prevention.

In Romania, originating from 2004 the legislation stipulates the necessity to establish neurovascular emergency units in all county hospitals. These units were designed to provide emergency care for acute stroke victims and to work in the medical units that provide emergency neurological care, close to the department of neurology. The Stroke Units were planned to have all technical devices required, including an emergency laboratory for tests and a highly specialized emergency team in order to assure timely diagnosis and treatment for stroke patients. However, only since 2013 the National Programmeme for Trombolysis has been implemented. Currently, seven pilot Stroke Units are prepared and financed by the Ministry of Health to deliver thrombolytic therapy of strokes. These units cover the whole territory and are located in the following large University centres: Bucharest, Iasi, Timisoara, Targu Mures and Oradea.

Neurology service in the Republic of Serbia are organized on several levels. In the Primary Health-care Centres, specialized medical doctors (neurologists) perform control check-ups of neurology patients. Secondary level health-care involves neurology departments in Clinics/Hospitals and Regional health-care institutions as well as the Special Hospital for Treatment of Cerebrovascular Disorders 'St. Sava' in Belgrade, while tertiary level care centres include Neurology Clinics at the Clinical Centres (Belgrade, Novi Sad, Nis, Kragujevac) and the Military Medical Academy.

Neurosurgical departments are stationed in tertiary level institutions as well as in certain secondary level health-care institutions, and the same scheme is applicable for vascular surgery departments. At the tertiary health-care level, all centres have specialized Units as separate divisions for cutting-edge diagnostics and stroke treatment. A majority of secondary level institutions have available intravenous thrombolytic therapy, while some of them also have defined Stroke Units.

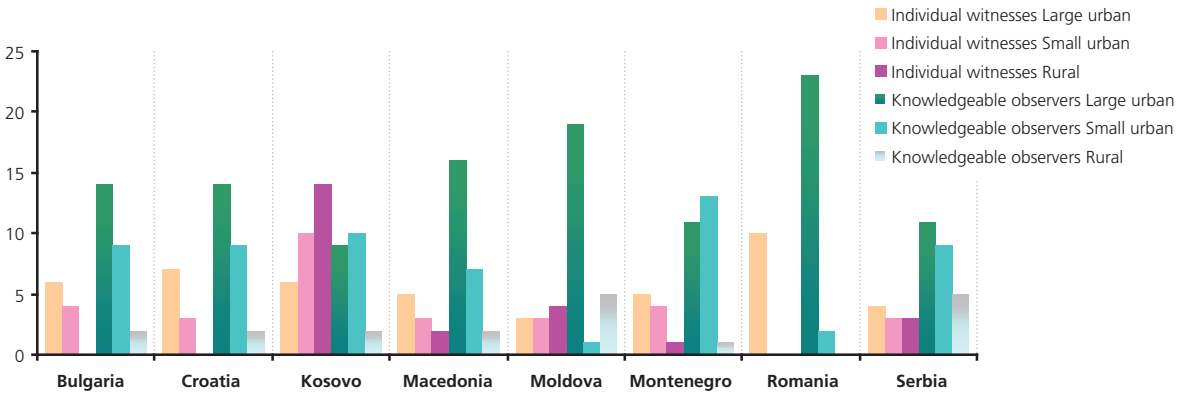
Treatment of patients with ruptured and non-ruptured aneurysms is performed in the neurosurgical departments as well as in the Special Hospital for Treatment of Vascular Brain Diseases "St. Sava". Treatment of patients with stenosis of the magisterial neck vessels as well as intracranial vessels is performed at the Departments for Vascular Surgery and the Special Hospital for Treatment of Vascular Brain Diseases "St. Sava".

3.3.2 Interviewees on Strokes

On the topic of strokes a total number of 296 interviews, of which 100 individual witnesses and 196 knowledgeable observers, was carried out. The number of interviews per country varied between 10 and 30 individual witnesses and between 21 and 25 knowledgeable observers respectively.

In each country, the study covered regions such as metropolitan (163 interviews), urban (90) and rural (43) areas. At sample level, knowledgeable observers from large urban settings are highly represented[121] in Romania, Moldova and Macedonia and account for 60% of the total sample on strokes. The respondents from rural areas, both individual witnesses and knowledgeable observers, represent 15% of the total sample. In this context, with 14 interviews realized with individual witnesses from rural areas, Kosovo demarcates itself from the other countries.[122]

Figure 25. Stroke: Distribution of the sample by interviewee's type by area and by country (number of interviews)

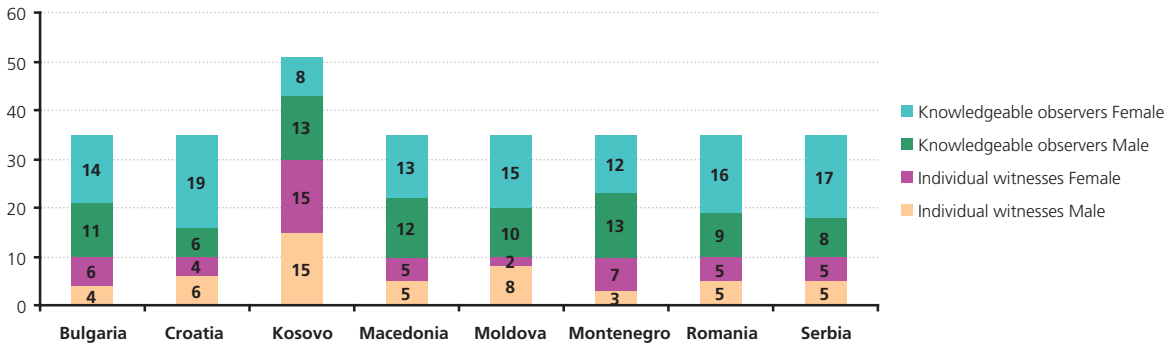


Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. **Note:** Types of areas (rural or urban) according to the national administrative definitions.

[121] More than 45% of total sample on stroke per country.

[122] Compared with Bulgaria (0), Croatia (0), Romania (0), Montenegro (1), Macedonia (2), Serbia (3) and Moldova (4).

Figure 26. Strokes: Distribution of the sample by interviewee's type and gender and by country (number of interviews)



Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*.

Both women and men participated in interviews. The higher prevalence of strokes in the male population is reflected by the sample, as 51% of the total individual witnesses are men. The distribution of knowledgeable observers by gender doesn't respect the incidence of the health condition on the general male population, in the fact that in the majority of health-care systems there are more women employees than men. Female knowledgeable observers represent 58% of total medical representatives that participated in the project on strokes.

Individual witnesses who participated in the study were mainly patients diagnosed during the period 1st of January 2010 - 31st of December 2011, aged between 22 and 98 years old (with an average age of 62), from a range of ethnic groups,[123] with various levels of education[124] and a range of occupations.[125]

The interviews covered both ischemic and hemorrhagic strokes. The interviewed patients provided information about the treatments they received, being they surgery or medication.

Knowledgeable observers are medical representatives, aged between 20 and 66 years old (with an average age of 44). The interviewees include specialists (77 interviews), general practitioners (56), emergency centre representatives (21), hospital representatives (17), public health representatives (12), patients' organizations (2), NGOs (3) and others (8).

The main characteristics of the sample on strokes, regarding both individual witnesses and knowledgeable observers, are presented in tables A.5 and A.6 in Annex.

3.3.3 Accessibility to the state-of-the-art treatment in Strokes

This section analyzes the actual access of stroke patients to state-of-the-art diagnosis, treatment, monitoring and rehabilitation based on interviews with knowledgeable observers and individual witnesses from the eight selected SEE countries. The analysis is organized according to the adjusted 6-access-steps model presented in subchapter 3.1.1.

(A) Content of the national benefits package

In all studied countries, acute cerebral vascular accident is included in the list of major med-

[123] Bulgarians, Croatians, Kosovars, Albanians, Macedonians, Montenegrins, Romanians, Moldovans, Roma, Ukrainians, Russians, etc.

[124] Interviewed was 1 person with no education, 15 persons with elementary education, 28 with high school, 26 with college or more. For Kosovo data regarding the level of education of the interviewees is not available.

[125] Employed (44 interviews), pensioners (36), housewives (15), students (4).

ical-surgical emergencies covered by emergency medical assistance at the pre-hospital stage, including medical-assisted transportation to the hospital institution. Some different regulations were reported only in Croatia, Kosovo and Macedonia.

In Croatia, stroke diagnostics are fully free of charge, whereas costs of treatment are fully covered only for patients with additional health insurance. In the standard case of national health insurance, a co-payment of 10-30% is required from the patient. A standard health-care insurance package covers the following services: doctor/specialist, nurses and other medical staff, laboratory tests and clinic/hospital medication.

In Kosovo, health-care services for strokes sufferers are free of charge only in public facilities.

In Macedonia, the services that are covered by health insurance include: doctor/specialist, nurses or other medical staff, laboratory tests, clinical/hospital medication and care. Co-payments are required for all services. Transportation services are not part of the official health package and are only free of charge in emergency cases.

(B) Formal and informal out-of-pocket costs

Neither patients, nor doctors nor health officials reported financial barriers at the pre-hospital stage of medical assistance.

In Bulgaria, treatment in public hospitals is free of charge. Out-of-pocket payments are required after the acute phase of treatment and may cover: home visits from a rehabilitation therapist (about € 10 per visit, negotiable) and medicines (most often € 30-40 per month).[126] Bulgarian medical specialists evaluated the total costs of a standard treatment of a stroke (covered by public funds) at about € 150-250, for tests, and € 1,750-2,500, for treatment. Health insurance covers only a limited number of procedures, which is not enough to cover treatment in more complicated cases.

In Croatia, a co-payment of 10-30% is required from the patient for treatment of strokes. According to our interviews, no other out-of-pocket payments are involved, be they for medical staff, laboratory tests, hospital medicines, proper care, transport (when clinic/hospital is far away from home), or drugs that should be taken regularly. If a patient cannot pay the demanded amount on site, the treatment will be performed anyway and after that the invoice is sent to a home address.

In Kosovo, treatment for strokes is free of charge in public facilities. However, a patient will usually have to pay for any supplies and/or medication which are missing in the public facilities as well as for additional diagnostics and treatment which are not provided in the public health-care system. Depending on the level of complications the costs can be quite high, up to about € 2000 (for a medical visit in a private facility, a patient has to pay between € 10 and € 40). In addition, medication is expensive for Kosovo standards. If a patient cannot pay the demanded amount then s/he will have to find support from a social network, borrow money and sometimes ask help from social services. Another problem is related to transportation costs. Although most citizens have good access to emergency services, there are areas in which families have to find a way of transporting the patient on their own. So, travel costs represent a burden for a significant number of patients.

In Macedonia, most patients have to pay a participation fee for tests (about 2-20% of the national gross monthly wage, of February 2013), which depends on the type and number of analyses, for treatment (additional 20-58%) and for medicines that have to be taken on regular basis (another 2-20%). Informal payments for medical staff were also reported in few cases. Out of all these payments, only the high cost of medications was declared a barrier to high quality treatment. When the patient cannot pay for services, the approach for financial coverage depends on hospital policy. In some hospitals the patient is allowed to pay in instalments. In most cases when there is a problem in covering expenses, the social worker tries to solve the problem,

[126] At an exchange rate of 1.95583 BGN= 1 EURO.

Table 8. The critical out-of-pocket payments (formal and informal) for patients with strokes in the SEE region

	Diagnostic (tests)	Treatment	Monitoring, rehabilitation	Medication	Transport to doctor or health facility
Bulgaria					
Croatia	Co-payments	Co-payments	Co-payments	Co-payments	
Kosovo					
Macedonia	Co-payments	Co-payments		Co-payments	
Montenegro					
Moldova					
Romania		(as gratitude)	***		
Serbia		(as gratitude)	***		

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Note: *** Only when NMR or similar tests are needed.

acting as a coordinator between patients and the Health Insurance Fund. Basic care for emergency cases is free of charge.

In Montenegro, neither patients nor health professionals declared in interviews any kind of formal or informal out-of-pocket payments.

In Romania, emergency care and treatment is free of charge. However, both patients and health professionals agree that due to many malfunctions in the health-care system, patients are more likely to have to pay out-of-pocket after stabilization. Most often, patients have to pay for medication and for NMR or similar tests which they should take in a private facility as the equipment of the public hospital is often out of order (due to damage, exhausted budgets, lack of medical supplies etc.). Most stroke patients are under continuous monitoring and medication. The medication is partially compensated, but a large part of the interviewed patients declare that post-stroke disabilities and mandatory medication have become a burden on the family budget. A 'little attention' to medical representatives was paid for receiving more attention, but they were offered as gratitude and not demanded.

In Serbia, all treatment costs are officially covered by the Health Insurance Fund. However, some patients have to make out-of-pocket payments for medications (that are not covered by Health Insurance Fund), medical staff, and non-standard services such as accommodation. In our interviews, out-of-pocket payments amounted to € 50-100. In addition, some patients have to pay for tests during the control checkups.

Box 5. Informal payments in strokes in Moldova (by Andrei Mecineanu)

Stroke patients reported that hospital treatment is only partially free of charge and there is a need for direct payments amounting to 200-1,000 MDL/day. These payments cover the entire chain of services delivered at this stage, including transportation of patients. Thus, a part of these payments is made to doctors, nurses and caregivers with a view to ensuring proper care; these payments are reported as being informal. Another part of these payments (about 200 MDL/day) are intended for the purchase of drugs, which according to patient experience are largely missing.

The existence of direct payments is confirmed by specialist doctors from hospitals. Thus, a 'standard' patient has to make formal payments amounting to 1,000-5,000 MDL for necessary investigations, which often are not available in the health-care institution, and payments amounting to 3,000-8,000 MDL in order to benefit from state-of-art treatment.

Also, according to patients and doctors, the absence of additional payments will result in the delivery of a less expensive treatment, with reduced efficacy and of a lower quality (including conformable attitudes and care from medical personnel).

In terms of the regulatory framework in force, the need for payments for medical services and medication, which are stipulated by the standard of care, is not justified. For insured persons, these are covered by the Mandatory Health Insurance Unique Programme, whereas uninsured persons, in the event of a cerebral vascular accident, receive medical care, including hospital care till his/her health condition is stabilized and the life-threatening danger is overcome.[127]

Patients also face financial risks regarding access to medicines in the post-hospital phase. They report an extremely reduced number of drugs that are compensated and high costs for the rest of prescribed drugs. Thus, the amount of patients reported spending for monthly purchase of drugs starts from 400 MDL and may go as high as 3,000 MDL.

Despite the need for direct payments for health-care services and medication, as well as the widespread existence of unofficial payments, the option for treatment in a public health-care institution remains a priority due to the fact that the cost for treatment in the private sector amounts to 30,000 – 50,000 MDL.

In conclusion, in the case of strokes, out-of-pocket payments are critical in Kosovo and Moldova, but also may be problematic in Bulgaria, Romania and Serbia for people with less financial means during the rehabilitation phase.

(C) Availability of services and geographical access for stroke patients

The majority of health professionals and officials (74%) interviewed within our study appreciate that state-of-the-art treatment for strokes is available in their country.[128] The negative answers are more numerous among representatives from Moldova and Romania as well as among medical representatives from rural areas. Specialists from the same countries plus Macedonia were the only ones more critical in their assessments towards the accessibility of the health-care services to every citizen.

Most of the interviewed medical specialists from Bulgaria claim that state-of-the-art treatment is available in their country, for all types of strokes. Nevertheless, some health professionals tend to emphasize that the state-of-the-art treatment is available only for people with health insurance and with a quick access to a better hospital. Large distances to clinics with neurovascular ward and sanatoriums (not necessarily in kilometres but in minutes), represent a major access barrier to state-of-the-art

[127] Law on Health Protection Nr. 411 of 28.03.2011 http://lex.justice.md/index.php?action=view&view=doc&id=312823

[128] A total of 187 valid answers.

treatment of strokes. In addition, rehabilitation services are insufficient and only a limited number of procedures are covered by health insurance, so in many cases patients must pay for private services.

In Croatia, nearly all medical professionals claim that state-of-the-art treatment is available for both types of stroke, and is also compliant with the European Guide (ESO) of diagnostic and treatment. Furthermore, it is accessible free of major charges to everybody. Only few doctors mention the limited access to health-care in the case of stroke for patient living a great distance from a hospital. However, in cases when a clinic/hospital is far away from home, transport is ensured. There is a consensus that the emergency services are available at all locations and are well equipped. So are the available neurological departments. Drugs are free of charge and are available at local pharmacies. The most frequent problem is rehabilitation, due to the limited capacity of the existing services.

State-of-art treatment of strokes is available in Kosovo. All services are available in the country, but some think that there are limitations in service provision ability. There are intensive care units which treat more complicated cases. Experts have developed treatment protocols based on models from western countries. These are applied in daily practice. Some services, like trombolysis are not available, although medical staff are trained for such procedures. There is no specific stroke unit at the Clinic for Neurologic diseases. While neurological departments are functional in all hospitals, the Mitrovica region suffers; this is due to the neurological department at the regional hospital not yet being established. This results in the referral of all patients from the Mitrovica region to Prishtina. As a result of this patients waste a lot of time wandering around in different facilities before they come to the right one: the neurological department.

Emergency services are available 24 hours in all regional hospitals and in the University Clinical Centre of Kosovo. They are available in most of the main family medical centres across Kosovo. The distance to hospitals/clinics with a neurovascular department is acceptable for most of Kosovo citizens (the most distant place is at about 40 kilometres). Patients travel the required distances normally in only few minutes. Only remote rural zones in south and west of Kosovo experience more difficult access. The emergency services are overwhelmed with patients. This is partly because patients tend to show up in emergency centre for everything, even in non-emergency situations when their care could be given at a primary care level. Emergency services are quite well developed.

Rehabilitation centres are few and are located at slighter longer average distances but no more than 80 kilometres or so. Private pharmacies are available in close proximity to health-care facilities.

In Macedonia, state-of-art treatment is available for both types of stroke and it is compliant with the European Guide of diagnostic and treatment, according to the majority of the interviewed knowledgeable observers. Nonetheless doctors and medical services, including neurovascular as well as emergency services, are not available in some localities or disadvantaged areas. In rural areas the access is rather limited and the low socio-economic status of the population has additional negative implications. Rehabilitation facilities are rather limited. There is not any nursing home, so patients must choose between outpatient rehabilitation units, which exist in all larger cities, and a couple of inpatient rehabilitation centres (the biggest one is in Skopje), which in most cases are far away from patient's homes.

In Moldova, the National Clinical Protocol 'Ischemic cerebral vascular accident'[129] reflects the latest standards of management and treatment of a CVA patient according to current international guidelines. The National Clinical Protocol stipulates the content of treatment for any level of health-care assistance – primary health-care, pre-hospital emergency assistance, specialized outpatient and inpatient health-care. The treatment of

[129] Order of the Ministry of Health No.286 of 18.07.2008.

CVA is delivered in hospital institutions – ICU wards, neurology wards or Stroke units. However, patients' experience and perceptions, on the one hand, and doctors' accounts, on the other, highlight the fact that state-of-art treatment is not delivered in the absolute majority of public health-care institutions. The main barriers that generate this situation are listed below, in section (E).

The stroke rehabilitation standard establishes the initiation of rehabilitation in the acute phase in hospital institutions where the stroke patient was admitted, these having the obligation to ensure the necessary conditions for rehabilitation.[130] Nevertheless, the access to rehabilitation treatment of stroke patients is extremely reduced. Patients and doctors, as well as health officials report a series of barriers, despite the fact that the need for rehabilitation services is perceived as very high. Thus, patients mention the lack of rehabilitation services in their local areas and in their nearest hospitals. In the absence of localized rehabilitation institutions (or of those with specialized medical rehabilitation units) a patient with CVA may benefit from such services (regardless of the rehabilitation period – early, late or sequelae/chronic) only in the Institute of Neurology and Neurosurgery at Chisinau.

Stroke patients face difficulties in obtaining medication, reporting cases when these were not available in the pharmacies located nearby their communities; thus, patients had to order the necessary medication, sometimes from outside the country. Such situations are not justified, because the National Medicines Agency has the obligation to provide the pharmaceutical market with the necessary medicines that are included in the national protocol.[131]

In Montenegro, all interviewed medical representatives share the belief that state-of-the-art treatment for stroke patients is available for the entire population of the country.

In Romania, the opinions regarding the existence and access to state-of-the-art treatment are heterogenic. While medical representatives from urban, university centres evaluate positively this aspect, medical staff from small cities completely disagrees. At some point there are convergent opinions regarding the potential that the human resources may have in providing quality emergency care for stroke victims, but only in the context of a massive investment in infrastructure. The dominant perception is that in Romania basic emergency intervention is not accessible for all groups of population. Residents of rural, remote communities, males over 50 years and the economically disadvantaged were identified as groups with the highest probability to suffer a stroke and not be able to access primary care. The health system fails in assuring two main performance indicators: to increase the survival rate and to reduce complications following a non-fatal stroke.

Basically, a stroke is a condition that affects equally all regions of the country, both urban and rural. Emergency health for strokes, at a medium standard at least, is available mainly in University hospitals. The great majority of Romanian hospitals are only partially equipped to properly address emergency stroke cases. From the access to health services perspective, to live in a big city is a natural advantage, but does not assure efficient access to emergency care for a stroke. Lack of mandatory technical devices for diagnoses were mentioned even by patients living in counties' capitals; who had to travel between hospitals from different counties (e.g. from Neamt county to Iasi county, North East region) to receive a diagnostic and proper stabilization treatment. The access to emergency care declines with the increase in the number of kilometers between home and a University hospital. The most difficult situation is for rural resident patients that need to go, with private vehicles, to the closest city to receive stabilization treatment. Patients that call an ambulance receive stabilization treatment the fastest.

[130] Order of the Ministry of Health No. 1323 of 26.12.2012 on the approval of the National Clinical Protocol 'Medical rehabilitation of the patient with a cerebral vascular accident'.

[131] Law on Health Protection Nr. 411 of 28.03.2011 http://lex.justice.md/index.php?action=view&view=doc&id=312823

Treatment in the acute phase of a stroke must be continued in stroke recovery units, which could provide a comprehensive neuro-rehabilitation programme. In Romania there are highly trained specialists in rehabilitation centres for neurological recovery, but unfortunately these centres are very scarce and fail to meet all needs. According to our respondents, most of them were forced to travel long distances in order to receive specialized help for recovery post-stroke. Only one patient (out of ten) could afford to pay a private medical specialist that visited him at home and helped him with the recovery programme. Most stroke patients are under continuous monitoring and medication. Medication is available all over the country, but is only partly compensated.

In the Republic of Serbia, most of the interviewed knowledgeable observers believe that the state-of the-art option is available, i.e. administration of cutting edge therapeutic protocol for all patients (provided they reach a hospital within the therapeutic window). Such opinion is mostly demonstrated by highly specialized doctors (neurologists, specialists of urgent and physical medicine and representatives of hospitals and health-care sector) in urban areas, while doctors from rural areas mostly do not share their opinion. Although it might strike us that doctors from urban and rural areas have extremely alternate views, we should be aware that the doctors from urban areas highlighted the necessity of arrival to hospital in time (which is the major problem during transportation of the diseased from rural areas that live further away from hospitals). As doctors from urban areas encounter more frequently the diseased from the same environment, such responses are logical. This is also confirmed by the fact that all twenty-five knowledgeable observers stated that the major population group that has the least chance for administration of the best therapeutic option is geographically determined. Besides this, insufficient health awareness in the general population, belated calls to the ambulance services, late arrival to hospital due to extended transport or delayed transport are mentioned as limiting factors for the best therapeutic option.

Rehabilitation services and special rehabilitation programmes are available both in specialized centres and in local daily clinics in Primary Health-care Centres (outpatient rehabilitation units). Medication is available, but pharmacies are not available in some areas and many existing rural pharmacies suffer from a shortage in supply, which results in irregular use of medications in some cases.

(D) Health-care providers for strokes

State-of-the-art treatment in stroke patients is provided both in public and private facilities, but tends to be concentrated in public facilities. Private services are not free of charge and are concentrated in larger cities, so they are accessible only for the financially better-off groups of the population.

(E) Waiting lists and other aspects of system organization that can result in barriers to access

In relation to strokes, long waiting times were mainly declared in interviews with individual witnesses, in Croatia, Kosovo, Moldova and Serbia.

In Croatia, the most frequent problem in stroke treatment is linked to rehabilitation, specifically due to difficult access and long waiting times for receiving inpatient rehabilitation. Many patients with 'weaker symptoms' transfer to 'home-care' from the clinic/hospital, although doctors usually recommend inpatient rehabilitation from 15 to 21 days, and home-care after that. Hospitals most often have a contract with only one of the rehabilitation units and have a limited account. Individual witnesses add a second problem, namely the long waiting times for consultation due to insufficient medical staff in public facilities.

In Kosovo, the waiting time for being received by a doctor or clinic/hospital or rehabilitation unit can be very long in the public sector. Money can speed things, according to patients.

In Moldova, long waiting times were reported throughout the entire therapeutic chain, during all interviews. Patients and their family

Table 9. Waiting times for treatment in stroke patients

	Direct access to specialist	Treatment	Rehabilitation services	Getting medication
Bulgaria				
Croatia				
Kosovo				
Macedonia				
Montenegro				
Moldova				
Romania				
Serbia	After discharge			

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Notes: Red cells indicate long or very long waiting times, light orange cells show a intermediate situation, and green cells point out the areas with no problems in terms of waiting times.

members estimated the time of arrival of the ambulance at 15-30 minutes, in urban areas, and 1-3 hours, in rural areas. This situation is perceived by patients and their relatives as a barrier to timely diagnosis.

A first barrier to access to treatment mentioned by patients with ischemic stroke is the long period till initiation of treatment, which was from 2 to 6 hours after the onset of symptoms. This situation indicates the likelihood that the treatment will fall outside of the therapeutic window aimed at limiting the effect of acute cerebral ischemia. at the same time, it represents the leading cause mentioned by patients for their low satisfaction and worsening of health status. Patient experience regarding this process highlights the lack of a causal link among the time of treatment initiation, ambulance response time and time of diagnosis, which proves the existence of specific barriers at this stage. Among these is the lack of interest and professionalism, as well as inadequate attitude of care of the medical staff. All of these factors are confirmed by both patients and doctors who specify the need for 'top-level' lobbying or informal payments.

The monitoring of stroke patients also has a series of quantitative and qualitative deficiencies. Thus, patients reported a low involvement of the family physician, the lack of a management plan depending on the disease evolution and inadequate monitoring of the long-term treatment. The existence only in Chisinau municipality of rehabilitation services, which are hospital-based, and the lack of rehabilitation outpatient services, of medical and social care institutions and of care and rehabilitation services at home minimizes access of stroke patients to these services. Consequently, the need to travel from the area of residence to Chisinau municipality is identified as a barrier in accessing rehabilitation services. In addition, patients and doctors report long waiting times of up to several months (4-7 months) in order to receive rehabilitation treatment.

In Serbia, both patients and health professionals mentioned extended waiting times for control checkups as a major barrier to accessing state-of-the-art treatment in strokes.

Besides waiting times, other barriers imposed by system organization were also highlighted. In Bulgaria, insufficient medical staff, mainly due to increasing migration either to big hospitals or abroad, represents a problem. In Croatia, besides insufficient medical staff, the over-bureaucratization of the public health system is perceived as a major issue that causes 'waste of time' as well as financial deficit.

In Kosovo, there are a number of identified concerns: the equipment is not at a desired level and most of it is non functional; diagnostic services are limited; there is a lack of emergency medicines and supplies; the clinics/hospitals are clean and tidy only to some extent; the waiting room, availability of chairs, and time spent in there is evaluated only as partially positive; the inter-clinic transport within the University Clinical Centre of Kosovo is a real hassle and not well organized - patients have to move from one building to the other in quite inconvenient conditions.

In Moldova, the barriers that lower the quality and effectiveness of health-care services include the poor endowment of public institutions with necessary equipment and drugs, insufficient specialized medical staff and the extremely reduced number of stroke units (2). Another barrier mentioned by patients is the lack of complex and coordinated medical rehabilitation programmes, including the lack of a multidisciplinary approach. In this regard, only certain rehabilitation elements were mentioned – physical therapy, medication treatment – which are mostly undergone in home settings without specialized medical assistance. Also, both patients and doctors report inadequate equipment of emergency medical transport units and limited availability of specialized emergency medical crews.

In Romania, the quality of health-care services for stroke victims is hindered mainly by shortages in specialized staff and insufficient and/or poor quality equipment; both linked to insufficient funding.

In Serbia, there are complaints from patients about the quality of care, mostly regarding hygiene, food and medical staff availability. On the other hand, doctors point out staff shortages as an important factor for the implementation of all modern procedures in a proper manner. The latter is opposed by hospital and health-care sector management who believe there are sufficient staff. However, they do identify problems arise from poor work organization with the existing numbers of staff. They also observe the lack of funds as one of the significant problems for adequate organization as well as medicines and medical equipment acquisition problems.

On the part of patients, few have outlined that there were delays, mistakes, maltreatments and so on. Although the interviews registered some criticism about the medical process or about the health systems' shortages, most patients offered positive feedback on the care received for stroke. Overall, patients declared that services were delivered on time, the medical staff was professional, and procedures were performed safely.

(F) Groups with limited access to health-care services in stroke

According to interviews with medical professionals, the public health-care systems fail in assuring fair access to health-care services for stroke victims. In all eight studied countries there are two groups with the highest probability to suffer a fatal stroke and more serious complications following a non-fatal stroke due to a greater distance from medical centres where adequate medical care could be provided: (i) rural/remote areas residents, especially those at large distances from health-care centres and (ii) economically disadvantaged persons, mainly people under social assistance protection.

In addition, the age factor was mentioned in Macedonia, that patients older than 70 years are at risk of not being provided care by an emergency team in the case of a stroke.

3.3.4 Main access barriers in stroke care

The interviews revealed poor knowledge and a low level of information, correlated with the lack of preventive health-related behaviour is considered to be one of the main barriers in accessing quality health-care for stroke victims in almost all studied countries (except for Montenegro). The low level of information is reflected by the fact that many patients fail to recognize the symptoms on time and delay contact with the neurological department. This affects their prognosis for recovery and mortality. In case of strokes the identification of symptoms is a key aspect, as the treatment of a stroke in the first three hours can reduce to zero the invalidity level. In this regard, patients identify the lack of educational programmes aimed at increasing the capacity for identification and recognition of strokes, therefore they report neglecting the symptoms or firstly informing relatives correctly of their symptoms.

On the one hand, medical advice on healthy life-style is easily neglected and followed only for a short period of time by a large part of population. On the other hand, distrust, inadequate moral and professional attitudes of medical staff are reasons invoked in patients not seeking primary care or emergency medical assistance. In addition, provision of explanations by the doctor and nurses is often very limited. In this sense, the private sector seems to provide better services. In many public facilities, patients do not receive any educational material that allows them to understand the disease and its treatment.

The insufficient coverage of existing medical services (specialized neurology services, rehabilitation and emergency services) represents the greatest barrier of access to state-of-the-art treatment for stroke victims in seven out of the eight selected countries, except for Montenegro. The larger the country and the more underdeveloped the infrastructure, the more difficult the provision of state-of-the-art treatment is to the entire population. Additionally, the quality and effectiveness of the existing services is negatively affected by insufficient medical staff, poor or non-existent equipment, as well as the need for out-of-pocket payments.

Table 10. Main access barriers in public health-care to state-of-the-art treatment in stroke

Access barriers	BG		HR		RKS		MK		MD		ME		RO		SRB	
Delayed first contact with a doctor						x		x						x		x
Poor knowledge and level of information of population. Preventive health related behaviour is uncommon.		x		x		x		x		x				x		x
Doctor or medical services are not available in some areas		x				x		x	x	x			x	x		x
Neurology services are available only in some areas	x	x				x	x	x	x	x			x	x		x
Rehabilitation units/ services are not available/enough in some areas		x		x		x		x		x			x	x		
Pharmacies are not available in some areas								x	x							x
Emergency services are not available in some areas or are underdeveloped		x				x	x	x	x	x						x
Transport services are underdeveloped or too costly					x	x							x			x
The waiting time for being received by a specialist is very long			x		x				x	x					x	x
The waiting time for getting medication is very long									x	x						
The waiting time for rehabilitation services is very long				x	x				x	x						
Lack of interest or unprofessionalism of the doctor or medical staff					x				x							
Lack of trust in doctors, nurses or medical staff					x				x							x
Lack of humanness of the staff	x				x	x			x	x						
Lack of money to pay the doctor									x	x						
Lack of money to pay the needed tests					x	x			x				x	x	x	
Lack of money for out-of-pocket payments					x	x	x		x	x			x			x
Low quality and effectiveness of medical services		x		x	x		x	x					x	x	x	x
High costs of medication							x	x					x			
Poor equipment of public clinics/ hospitals					x	x			x	x			x	x		
Lack of accessibility and continuity of care			x		x			x					x		x	
Specialists of certain subspecialties are missing or insufficient		x												x		

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Notes: Lack of humanness of the staff: not treated well, disrespectful, not provided with explanations about disease and treatment. Low quality and effectiveness of services: inappropriate waiting times, laboratory tests not reported promptly and correctly, poor working equipment, unclean and untidy hospital/clinic. Lack of accessibility and continuity of care: inappropriate numbers of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

3.4 CANCER

3.4.1 GENERAL SITUATION

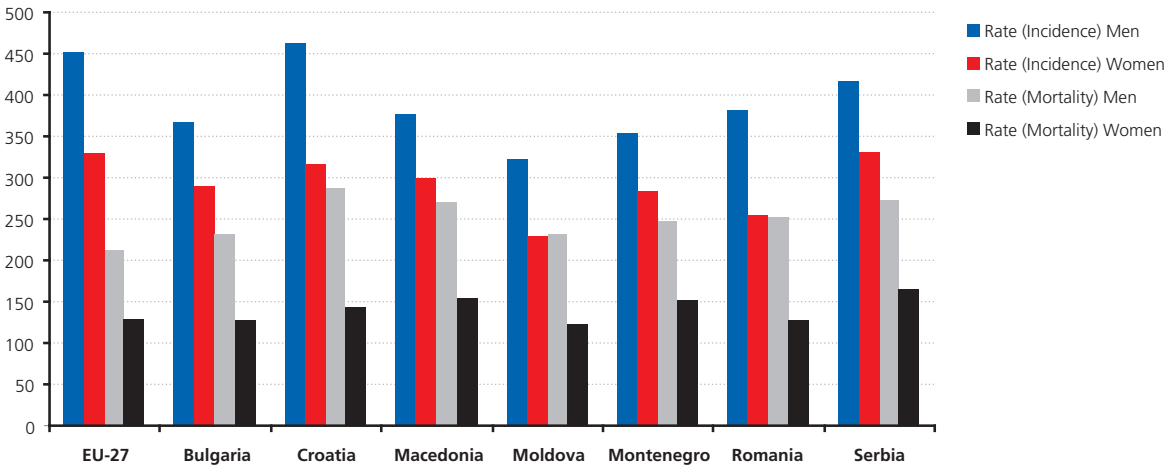
Malignant neoplasms are the second most frequent cause of death in the region, after cardiovascular diseases, as we have already shown (figure 13). There were over 195 thousand incident cases of cancer in 2012 and almost 118 thousand cancer deaths estimated by the International Agency for Research on Cancer (Ferlay et al., 2013) in the eight studied SEE countries. Between 1990 and 2010, cancer incidence rose significantly across all selected countries for which data is available (WHO data).

There are large variations in rates of cancer across SEE countries, both in men and women. Cancer incidence is higher than the EU-27 average in Croatia for men (462 per 100,000 inhabitants) and in Serbia (data includes Kosovo) for women (330 per 100,000 inhabitants). The other six countries recorded lower cancer incidence in men as well as in women, with the lowest rates registered in Moldova (323 for men and 229 for women per 100,000 inhabitants). Nonetheless, mortality from cancer was equal or higher than the EU-27 average. While the new cases of cancer in the eight SEE countries represented about 7.4% of all newly registered cases in Europe in 2012, the number of cancer deaths accounted for 9.3% of total. The highest mortality from cancer was recorded in Croatia for men and in Serbia (data include Kosovo) for women, while the lowest rates were in Moldova. However, this positive situation in Moldova is mainly the result of the shortcomings in detecting oncologic diseases among the population, which represents in fact a sign of poor access (Sanigest International, 2010).

Cancer mortality rates are higher for men than for women. Most of the time, this gap can be explained by the greater prevalence of risk factors among men, as well as the lesser availability or use of screening programmes for cancers affecting men, leading to lower survival rates after diagnosis (OECD, 2012).

The most frequent cancers in men were lung (including trachea and bronchus), large bowel and prostate, in all eight countries, in 2012. Among women, the three most frequent newly registered cancers varied between: (i) breast, large bowel and lung (including trachea and bronchus), in Croatia, Montenegro and Serbia (including Kosovo); (ii) breast, corpus uteri and large bowel, in Macedonia, and (iii) breast, cervix uteri and large bowel,

Figure 27. Cancer incidence and mortality from cancer per 100,000 by gender and by country, 2012



Data: Ferlay et al. (2013), International Agency for Research on Cancer, January 2014. Notes: The data for Serbia include Kosovo. Estimated incidence & mortality from all sites but non-melanoma skin. Mortality based on age standardized rate (European) per 100,000.

in Bulgaria, Moldova and Romania. Overall, these six most frequent cancer sites made up 52-58% of all new cases of cancer recorded in 2012 in each of the eight countries.

National institutional arrangements and policies

National Cancer Registries are available in Bulgaria, Croatia, Macedonia, Moldova, Romania, Serbia, and are under development in Montenegro.

In Bulgaria, a specialized cancer network was founded in 1952. It consists of 13 Regional Oncologic Centres (dispensaries) and a National Oncologic Hospital in Sofia. The Regional Cancer Registries are part of the structure of each Regional Oncologic Centre and the Bulgarian National Cancer Registry (BNCR) is a part of the National Oncologic Hospital. There is a compulsory registration of malignant neoplasm, regulated by the Ministry of Health (1964, 1990 and 2005). According to the legislation every physician/medical worker is required to send a 'rapid notification' to the Regional Oncologic Centre for each newly diagnosed cancer case, for persons suspected of having cancer and/or for those dying from a malignant neoplasm (and since 1975 for carcinoma in situ, as well) according to the patient's permanent residence.

The Croatian National Cancer Registry was established in 1959 with the aim of collecting, managing and analyzing cancer incidence data. Since 1994, the Croatian National Cancer Registry has been a full member of the International Association of Cancer Registries (IACR) with the head office in Lyon, France, and is also a member of the European Network of Cancer Registries (ENCR). In the public health-care strategy, cancers figure predominantly among the preventive programmes. Specific preventive programmes have been implemented for colorectal cancer, breast cancer and cervical cancer.

Box 6. Health-care in cancer in Kosovo (by Ilir Hoxha)

Unfortunately, Kosovo lacks data regarding cancer incidence. Based on estimates, and opinion of experts, cancer represents the most common random cause of mortality among Kosovo citizens. While the number of reports of cancer has increased in Kosovo, the conditions for prevention, early detection, and treatment are extremely limited. In 2013, with the support of the WHO, there has been an initiative to set up a Cancer Registry and to develop protocols for treatment of cancers and measures for early detection. Now there are 20 protocols which have been approved and are in official use. Professionals are working on another 20 which will become official soon.

Kosovo lacks elementary conditions for fighting cancer: an Oncology Institute with qualified medical personnel and necessary equipment; an institutional and social organization for offering treatment and support for these institutions and programmes. Although the service provision for cancer treatment is limited, there have been a number of positive trends in addressing the needs of patients. Among them is the establishment of an Oncology Institute, the training of new residents for oncology, the introduction of chemotherapy treatment at the Institute and utilization of standards of care (like protocols for treatment) in daily clinical practice. The care for cancer treatment is primarily provided in the University Clinical Centre of Kosova (UCCK). Region hospitals provide only limited surgery services for less advanced forms of cancer. For everything else they refer to the UCCK.

There is a perception that females are more susceptible to cancer as well as people with more stress too. This is the result of change of life-styles within situations of rapid social transformation and post-war physiologic consequences. People from rural zones usually show up for diagnosis and treatment when the cancer is already advanced. This, in a way, is a reflection of the failure of country health-care systems and early detection provision (primary and secondary care).

In Moldova, the National Cancer Registry still needs adjustment and technical support for improving the early detection of oncologic diseases. The high percentage of cases identified at stage III-IV represents an argument in this regard. Except for breast cancer, where the share of cases identified at stage III-IV is 36.3%, for the other cancers this value is over 55%. Thus, stage III-IV lung cancer is detected in 72.8% cases, cervical cancer – 56.1%, colon cancer – 61.2%, and rectal cancer – 63.6% (Conseil Sante, 2012).

Under the centralized Moldovan oncology system, some elements of oncology treatment are provided in Cahul Rayonal Hospital (for the southern region of the country) and Balti Municipal Hospital (for the northern region of the country). The Institute of Oncology from Chisinau provides specialized, highly specialized and high performance health-care; surgery, radiotherapy, chemotherapy, etc. (National Centre for Health Management, 2012). In the opinion of doctors, hospital representatives and health officials, the implementation of state policy in the field of oncology faces an imbalance between availability of oncology services, which are characterized as falling within the range of well-medium, and accessibility of oncology services, which are seen as falling within the range of medium-poor.

In Montenegro, the exact number of people affected by cancer is not known as registers for chronic non-communicable diseases are not yet in use. A Disease Registry, which is expected to be in use in the near future, will enable more efficient recording of incidence, prevalence and mortality from disease. Regulations/decisions were adopted and terms of reference for the preparation of registers for major chronic diseases were developed.

Box 7. Cancer control policies in Montenegro (by Agima Ljaljevic)

In Montenegro, according to the Law on Health-care and the Law on Health Insurance, all inhabitants exercise their rights to health-care within the basic package of health-care services. Policies that are related to cancer control in Montenegro are based on international and European documents related to the treatment of malignant diseases. National policies relate to the Strategy for Prevention and Control of chronic non-communicable diseases, adopted by the Government of Montenegro in 2008. The Government of Montenegro, in 2009, nominated a Commission to support the implementation of the Strategy for the Prevention and Control of Chronic Non-communicable Diseases. In order to monitor the implementation of strategies and evaluate the results, the National Office for Prevention and Control of HNCD was established at the Institute of Public Health, which will be lead by staff of this institution.

Also, the National Programme for Cancer Control is a comprehensive approach to prevention, early diagnosis, optimal treatment and palliative care based on the needs of patients and their family members throughout the course of malignant disease. Bodies responsible for the implementation of these policies include the National Commission for Control of Malignant Diseases, appointed by the Ministry of Health with the aim to provide support to the development and implementation of policies related to the treatment of malignant diseases in Montenegro. In addition, all other institutions, within their jurisdiction, are required to initiate, implement, monitor and evaluate the implementation of measures related to malignant disease. The network of health institutions composed of 18 Primary Health-care Centres, 3 Health Stations, 7 General Hospitals, one Clinical Centre, the Institute of Public Health, the Pharmaceutical company "Montefarm" and a number of private institutions incorporated into the health-care system are responsible for the treatment of patients suffering from cancers at all health-care levels using methods within their jurisdiction.

Recently, the reformed Primary Health-care Centre through the organizational auspices of the prevention centres began providing conditions for the implementation of measures of health prevention and promotion, early disease detection and the monitoring and control of health conditions; while conditions for necessary technical support for diagnosis and treatment of cancer are established in hospitals. The Clinic for Oncology is equipped with modern equipment for the treatment of persons suffering from cancer. The Centre for Cancer Screening is being developed, which will include various types of health-care provision in order to consolidate their activities and to ensure the highest possible level of early detection of cancer, which could have an impact not only on the disease, but also on health-care costs.

In Romania, cancer patients have been registered with the Romanian National Cancer Registry since 1981.[132] This Registry gathers information about cancer patients from the 41 counties of Romania and from the six Bucharest districts, in which Territorial Cancer Registries have been established within the oncology county departments. The Romanian National Cancer Registry has encountered many changes but since 2008 it has functioned in accordance with the European guidelines, as stated in the European Network Cancer Registry (ENCR).[133] In our interviews, opinions were convergent when talking about the National Cancer Registry. Nearly all interviewees had heard of its existence, but very few had a clear representation of what it is, or what it is supposed to do. Medical representatives see only the statistical output and consider that so far, 'other than counting cancer patients, this registry provides nothing'. In the view of the interviewed health professionals, the National Cancer Registry has not been used as evidence for any public health policy and so it has not brought until now any improvement to either the system or patients' lives.

In Romania, a cancer patient should be able to receive proper cancer treatment at the regional oncology units in every County General Hospital and/or at affiliated ambulatory oncologic services (if and where they exist). There are only two Oncology Institutes: Bucharest Oncology Institute (IOB) and Cluj Oncology Institute (INOC).

At a national level, until 2012, Romania did not have in place a functional programme for prevention and early detection of cancer. This fact is highly reflected by the top position that Romania registers on the incidence and mortality from cervical cancer. This is a relevant example of insufficient prevention and early treatment, as the deaths from cervical cancer can be substantially reduced by screening programmes with referral for treatment services. One isolated step in this direction was made in 2012, when the Ministry of Health launched a screening programme for cervical cancer that aimed to include all 25-64 years females. Within the programme, the Ministry of Health planned to test more than 200,000 women for cervical cancer. However, up to now there is no official position or data about the results or the evolution of this programme. Generally, the detection of cervical cancer, as well as of other types of cancer, is delayed and diagnosed in its advanced stages.

In Serbia, the epidemiological situation with regard to malignant tumors was monitored until recently only on the basis of mortality data, although the Cancer Registry was established in 1970 and legal regulations for medical doctors to report cases of malignant tumor were in place. Since 1996 when the Population-Based Cancer Register in Central Serbia was reorganized, the number of recorded newly diagnosed cases has doubled. The National Cancer Registry includes precise data about geographic, age and gender groups. However, there is no data about ethnical, socio-economic, religious, and some other group specific disproportionate risk. Some of the data has been extrapolated from the main registry; published yearly by the Institute of Public Health of Serbia, as a part of the Health Statistic Yearbook.

[132] Romanian National Cancer Registry was established through the Ministry of Health Order 219/1981.

[133] http://www.cdt-babes.ro/cercetare/eurochip_monitoring_report_romania.php

There is no integrated or topic-specific policy, programme, or action-plan which is currently operational in Oncology. However, with the help of the European Union (EU) and Japan, some programmes are about to start. For example, a programme for early detection of breast cancer is supported and financed by the people of Japan with the donation of devices for mammography. In addition, the EU supported the programme for early detection of colorectal cancer, with a donation for the flexible endoscopes, but also with knowhow about the organization of the programme in respect to local specificity.

In addition, all countries (except for Kosovo) have adopted strategic documents and laws for the control of tobacco, alcohol and drug abuse as well as on food safety (regulating maximum amount of sugar, salt, saturated fat and various additives in industrially produced foods, as well as more accurate labelling of food composition), which are important for the prevention of carcinoma and have the ultimate goal of reducing morbidity and mortality as consequences of the devastating impact of risk behaviours. Overall however, public information, prevention and early detection are insufficiently developed in the region.

3.4.2 Interviewees on cancer

In all 8 countries a total number of 304 interviews on cancer were conducted, of which

Box 8. Cancer and risk factors in Serbia (by Milos Bjelovic), according to Institute of Public Health of Serbia (2012)

According to the Cancer Register data, men were mostly diagnosed with and died of bronchial, lung, colon and rectum and prostate cancers. In women, the most frequent sites of malignant tumors were breast, cervix, colon and rectum. At the same time, women were also victims of breast, bronchial, lung, colon, rectum and cervical cancer.

While dietary factors are well-established risk factors for colonic and rectal cancer, cigarette smoking is a major factor for lung cancer. In 2006 fresh vegetables were eaten daily in Serbia by 54.8% of adults, which was significantly more than in 2000 when only 42.4% did so. Fresh fruits were a part of the everyday diet of 44.0% of the population. The frequency of use of fresh fruits has increased in comparison with 2000 when it was 34.4%. Richer people consume fresh fruits and vegetables more often. In 2006, one in five adults in Serbia (19.9%) never thought of the health implications when they chose what to eat, which was more than in 2000 (15.4%). When selecting their diet, the elderly (75+) appeared to think less (25.3%), and so did the population of South-eastern Serbia (24.8%) and the poorest part of population (28.7%).

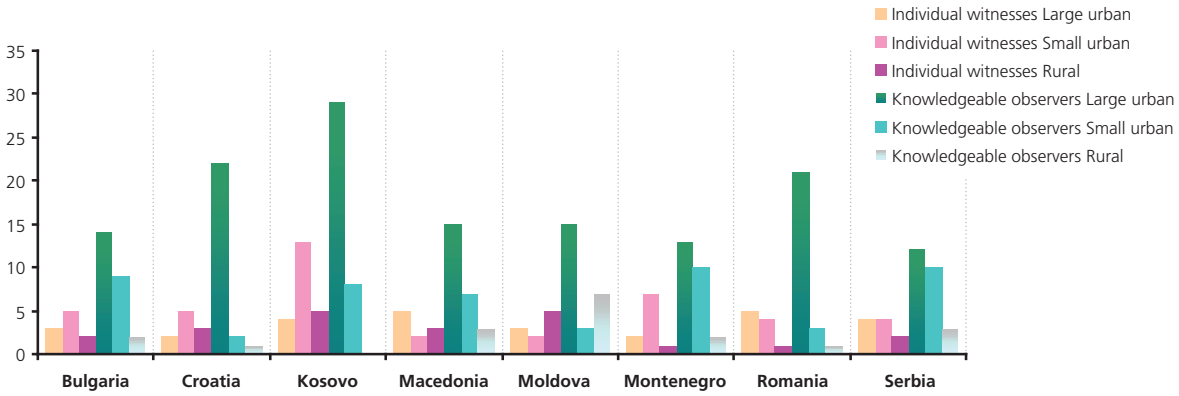
In 2006, in Serbia 33.6% of the population were smokers (regular or occasional), suggesting a reduction of the smoking rate by 6.9% in comparison with 2000. Although the reduced number of smokers was higher among men, the habit was still more prevalent among them (38.1%) than among women (29.9%).

In Serbia, tobacco use control was legally supported in 2005, with the law that prohibits indoor tobacco use. In 2006, in Serbia, 27.7% of adults, (almost one in four women (23.7%) together with one in three men (32.5%)) smoked on a daily basis. Out of the total number of people that smoked daily 66.8% smoked more than 20 cigarettes a day, while the history of smoking of those that smoked every day was 18.8 years on the average. Almost two thirds of the population of Serbia (61.7%) was exposed to tobacco smoke at home and 44.9% were exposed to tobacco smoke at work. In 2006, 57.5% of the population of Serbia were aware of the noxious effects of smoking, i.e. tobacco smoke, which was an outstanding improvement over 2000 when only 34.6% reported knowledge of these effects.

92 were individual witnesses and 212 knowledgeable observers. The number of interviews per country varied between 10 and 22 individual witnesses and 25 and 37 knowledgeable observers respectively.

The study covered in each country various regions including metropolitan (169 interviews), urban (94) as well as rural (41) areas. As per the entire study, the knowledgeable observers interviewed for cancer from large urban areas represent the largest group of interviewees on the topic (46% of the total interviewees on cancer).

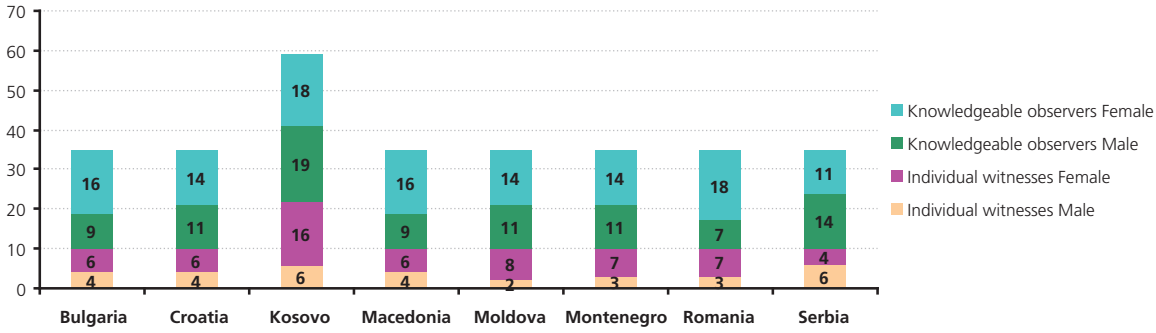
Figure 28. Cancer: Distribution of the sample by interviewee's type by area and by **country (number of interviews)**



Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Note: Types of areas (rural or urban) according to the national administrative definitions.

Interviews were carried out on both with women and men. The higher presence of female interviewees (65% of individual witnesses and 57% of knowledgeable observers) can be explained by (a) their propensity to accept an interview on the subject of health-care problems and by (b) the fact that in the majority of health-care systems there are more women employees than men.

Figure 29. Cancer: Distribution of the sample by interviewee's type, gender and by country (number of interviews)



Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*.

Individual witnesses who participated in the study were mainly patients diagnosed during the period 1st of January 2010 - 31st of December 2011, aged between 30 and 85 years old (with an average age of 54), from a range of ethnic groups,[134] with various levels of education[135] and a variety of occupations.[136]

The interviews covered a large range of cancer diagnostics, in all phases: cancer of the prostate, colon cancer, breast cancer, ovary cancer, corpus uteri cancer, melanoma, pancreas cancer, rectum cancer, Hodgkin lymphoma, throat cancer, brain cancer, gastro intestinal stoma tumor (GIST), malign melanoma, osteosarcoma, vesica fellea cancer, and sigmae cancer. The interviewed patients provided information about the cancer treatment that they followed, including: surgery, chemotherapy, radiotherapy and medication. Hormonal therapy was mentioned by only one individual witness.

Knowledgeable observers are medical representatives, aged between 24 and 73 years old (with an average age of 42). The interviewees include specialists (68 interviews), general practitioners (52), hospital representatives (32), patients' organizations (21), public health representatives (20), emergency centres representatives (8), NGOs (8) and others (11).

The main characteristics of the sample on cancer, regarding both individual witnesses and knowledgeable observers, are presented in tables A.7 and A.8 in the Annex.

[134] Bulgarians, Croatians, Kosovars, Albanians, Macedonians, Montenegrins, Romanians, Moldovans, Roma, Ukrainians, Russians, etc.

[135] Were interviewed 2 persons with no education, 19 with elementary education, 27 with high school, 22 with college or more.

[136] Employed (52%), pensioners (42%) or other economically inactive persons (21).

3.4.3 Accessibility to the state-of-the-art treatment in cancer

This section analyzes the actual access of cancer patients to state-of-the-art diagnostic, treatment, monitoring and rehabilitation based on interviews with knowledgeable observers and individual witnesses from the eight selected SEE countries. The analysis is organized according to the adjusted 6-access-steps model presented in subchapter 3.1.1.

(A) Content of the national benefits baskets

National programmes of oncology for some types of cancer (usually the major types) have been developed in Croatia, Macedonia, Moldova and Romania. However, universal coverage of health-care services for patients with oncologic diseases under National Insurance Funds is acknowledged by law in only seven of the eight countries (without Kosovo).

Thus, in most countries, the tests and diagnoses, the treatment itself including drugs, the work of specialists, doctors, nurses and laboratory tests are free of charge by law, being covered by compulsory health insurance. This is the case of Bulgaria.

Croatia does not cover accommodation in hospitals. Croatia has a special budget within which a large number of expensive drugs for treating cancers are reimbursed (by the state insurer). For the drugs not reimbursed through this budget or a regular reimbursement list, a hospital may decide to buy oncology drugs for their patients from its own budget, (which is not a rare event).

In Macedonia, health services are not free of charge during the diagnostic period (laboratory, x-rays, magnetic resonance, computer tomography etc.). In the Law for Health Protection there isn't such a statement/rule/article by which patients with cancer are in a category that receives free of charge health services in other health institutions outside the Clinic for Oncology.

In Moldova, confirmed oncologic and malignant hematological diseases are included

in the List of Social-Related Diseases with a Major Impact on Public Health. Oncology diagnostic services at the primary health-care level (medical laboratory services) as well as inpatient treatment are covered by mandatory health insurance[137] both for insured and uninsured people. Oncologic medication used in outpatient treatment is centrally purchased by the Ministry of Health with state budget resources.[138] However, only a very limited list of medicines is covered.

In Montenegro and Serbia, the Compulsory Health Insurance Funds cover additionally the costs of transportation to the doctor or medical service, for the patients and, if necessary, for family members.

Cancer treatment in Romania, officially, is free of charge, but all costs are covered only within the availability of resources of the National Health Insurance Fund (since 2008). Although funds allocated increase every year,[139] they are still insufficient to cover the needs of cancer patients. The shortages in financing the National Programme of Oncology deny or delay access to treatment for many patients. At the end of 2012, about 1300 patients[140] were on the waiting list; whose treatment was already delayed on average by more than 3 months. Also, half of the 2012 budget was directed to innovative treatment that addresses 10% of total cancer patients.

[137] Order of the Ministry of Health and the National Health Insurance Company No. 348/56-A of 29.04.2011 on the approval of methodological norms for implementing in 2011 of the Mandatory Health Insurance Unique Programme.

[138] Ministry of Health of Moldova. www.ms.gov.md

[139] In 2012, the allocation for the entire programme was about 1,031 million lei, with 10% more than in 2011 and 30% more than in 2008 (at the onset of the National Programme of Oncology).

[140] In 2012, the waiting lists registered and historic low. Due to an increase of budget, the shortage of the list was of about 42%.

(B) Formal and informal out-of-pocket expenses

In spite of the universal coverage with free of charge services for cancer patients, out-of-pocket payments (formal and informal) were reported in interviews across all involved countries.

Based on the insurance principle that money follows the patient, the health-care system in Bulgaria makes no differentiation between public and private entities. If the private sector meets the requirements for signing a contract with the National Health Insurance Fund, then there are no obstacles to have access to public funds. However, a cancer patient who prefers/chooses to go for private testing (for a second opinion or to avoid waiting lists from the public units, etc.) should pay, for example, for the contrast agents used in imaging. Due to the concentration of health-care services for cancer treatment in the largest cities in the country, many patients have to deal with rather high costs for transportation and accommodation.

The interviewed professionals evaluated the approximate cost of a 'standard' patient to be € 150-250[141] for required tests and examinations and between approximately € 1,500 and € 5,000 for the treatment, but as some of them said: 'there is no upper limit'. These figures are only estimations if the patient must pay her/himself. In the public health-care system the treatment (tests, examinations, procedures, medications) of patients with cancer is free. Although in our study, the interviewees did not mention informal payments, other studies from Bulgaria (e.g. Balabanova and McKee, 2002) showed that they are widespread, mostly as gratitude or for ensuring proper care.

In Croatia, besides the free of charge services, informal payments were reported as being requested for tests, and in rare cases, offered as gratitude, especially for surgical interventions. Formal out-of-pocket payments were

[141] At an exchange rate of 1.95583 BGN= 1 EURO.

mentioned for tests made in private facilities (chosen in order to avoid waiting lists) for certain types of chemotherapy. The high cost of medication is seen as a problem, as the regular reimbursement list of medicines does not include the new ones with better effect. Medicines are available in pharmacies but are expensive and are not accessible for people with modest incomes.

In Kosovo, most diagnostic services are available in private practices. In the public health-care system, services are free of charge, but the capacity is very limited. Because many people do not have money to pay for the services, delays in visiting the doctor are widespread. In some cases, patients need to travel abroad in order to diagnose the disease. Besides the cost of health services, transport related costs increases further the burden on patients, particularly on the poor and on those who live in remote areas and cannot travel during the winter. The treatment of cancer is highly expensive as most services are provided in private sector or have to be purchased with out-of-pocket payments. Usually, patients have to bring medication and supplies that are needed for treatment. In many cases they have to buy/bring everything, even clean sheets, in the case of hospitalization. Medication is not only expensive but also unavailable, so people have to obtain it from abroad (through relatives, friends or other connections). Also, there is some indication that people do pay medical staff 'under the counter', which is made easier by the lack of a control mechanism. Thus, the overall costs reported in cancer treatment reach about € 10,000, including travel and accommodation (as against an average national wage of € 300 per month). The situation is even worse in those types of cancer in which treatment is not available within the country. So, many patients cannot afford the treatment. Health monitoring services are available in the public sector, but only in the country capital in the Institute of Oncology. Accordingly patients who do not live in Prishtina have to travel in order to receive the appropriate services (between 40 and 85 km one way), hence travel costs represent again an access barrier for many people. If a patient does not have money, s/he may apply to the fund available for treatment abroad (which is very limited, about €3 million), or may take a loan (from relatives and friends) credit in a bank. Only few people are insured with private health insurance, which usually covers about 80% of the costs for diagnosis and treatment.

In Macedonia, payments are usually higher during the diagnostic period when the health services are not free of charge. Participation fees reported in interviews covered tests and examinations such as blood tests, ultrasound, X-ray, mammography, computerized tomography, magnetic resonance, biopsy, cystoscopy and amounted to between 10% and 50% of the national gross monthly wage (in February 2013). The overall costs of tests vary widely depending on the type of cancer as well as on the number and diversity of tests needed for diagnosis. Under the National Programme of Oncology, treatment for cancer is free of charge (within the Clinic of Oncology). Nonetheless, co-payments usually cover part of the services of doctors/specialists, nursing and other medical staff, laboratory tests, medicines, proper care and other services. The overall costs of treatment vary significantly from one type of cancer to another, depending on the kind and complexity of interventions. For example, co-payment for surgical treatment declared in interviews reached 65% of the national gross monthly wage (in February 2013), while co-payment for chemotherapy was 117%. Similarly, the costs for medicines ranged between 10% and 100% of the national gross monthly wage (in February 2013). The patient transportation service is not part of the general package of health services. If the patient is not an emergency case, the transport from home to the health-care institution can be carried out by ambulance but at the patient's expenses. Patients with cancer are in a category of very sick persons, but are not always emergency cases, which makes their transport complicated and costly.

The situation when the patient cannot pay for the entire treatment is also a problem that doesn't have a unique solution in Macedonia; it depends on the patient's health condition and on whether the cancer diagnosis is confirmed and so on. In most cases the patient

will receive treatment, then the social services will try to solve any payment issues. Generally, through the National Programme of the Ministry of Health all expenses are covered, however there are also a lot of humanitarian activities that are involved. In some rare cases patients will have to wait longer for treatment or will be forced to find additional private sources to provide a proper treatment (mostly for medicines).

In Moldova, formal and informal payments were reported both by patients and doctors, as well as by health officials, at all stages of the cancer care delivery process. During the process of diagnosing, oncology patients have to make direct payments for laboratory examinations amounting to € 9-125,[142] reasons invoked including the requirement to get referrals for medical investigations, reduction of the waiting time, payment for medical investigations, etc. It is difficult to assign such direct payments in either the formal or informal category because such payments are made directly to the doctor, even in cases when they are intended for service charges according to the catalogue of unique tariffs for public health-care services. An analysis of the types of medical investigations for which patients report making direct payments highlights the fact that these are both 'standard' investigations (ultrasound, radiography, mammography, EGDFS, etc) and high performance investigations (bronchoscopy, computed tomography, MRI, etc) included in the Unique Programme (covered by mandatory health insurance). Because the decision on the type and volume of oncology treatment is finally taken at the Institute of Oncology, in Chisinau, patients from the entire country are expected to cover the transportation costs to the capital city.

Regarding hospital treatment, the interviewed patients estimated informal payments in a range (depending on the health-care institution and doctor) from € 500 to € 1,000 for surgical treatment, from € 200 to € 300 for chemotherapy treatment and from € 200 to € 250 for radiation therapy. Additional informal payments made during hospitalization are directed to medical staff in order to receive proper care as well as towards drug procurement (most often of opioid analgesics (€ 20 to € 60). A very critical aspect is that in many cases informal payments are conditioned by the medical staff, a fact which was mentioned by patients, hospital representatives and health officials.

By contrast, no informal payments were declared in Montenegro. Individual witnesses agreed with knowledgeable observers that cancer treatment is free of charge, with all costs being covered by the Health Insurance Fund of Montenegro. There are mentioned cases of patients who needed to go to private health-care institutions for lab tests (due to lack of reagents, diagnostic equipment failures, lack of medicines), but all costs were reimbursed from the Health Insurance Fund.

In Romania, the centralization of oncology care in only a few University Hospitals and only two Oncology Institutes creates an overload of the system, which translates into financial pressure on the patient. According to the law, any standard insured patient is entitled to receive treatment for cancer free of charge. Nevertheless, in order to overcome insufficient public resources and to accelerate the process of healing, many patients use private services for mandatory tests. The underground 'cancer economy' facilitates these types of practices, as is the case when a public hospital has only one functional NMR device, a private clinic for cancer tests is then allowed to function. So, for the patients who want to avoid a two-month waiting list for an NMR, the € 180[143] private solution is available.

Apart from the fee-for-service paid in the private sector (for tests needed for diagnosis), no supplementary payments were required. As an individual witnesses declared, cancer treatment costs in the private sector are so high that 'even the richest that start treatment for

[142] At an exchange rate of 15.9967 MDL = 1 EURO, as at December 2012, http://www.curs.md/

[143] At an exchange rate of 4.456 RON = 1 EURO, 2012 average, http://cursvalutar.dailybusiness.ro/curs-valutar-mediu-lunar

cancer at their own expense, end up on public waiting lists'. All patients declared that they were not asked for informal payments but felt responsible to offer extra money to medical staff in order to receive better services. Most of them considered that the informal payments were not mandatory, but facilitated and improved the process of care.

During the monitoring phase, many patients prefer to visit their doctor in the private sector, in order to ensure greater efficiency. Their testimonials reveal that the same doctors perform better when remunerated in the private sector, than in the public sector. Periodic consultations are a problem for patients who cannot access these types of services at the nearest hospital. For some patients, the therapeutic scheme for cancer ends with cessation of the medication treatment. High costs for transportation are one of the main reasons for this. Thus, with regard to payments, the main difficulties of the cancer patients in Romania relate to the high costs for transportation to Oncology centres and for tests in the diagnostic phase.

In Serbia, during the diagnostic process, the trend of referring patients to private Clinics is increasing steadily. It is hard to calculate average formal payments, since there are two categories of such patients. One is the category not in the position or not willing to pay, and the other are those willing and in a position to pay formally out-of pocket. It is likely that, on average, the diagnostic process will take more time in the case of using solely resources of the public health sector.

In Serbian public clinic/hospitals health-care services are free of charge. Cancer patients do not have to pay the medical staff to receive proper care, laboratory tests or medications. Patients with cancer do not have to pay the public clinic/hospital surgery or for other therapeutic options. Out-of pocket payments (formal and informal), in the public hospitals for the cancer patients is illegal in Serbia. However, in some cases, patients are faced with the request for informal payments. So, informal payment is a problem in Serbia too, not to the extent that it endangers the function of the system, but enough to decrease trust in some specific areas (critical resources) and situations (temporary shortage of medications, malfunction of the machines for radiotherapy, etc.).

In the cases of some diagnostic procedures (laboratory tests, imaging procedures, flexible endoscopy, etc.) patients visit private facilities too. All the health-care services that were needed during the monitoring period were not always present at the nearest clinic/ hospital, and patients had to visit different doctors located in various places. The distance from the home to the clinic/ hospital could be a problem. However, in Serbia, the cost of transportation to the doctor or medical service is not an issue because the Compulsory Health Insurance Fund reimburses travel expenses for patients and, if necessary, family members.

If medications needed for the treatment of cancer patients could not be obtained from the local pharmacy, they would be applied in the Oncologic Centre by specialized medical staff. All medications, which are included in standard protocols of treatment, are free of charge. Patients who are seeking medications that are not covered by the Compulsory Health Insurance Fund have to pay formally out-of-pocket. In that case, expenditures per month for specific medications range from a few hundred Euros (for example oral 5FU), to a few thousand.

Table 11. Critical out-of-pocket payments (formal and informal) for cancer patients in the SEE region

	Diagnostic (tests)	Treatment	Monitoring, rehabilitation	Medication	Transport to doctor or health facility
Bulgaria		(as gratitude)			
Croatia		(as gratitude)			
Kosovo					
Macedonia					
Montenegro					
Moldova		(conditioned)			
Romania		(as gratitude)			
Serbia					

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries.*

Finally, table 11 presents in a systematic way the out-of-pocket payments that are critical to funding in the eight SEE countries with regard to cancer treatment. The results of our qualitative study reconfirm to a large extent the evidence given by the financial indicators (figure 15). Moldova and Kosovo, where out-of-pocket payments for health services exceed 40% of total health expenditure, cumulate critical areas at all stages of cancer care delivery. For the other two countries with high shares of out-of-pocket payments in total health spending (Bulgaria - 43% and Serbia - 36%, in 2011),[144] financial protection appears to be ensured in the specific case of oncology diseases.

(C) Availability of services and geographical access for cancer patients

The majority of health professionals and officials (74%) interviewed within our study appreciate that state-of-the-art treatment in cancer is available in their country, at least for some types of cancer.[145] The negative answers are more numerous among representatives from Moldova, Romania and Serbia as well as among general practitioners from rural areas and patient organizations.

The delivery of a state-of-the-art treatment for all types of cancer or, at least, for cancers with the highest prevalence in Moldova, is not possible due to the lack of medical technologies in the field of oncology (devices, medication, therapeutic and surgical procedures). The most frequently cited reason among oncologists is that, in practice, the standard chemotherapy schemes are changed depending on the type of drugs centrally purchased by the Ministry of Health or public health-care institutions (Institute of Oncology).

In Romania, most of the knowledgeable observers consider that state-of-the-art treatment for cancer is available for almost all types of cancer. Theoretically, treatment for cancer should be available at county hospital level. In practice however, very few public hospitals offer state-of-the-art treatment free of charge; they are overcrowded, and the budget allocated to the oncology programme is most times insufficient. For example, treatment for prostate cancer is available only in the two Oncologic Institutes. A similar situation could be observed with regard to the use of the European Guides for Diagnostic and Treatment. Theoretically, in Romania, all oncologic departments follow these protocols, in practice though, everybody does what s/he can given thelimited resources. For example all guides state that all cancer patients should receive psychological counselling. In reality, patients 'receive five-minute consults' after, sometimes, more than 12 hours of waiting.

[144] Data: WHO/Europe, European HFA Database, July 2013. For Kosovo, data from Stubbs and Haxhikadrija (2008).

[145] A total of 199 valid answers.

The NGOs' perspective is even more critical regarding the subject. Their experience in helping poorer patients getting treated showed that treatment considered state-of-the-art in Romania is nothing but 'baseline treatment, including surgical interventions, chemotherapy or radio therapy', drugs are very expensive, inefficient and delayed and hospital conditions and devices are 'the opposite of state-of-the-art'. The main topic brought into the discussion by medical representatives was not the system's capacity to offer high quality treatment but, the fact that, in most cases, the diseases are discovered in an advanced stage. Thus, lack of prevention and information are seen as the main factors that negatively influence the outcomes of treatment rather than the lack of state-of-the-art treatment.

In Serbia, the interviewed knowledgeable observers claim that in significant number of malignant tumors, state-of-the-art treatment of cancer is not available. In Serbia, there is only one Compulsory Health Insurance Fund. Fund Commissions, composed of medical and non-medical stuff, generate standards/protocols for the treatment in respect to precise control of expenditure. Thus, some protocols are outdated, and do not comply with the current European Guide (ESO) of treatment. Nevertheless, with full awareness of the positive therapeutic effect of some new treatment options (mainly chemotherapy and biological therapy), some new Commissions are made within the Fund to approve and monitor the use of the new potent (and expensive) drugs in highly specific circumstances. These treatment options include, for example, the use of Imatinib Mesilat in the treatment of Gastrointestinal Stromal Tumors and some types of Leukaemia and Bevacizumabin in the treatment of some metastatic cancers etc. In the case when the patient is informed about state-of-the-art treatment and willing to pay out-of-pocket (formal payment), that kind of treatment could be applied in the private Clinics with privileges to treat cancer patients.

Protocols and guidelines for good medical practice that enable achievement of the highest possible level of quality of health-care services to be provided under the existing conditions were developed in all eight countries. National protocols and guidelines comply with the European Guide of diagnostic and treatment (ESO), at least for some types of cancer. Only in Montenegro, domestic protocols are in place, but service providers are not fully aware of the development status of these guidelines, and most of them tend to state that European standards are in use.

State-of-the-art treatment has been given different meanings from one country to another. In Bulgaria, the most common meaning of *state-of-the-art treatment* in cancer refers to 'the one that can be treated surgically'. In Croatia it encompasses brain radio surgery and head and neck radiotherapy. In Kosovo, the opening of the Institute of Oncology a few years ago and the recent introduction of protocols[146] for treatment of cancers and measures for early detection, with the support of the WHO, improved significantly the availability of state-of-the-art services; the most advanced care is available for treatment of breast cancer, prostate and stomach cancers.

Geographic access represents a major problem in all countries under study, as oncologic facilities, particularly state-of-the-art services, are highly concentrated in the larger cities, especially in capitals. Medical services and pharmacies are also missing in some localities. Specifically for this reason, the implementation of state policy in the field of oncology faces an imbalance between availability of oncology services, which is generally characterized as falling within the limits well-medium, and geographic accessibility of oncology services, which is described as medium-poor.

In Bulgaria, cancer patients reported the need to travel between 30 and 160 kilometres during the monitoring period, as public hospitals with appropriate facilities are located only in the main districts' cities. In Croatia, some cancer patients declared to attend one hospital with different departments, some went to various institutions in the same city, some

[146] There are now 20 protocols which have been approved and are in official use. Professionals are working on another 20 which will become official soon.

had to go to the capital city for monitoring, while others had to travel to a larger cities or abroad to obtain medication. The most disadvantaged are people living on the islands and more rural remote areas, from which they need to travel up to 200 kilometres in order to reach appropriate service. In Kosovo, oncology services are available in the capital so most patients have to travel a lot to receive services. Since Kosovo is relatively small in size, the amount of travel is never more than 170 km per journey, but travel is an intensive exercise if the patient has to travel several times during the week to be present for specific procedures. Travel becomes a serious limitation especially during the winter. A rather similar situation is recorded in Moldova, where all citizens have to travel to the capital to get a final diagnosis and state-of-the-art treatment in cancer.

Romania is a bigger country, so cancer patients have to travel even larger distances in order to receive appropriate health-care (in a few University Hospitals and only two Oncology Institutes). The transportation related costs represent in some cases the main reason for the interruption of treatment, particularly for poorer people from rural areas. Actually, Eurobarometer data from 2002 showed that only about 35% of the population from Bulgaria and Romania have access to a hospital less than 20 minutes away (compared with approximately 53% in the EU-15). At the same time the proportion of people whose access to hospitals is severely impeded by distance - need an hour or more to get to a hospital - is about 13%. In terms of proximity to a general practitioner, the proportion reaches about 68% compared with 85% in EU-15 (Wismar et al., eds., 2011, p. 62).

In Macedonia, there is also a lack of health-care facilities throughout the country that are specialized to provide care for patients with cancer. These patients are usually treated at different departments inside the general/clinical hospitals of bigger cities and at one Oncology Clinic within the Clinical Centre-Skopje. Also, in Serbia, the inequity in the diagnostics, monitoring and treatment in cancer is mainly geographically driven. Medical services and pharmacies are not available in some localities or disadvantaged areas (mainly rural). Additionally transport services are underdeveloped. In large urban areas, there is more likelihood that patients will receive necessary diagnostic procedures (CT scan, MRI, etc.) and standard treatment than in small urban and rural areas.

(D) Health-care providers in cancer

In all eight countries, health-care services in cancer, especially state-of-the-art treatment, are concentrated in the public sector. Kosovo makes a notable exception with a higher proportion of patients who are referred for cancer treatment outside the country (usually to Albania and Macedonia, but also Turkey, Croatia and Western Europe, mainly depending on the type of cancer).

Usually, specialized oncology care is provided in large public health-care institutions. Private health facilities have the right to render this type of services only under a public-private partnership, based on contracts with the National Insurance Funds. However, with respect to oncology health-care, most private providers operate at the primary and secondary levels, so are available mainly in the phases of diagnosis and rehabilitation as well as pharmacies.

(E) Waiting lists and other aspects of system organization that can result in barriers to access

Waiting lists but also a number of organizational aspects have been mentioned as sources of access barriers for cancer patients in the eight studied countries.

(1) In all eight countries, routine and preventive consultations as well as systematic screening are rare. The majority of patients felt ill one day and went to a doctor. It is not likely that the average patient got information or took preventive action before getting ill. The major sources of preventive information include TV, newspapers and the Internet. Nevertheless, patients from large urban areas and those with high levels of education are more likely to have information on risk factors and conduct

routine actions and examinations. In addition, in some countries such as Serbia, in the past couple years more and more companies have initiated policies of mandatory systematic exams for their workers. However, delayed visits to the doctor, usually when the health condition aggravates or the patient has persistent pain, seem to be widespread within the region.

(2) Patients' experiences across all eight countries show that the establishment of diagnosis is a process that does not fully reproduce the official referral mechanism. In most cases patients talk about the disease firstly with a family member or friend. The next step is visit to the general practitioner (GP), but a significant number of patients visit the specialist first, and the GP doctor only afterwards, for getting the necessary permission for the diagnostic process and therapeutic procedures to go ahead.

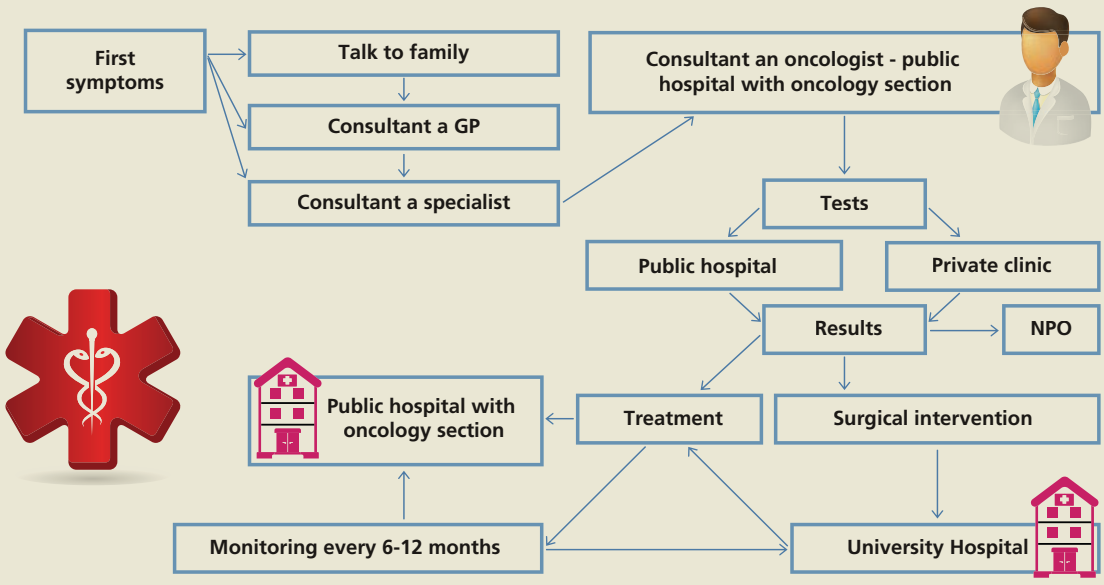
Box 9. Inequities in the navigation of the health-care system in Romania (by Georgiana Neculau)

In terms of optimal utilization of the health-care system, a standard cancer patient in Romania would follow the route outlined below. Discussions with both patients and medical representatives revealed alternative ways of accessing diagnostic, treatment and monitoring for cancer, depending on levels of income, social networks, education and residence.

The great majority of patients, after discussing symptoms with family members or friends, address themselves directly to a specialist. In most cases, the specialist is the first to diagnose the cancer with only few patients choosing to visit a GP first. Most cancer patients are afterwards referred to one of the National Oncologic Institutes and/or University Hospitals for confirmation of diagnosis and for treatment. Very few receive the care needed at the Oncology department within the county hospital.

The period between the first appearance of symptoms and the establishment of a diagnosis depends on variables such as patient income, education, residence (rural/urban) and the distance from home to oncologic departments and/or Oncologic Institutes. Despite the existence of a health structure (oncology departments in all county hospitals) that formally provide all groups of the population access to the basic package for cancer treatment, there are still groups that have limited or inadequate access to them.

The 'standard' route of cancer patients in the Romanian health-care system



For example, access to treatment will be easier for a patient from Bucharest than for one living in the rural area of Vaslui (North East Region). The first may receive the diagnosis within few weeks, while the other would probably have to wait months. The capitals' residents' access in the health system will be directly through the Oncologic Institute, where they will receive all mandatory tests, in the same location and with high-level specialists. By contrast, the patient from rural area, in the best-case scenario, will receive a diagnosis in the County Hospital and afterwards s/he will have to confirm the diagnosis in a University Hospital or in an Oncology Institute. For a poor rural resident patient, long distances, requests for informal payments (in order to receive proper care), requirements for tests in the private sector (to avoid waiting lists) translate in delays in getting diagnosed and limited or no access to care.

(3) Diagnosing cancer could last for months in some cases but as the majority of patients have one or more alarm signals or symptoms of the disease, diagnosis is normally established in less than one month. In Moldova, according to patients, the phase between symptoms identification and establishment of a diagnosis may last from 3 to 15 weeks. In Kosovo, instead, most individual witnesses waited two to six months. In Macedonia were reported cases of cancer uteri or vesicae felae that waited one year for a proper diagnosis (Eastern part of the country). More generally, in cases with no alarm signals, loss of time could be significant, from a few months to more than a year. There is significant variation in the number of doctors and specialists consulted for getting the diagnosis, between 3 and 10 in our interviews; both in the private and public health facilities. In Moldova, Serbia and Romania, the 'average' cancer patient does not ask for second opinion. By contrast, in Macedonia, half of the interviewed patients asked for second opinion.

(4) The centralization of oncology care in few clinics/hospital leads to considerable waiting times in all studied countries. Regarding waiting times, our interviews produced results very similar with those provided by the Euro Health Consumer Index (2013) as shown in table 12. Nevertheless, in every country there are places with good waiting time history, where patients get services without major delays.

Table 12. Waiting times for treatment in cancer

	Direct access to specialist	Major surgery < 90 days	Cancer therapy < 21 days	CT scan < 7 days	Getting medication*
Bulgaria					
Croatia					
Kosovo*					
Macedonia					
Montenegro*					
Moldova*					
Romania					
Serbia					

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries* and Health Consumer Powerhouse (2013). Note: * Countries/item not included in the Euro Health Consumer Index study. Regarding waiting times, ECHI methodology is based on interviews with patients, expert reference panel discussions and survey to Patient Organizations. Red cells indicate long or very long waiting times, light orange cells show a intermediate situation, and green cells point out the areas with no problems in terms of waiting times.

Lack of medical professionals in some areas, but also the absence of specialists in some specialties, raises serious problems of access to care in reasonable time. The numbers medical staff is insufficient and/or is not so specialized in regional, district or county hospitals, although in some countries (such as Kosovo) this situation has improved in the past few years and access to reliable services has improved. In other countries (such as Bulgaria, Moldova and Romania) the situation has worsened in recent years, mainly due to the emigration of health professionals for work abroad. Within the national oncology clinics, hospitals or institutes, there are specialists, but the capacity is rather low in relation with to overall need and medical staff become overburdened with work as they have to provide treatment to all cancer patients in the country. It is well known that conditions of work undermine the performance of professionals regardless how capable and dedicated they are. For example, in Romania, insufficient human resources and underperforming equipment reduce times for consults per cancer patient by at least five minutes, claimed our interviewees. Another result encountered for instance in Croatia is that cancer patients have to deal with continually changing medical staff/ doctors, with different opinions.

Patients' experience allowed the identification of another barrier in accessing treatment, namely the waiting period for chemotherapy and radiation therapy, which in the absence of a decentralized system of these types of treatment, generates a series of collateral barriers.

(5) Not only that there are insufficient specialists in cancer treatment services but there are some of the opinion that the qualifications of Oncologists is limited compared with developed countries, at least in some countries such as Kosovo, Moldova and Romania. The health systems in the region is rather restrictive and provides only limited career opportunities to the younger generation of physicians.

(6) According to the interviewed oncologists, the delivery of a state-of-the-art treatment for all types of cancer or, at least for cancers with the highest prevalence in the region, is impeded by the lack or insufficiency of medical technologies in the field of oncology (devices, medication, therapeutic and surgical procedures). Radiotherapy is not available in Kosovo. Standard chemotherapy schemes are changed depending on the type of drugs available, in Moldova and Romania. Lack, insufficient, out-dated and damaged machinery and apparatus over the period of their depreciation was reported in all eight countries as a significant problem, particularly (but not only) regarding the smaller facilities. Medications, particularly the new ones, are not available, are expensive and/or are very difficult to obtain in some countries.

(7) Although hospitals offering specialized services in cancer treatment are overcrowded, the interviews highlighted a tendency towards hyper-hospitalization, on the one hand, patients being recommended hospitalization, including for establishing the treatment strategy, accompanied, while on the other hand, a tendency of refusal of hospitalization (and prescription of palliative treatment at home) for oncologic diseases in advanced stages.

(8) Doctors, patients and health officials report that monitoring, recovery and palliative care services for oncologic diseases have shortcomings similar to those of cancer treatment services. Shortage of palliative care institutions and of specialized personnel in the field represents a problem in the entire region. Some, but not all, private long-term health-care facilities accept chronically ill patients, but none of them care for patients with cancer. Consequently, in most cases, all activities regarding the care of cancer patients are usually the responsibility of family members. Only in some countries (e.g. Macedonia) public health services have departments for home visits that deliver therapy for cancer patients.

In conclusion, in the opinion of most health professionals the above mentioned aspects are inter-related and all are linked to the system under-financing. Lack of medium and long term coherent and integrated strategies for disease management, lack of human resources and poor medical technologies need to be addressed within a comprehensive

framework in order to improve quality, accessibility and equity of the health-care systems in the oncology field. For the time being, the quality of services in cancer care is overall rated as medium-low in the region.

Even so, the majority of individual witnesses, although they could not tell whether they received health-care services at the *state-of-the-art* level, were generally satisfied with what they got. Many tended to share the belief that medical staff ware underpaid, so that 'they strive' to give the best care they can. Only in Moldova, the level of distrust in, and dissatisfaction with, the health-care services seems to be more pronounced among cancer patients (but not in the phase of diagnosis). In all countries, the specialized clinics from large urban areas, especially capital cities, are much more trusted and better assessed by patients, compared with the doctors and hospitals from small urban areas. Overall, services provided by the public health-care system are rated by patients as medium-good, with most therapeutic phases being delivered in a professional and timely manner. This result may be easily biased by the fact that we only talked with patients and family members of patients that survived the disease and are grateful to be alive.

(F) Groups with limited access to health-care services in cancer

Taking into consideration knowledge about the public health-care system, the health professionals, health officials as well as Patient organizations from all eight studied countries, there is a strong belief that poor knowledge and lack of information, within the general population, represents a significant factor that affects prevention and early diagnosis of cancer, but does necessarily negatively effect the treatment itself.

In the entire region, the health culture among the general population regarding the preventive anticancer activities is still at a low level, which results in diagnoses taking place in a late stage of the disease. This is especially true in rural and less developed areas, among the population with low levels of education and socio-economic opportunities. These latter categories of the population have less access to the health-care facilities due to economic and/or geographic reasons. In Kosovo, these barriers affect to a larger extent women more than men. Women with low levels of education, usually, work at home and do not think about visiting a doctor in the city, which is fatal for a large number of them, as they present with terminal stages of disease although symptoms have long been apparent. For men, the situation is a bit different as they tend to work in different places and access is more spontaneous, they can show up for medical checks much earlier than women from the same places. In addition, in some countries (e.g. Moldova and Romania), elderly and patients in advanced phases of cancer were included among groups with less access to high quality treatment in the public health system.

In our study, specific ethnic culture, customs and traditions were not reported among the groups with difficult access to state-of-the-art services. Nonetheless, various national and international studies on the region indicate the Roma population as suffering discrimination in access to medical care, not to mention state-of-the-art treatment (see subchapter 2.2.4).

In this context, the national prevention policies and services are insufficiently developed in the entire region, which is reflected in the populations' general attitude towards routine and preventive consultations. For example, a national representative study done in Romania in 2011 revealed that 58% of the population aged 18 years or more do not attend any routine annual consultations and visit the doctors only when they have critical health problems. Of all respondents, 45% mentioned that they did had not made any routine medical checkup in the past two years, while 6% have never been to such a control.[147] It is also highly

[147] IMAS (2011) *Survey on attitudes and behaviors of the Romanians on health status and* access to health services, Research conducted in August 2011, nationwide, on a sample of more than 1,000 persons. Source: http://medlive.hotnews.ro/studiu-imas-peste-jumatate-din-romani-nu-merg-la-medic-decat-atunci-cand-au-o-problema-de-sanatate.html

relevant that the TV, newspapers and Internet were declared the main sources of preventive information in the entire region.

The elderly (with the observation that cancer incidence is increasingly higher among people over 35 years old), men and people with risk-behaviours (e.g. smokers) have been mentioned as the main groups at risk of cancer in the entire region. In Kosovo, groups with disproportionate risk to cancer also include people exposed to chemicals from areas heavily bombing during the war.

3.4.4 Main access barriers

This section summarizes the information on access barriers extensively discussed in the previous chapter. Table 13 presents the access barriers mentioned in each country both by individual witnesses and health professionals or officials.

Seven major access barriers to state-of-the-art treatment in cancer are common to nearly all countries included in the study. Concentration of oncologic services in only few hospitals/clinics in each country, to which most of the population have to secure transportation represents the most frequently mentioned access barrier in the region. Correlated, geographic barriers are frequently declared, especially given that doctors and/or medical services are not available in some areas.

The second group of obstacles refers to the serious lack of information on cancer prevention available from the Health authorities as well as the lack of initiative among patients who usually neglect the first symptoms of the disease. Poor knowledge and levels of information with the population do not support preventive health related behaviours, which leads to delayed first contact with a doctor. The situation is worsened by a certain lack of humanness of the medical staff. Although cancer patients are mostly satisfied with the health professionals' competences and performances, patients have mentioned lack of humanness of the staff, especially for not giving them enough information about the disease and its treatment. In some countries, lack of trust in medical staff was also considered an obstacle.

Finally, the waiting time (especially that for being received by a specialist), which is considered to be too long, and the poor equipment of clinics/hospitals (particularly in the opinion of the health professionals) pose serious barriers to accessing state-of-the-art treatment in oncologic diseases.

Table 13. Main access barriers in public health-care to state-of-the-art treatment in cancer

Access barriers	BG		HR		RKS		MK		MD		ME		RO		SRB	
Delayed first contact with a doctor	x	x			x	x	x		x	x			x	x	x	x
Poor knowledge and level of information of population. Preventive health related behaviour is uncommon.	x	x		x		x	x	x		x		x	x	x	x	x
Doctor or medical services are not available in some areas		x		x	x		x	x	x	x				x		x
Oncology services are available only in some areas	x	x		x	x	x	x	x	x	x	x		x	x		x
Oncology services are available mainly in private hospital/clinics or out of the country						x	x									
Pharmacies are not available in some areas		x		x				x						x		x
Transport services are underdeveloped or too costly					x	x			x				x	x		x
Distance from home to a hospital/ clinic is too large and/or too costly					x	x	x	x	x				x	x		
The waiting time for being received by a specialist is very long	x			x		x	x	x			x	x	x	x		
The waiting time for getting treatment or medication is very long						x		x	x				x	x		x
Insufficient competence of nurses or other medical staff						x		x								
Lack of interest or unprofessionalism of the doctor or medical staff								x								
Lack of trust in doctors, nurses or medical staff				x		x	x	x	x	x						
Lack of humanness of the staff	x		x		x		x						x		x	
Lack of money to pay the doctor													x		x	
Lack of money to pay the needed tests					x	x							x	x		
Lack of money for out-of-pocket payments				x					x	x			x			
Low quality and effectiveness of medical services			x			x		x					x			
High costs of medication				x		x		x								
Poor equipment of public clinics/ hospitals		x		x	x	x	x	x					x	x	x	x
Lack of accessibility and continuity of care						x							x	x		
Specialists of certain subspecialties are missing or insufficient				x		x										
Low clinic/hospital capacity				x		x										

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Notes: Lack of humanness of the staff: not treated well, disrespectful, not provided with explanations about disease and treatment. Low quality and effectiveness of services: inappropriate waiting time, laboratory tests not reported promptly and correctly, poor working

equipment, unclean and untidy hospital/clinic. Lack of accessibility and continuity of care: inappropriate number of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

3.5 INJURIES

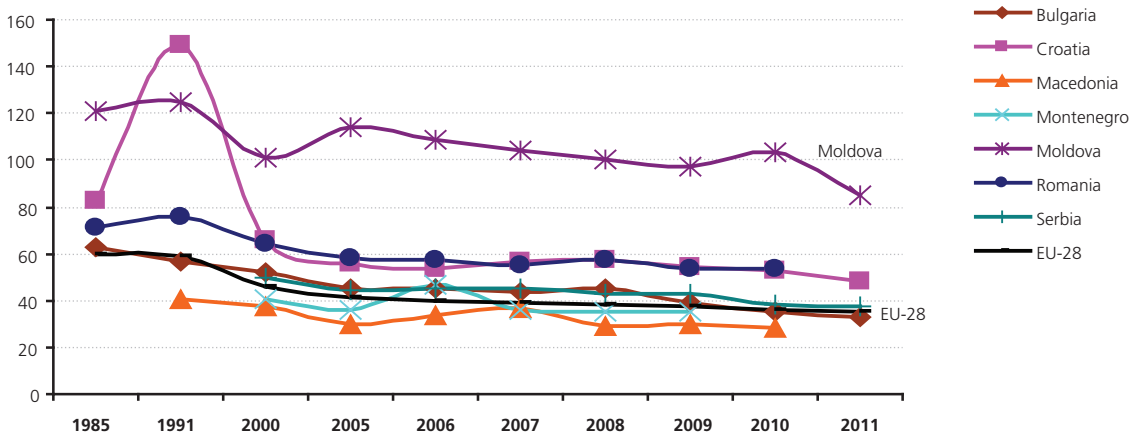
3.5.1 General situation

Injuries represent one of the public health problems that can be improved by preventive actions. According to data from the European Commission (EuroSafe, 2013), every two minutes one EU citizen dies as a result of an injury. It is estimated that each year 5.7 million people are admitted to hospital and 33.9 million people are treated at hospital outpatients units as a result of an accident or violence related to injury. This public health problem has implications to individuals, families and to society as a whole. The injured person is absent from home and can't be productive at work, which results in a significant loss in working days. If the injury results in some disability, than that person should make life changes, which have many implications to him or her self and to the family and wider society.

In the EU, injuries have been ranked as the fourth most common cause of death. In the studied SEE countries, injuries are among the top five causes of mortality (figure 13). However, for people below the age of 60 years, cardiovascular diseases and injuries represent the main contributors to differences in health indicators between eastern and western Europe (Powles et al. 2005 apud Mladovsky et al., 2009).

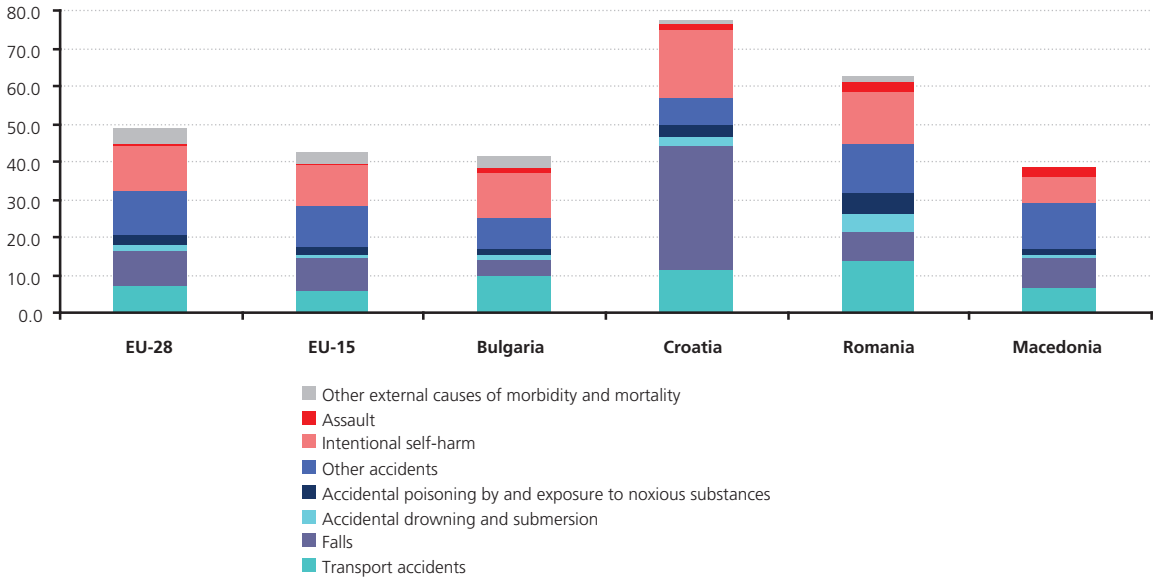
Overall, almost 23 thousands deaths occurred due to injuries in the studied countries in 2010. There are considerable differences in the rate of fatal injuries throughout the SEE region. In all eight selected countries the fatality rates due to injuries have registered a decline in recent years, but have remained higher than the EU-28 average in Croatia, Romania and especially Moldova.

Figure 30. Trends in age-standardized death rates due to external causes (injury and poisoning), in all ages per 100,000 inhabitants



Data: WHO/Europe, European HFA Database, July 2013. Data not available for Kosovo.

Figure 31. Mortality profile by cause of death, age-standardized death rates due to external causes, 2010



Data: Eurostat, September 2013.

Injuries represent a major health problem in Kosovo too. More than 20 thousand emergency situations were treated in the first five months of 2011 at emergency centre of the University Clinical Centre of Kosovo alone; 69.1% of all cases were admitted are as a result of injuries.

There are differences between countries as to the main causes of injury-related deaths. Nonetheless, in countries for which data is available, suicides, road accidents and falls are the three main causes of fatal injuries, together representing between 54% of injury deaths in Macedonia and 80% in Croatia (in fact, in Croatia, over 42% of injury-related deaths are caused by falls).

More generally, unintentional injuries (accidents) account for 60-75% of fatal injuries. Intentional and unintentional injuries are one of the major causes of disability leading to massive loss of 'healthy years of life' (particularly of young people).

Table 14. Environmental burden by disease category (DALYs per 1,000 capita) per year, 2009

	World's lowest country rate	SRB & ME	HR	MK	BG	RO	MD	World's highest country rate
Road traffic injuries	0.3	0.9	1.0	1.1	1.2	1.3	1.9	15
Other unintentional injuries	0.6	2.1	1.9	3.5	3.1	5.1	7.1	30
Intentional injuries	0	0.8	0.8	0.8	0.6	0.7	1.3	7.5

Source: WHO, *Country profile of Environmental Burden of Disease,* 2009. Data not available for Kosovo. Country acronyms: BG - Bulgaria, HR - Croatia, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

In the whole of Europe, homicides, fatal road and work-place[148] accidents showed the most favourable trends during 1998-2010 period. Suicides and home and leisure accidents, mainly attributed to falls among the elderly, have also decreased but less impressively (EuroSafe, 2013). However, between 1998 and 2010, WHO data for the studied countries show that suicides almost halved in Bulgaria, decreased considerably in Croatia and Macedonia, declined to a lower extent in Serbia and Montenegro, but remained rather constant in Romania and Moldova (no data for Kosovo).

Transport accidents represent the main external cause of death in Romania, for both sexes. With a death rate in excess of 14 deaths per 100,000 population, in 2010 (Eurostat data), Romania occupied first place in Europe. Data from Global Road Safety Partnership[149] show that the number of people who die in road accidents in Romania has steadily declined. In 2011, Romania registered a historically low 2,015 victims. However, while the European average registered a decrease by 45% between 2001 and 2011, Romania managed only a reduction by 18%. Also, Romania is among the three countries in Europe where the number of seriously injured in road accidents increased during the period 2001-2011, along with the Netherlands and Bulgaria.

Both in Europe and the SEE region, in almost all age groups, males bear a considerably higher risk of fatal injury than females. Injuries are a leading cause of death for young people, from early childhood, until middle age (EuroSafe, 2013).

[148] For example, the number of accidents at work with more than 3 days lost has decreased in Bulgaria from 2,437 in 2008 to 1,748 in 2011. Romania has registered a similar evolution, from 4,040 to 2,810 during the same period. Data for Croatia are available only for 2010 and 2011 and show an increase from 9,356 to 10,875 accidents. (Eurostat data)

[149] The Global Road Safety Partnership was established in 1999 by the World Bank, Department for International Development of the UK and the International Federation of Red Cross. Its members are multinational companies, UN agencies, vehicle manufacturers, oil companies, automotive manufacturers, research and development organizations, non-governmental organizations, equipment manufacturers and road safety systems. See more at: http://www.grsproadsafety.org/

National institutional arrangements and policies

Most of the severe injuries in the EU are treated in hospitals making them the proper place for injury surveillance. The human and hospital capacity (both in public and private sectors) is available for treatment of injuries in most health-care institutions from all eight studied countries. The injured people are usually treated by emergency services and by surgical departments. Injured people can be accepted by the emergency team and transported to the nearest hospital. Then, patients are usually examined by a surgeon and sent to X-ray in order to estimate if there are some bones fractures. The diagnosis for damage of soft tissues and organs is done by ultrasound, but only in larger hospitals having computer tomography or magnetic resonance. In most countries, state-of-the-art treatment in injuries is concentrated in specialized Orthopedics and Traumatology hospitals or departments of bigger hospitals, which (at the level of subspecialist) meet the needs of injured persons that could not be met at the level of general hospitals and outpatient health facilities.

The responsibility for injury prevention is quite dispersed over a variety of policy sectors - depending on the setting in which they occur and the circumstances (at home, at the workplace, in leisure and sport activities, on roads, etc.). In the studied countries, Governments adopted strategies for chronic non-communicable diseases, which cover the area of injury, due to the importance that injuries make in the national pathologies. In addition, all countries have developed national strategies and legislation for road safety and/or for prevention of drug abuse, including alcohol and tobacco, which address the influence of risk factors on the increase in incidence and prevalence of injuries. However, in many countries however the law enforcement is rather poor.

Table 15. Institutional framework for road safety in selected SEE countries, 2009

	BG	HR	MK	MD	ME	RO	SRB
Lead Agency – status	Inter-ministe-rial	Inter-ministe-rial	Directly under the Par-liament	Inter-ministe-rial	No	Inter-ministe-rial	No
- Funded in the national budget	Yes	Yes	No	No	NA	Yes	NA
National road safety strategy	Yes	Yes	NA	Yes	No	Yes, but not for-mally en-dorsed by GoR	Multiple strate-gies
- Measurable targets	Yes	Yes	NA	Yes	NA	NA	NA
- Implementation funded	Yes	Yes	NA	Yes	NA	NA	NA

Source: WHO (2009c). Notes: Data not available for Kosovo. NA - not applicable. Country acronyms: BG - Bulgaria, HR - Croatia, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table 16. National legislation and estimated enforcement in selected SEE countries, 2009

	BG	HR	MK	MD	ME	RO	SRB
National legislation							
Speed limits set nationally	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Drink–driving law	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Law requiring motorcycle helmet	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Seat-belt law	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Law requiring child restraints in cars	Yes	Yes	No	No	No	Yes	No
Estimated enforcement							
Speed limits set nationally	6	6	4	NC	6	5	4
Drink–driving law	7	7	6	2	6	8	7
Law requiring motorcycle helmet	7	6	2	1	6	6	3
Seat-belt law	8	7	6	NC	6	5	4
Law requiring child restraints in cars	4	5	NA	NA	NA	3	NA

Source: WHO (2009c). Notes: Data not available for Kosovo. NA - not applicable. NC - no consensus. Estimated enforcement scores represent a consensus based on professional opinions on a scale of 0 - 'not effective' and 10 - 'highly effective'. Country acronyms: BG - Bulgaria, HR - Croatia, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

3.5.2 Interviewees on injuries

In all 8 countries a total number of 287 interviews on injuries were realized, of which 80 were individual witnesses and 207 knowledgeable observers.

The study covered in each country different regions such as: metropolitan (177 interviews), urban (73) as well as rural (27) areas. As per all 5 health conditions analysed within the study, out of the total sample on injuries, the knowledgeable observers from large urban areas represent the largest group of interviewees on the topic (48% of the total interviewees on injuries).

Both women and men were interviewed on the topic of injuries. The sample is balanced, with a slightly higher proportion of women interviewees, both among individual witnesses (57% of total patients interviewed on injuries) and among knowledgeable observers (51% of total medical representatives interviewed on injuries).

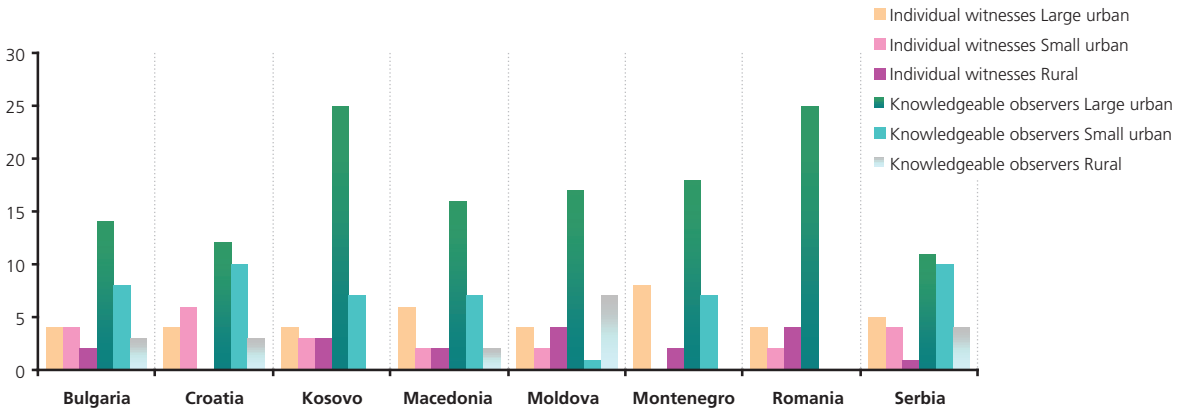
Individual witnesses who participated with the study were mainly patients diagnosed during the period 1st January 2010 - 31st December 2011, aged between 9 and 86 years old (with an average age of 45), from a range of ethnic groups,[150] with various levels of education[151] and different occupations.[152] The study covered a variety of situations in which patients had injured themselves, such as: incidents at home, falls on the street (mainly due to meteorological conditions such as snow and ice), bicycle accidents, motorcycle accidents, sport injuries, work-related accidents, and injuries caused by violent actions. However, for comparability reasons, in all countries, the interviews were carried out with individuals who suffered bone fractures.

[150] Bulgarians, Croatians, Kosovars, Albanians, Macedonians, Montenegrins, Romanians, Moldovans, Roma, Ukrainians, Russians, etc.

[151] Were interviewed 2 persons with no education, 10 with elementary education, 30 with high school, 27 with college or more. For Kosovo data regarding the level of education of the interviewees is not available.

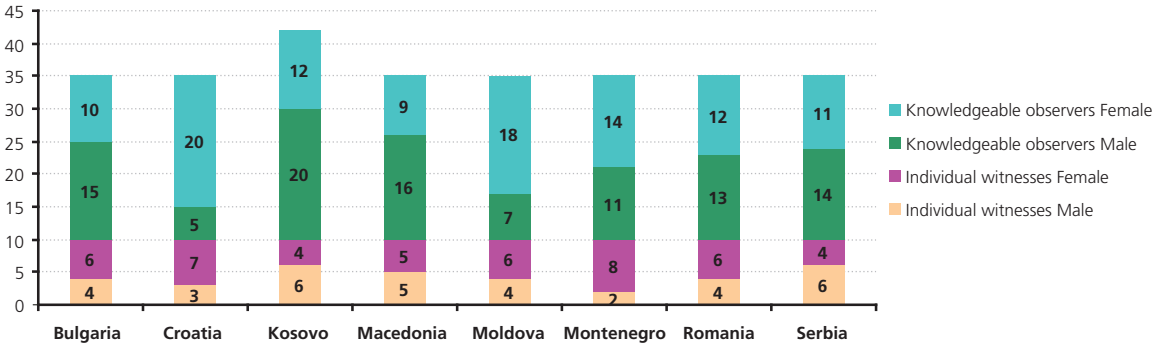
[152] Employed (49 interviews), pensioners (13%) or other economically inactive persons (18).

Figure 32. Injuries: Distribution of the sample by interviewee's type by area and by country (number of interviews)



Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Note: Types of areas (rural or urban) according to the national administrative definitions.

Figure 33. Injuries: Distribution of the sample by interviewee's type and gender and by country (number of interviews)



Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*.

The group of knowledgeable observers comprises medical representatives, aged between 24 and 64 years old (with an average of 43 years old). The interviewees include specialists (81 interviews), general practitioners (60), hospital representatives (16), emergency centres representatives (16), patients' organizations (13), public health representatives (12), NGOs (1), and others (8).

Main characteristics of the sample on injuries, regarding both individual witnesses and knowledgeable observers, are presented in tables A.9 and A.10 in Annex.

3.5.3 Accessibility to the state-of-the-art treatment in injuries

This section analyzes the actual access of injury patients to state-of-the-art diagnosis, treatment, monitoring and rehabilitation based on interviews with knowledgeable observers and individual witnesses from the eight selected SEE countries. The analysis is organized according to the adjusted 6-access-steps model presented in subchapter 3.1.1.

(A) Content of the national benefits baskets

In all countries, tests and treatment of fractures are totally covered if the patient has official health insurance: doctors/specialist, nurses and medical staff, laboratory tests, clinic/hospital medication, proper care, and in some countries transportation (Croatia, Montenegro and Serbia). If a person is not insured, the prices are paid according to the insurance price list. In Kosovo, only the public medical services offer free treatment.

(B) Formal and informal out-of-pocket money

In spite of universal health coverage with free of charge services for injuries, out-of-pocket payments (formal and informal) were reported in interviews across all involved countries.

In Bulgaria, mandatory health insurance covers a benefits package that does not include more sophisticated medical equipment or powerful pain-killers. So, it is legal that patients who want to be cured with better implants, better rods or polymer bandage to buy the certain medical device.[153] The medical device trade could be a potential field for inappropriate behaviour of doctors due to the informational asymmetry between themselves and the patient. In some cases, the rehabilitation needed for a complete recovery requires more procedures than the ones covered by public funds, so the patient must pay some additional visits within the private health market (about € 5-10 per visit). Medication is easy to obtain and free of charge; usually people took pain-killers, anticoagulants and/or anti-inflammatory drugs.

[153] For example, in our interviews payments for medical devices ranged between € 90 (for orthopedic polymer bandage) and € 400 (for intramedullary rod), at an exchange rate of 1.95583 BGN= 1 EURO.

Nonetheless, high quality drugs are only, partly or not at all covered by mandatory health insurance. The interviewed patients declared they had to pay sums between € 15 and € 80, with an average amount of € 25.

In Croatia, the interviewed health professionals mentioned as a problem the fact that most of drugs are available, but sometimes, some of the high quality drugs are not reimbursed, so patients have to pay significant amounts out-of-pocket.

In Kosovo, there are no costs for public medical services but there may be co-payments or informal payments to medical staff. According to the interviewed patients, in case of injuries the costs of medical services, such as payment of the doctor, the nurses or other medical staff, or payments for the needed tests didn't seem to be a major issue, even in the private sector. In the worst-case scenario in Kosovo patients had to pay a few Euros out-of-pocket. During treatment, there can be payments for medical supplies that may be missing in the public sector. During rehabilitation, a day's treatment may cost around € 10-15 in the public system. Only the costs of medication were considered rather high, in particular for some antibiotics. Overall, a standard patient would pay approximately € 100 for all required tests (initial and monitoring) including informal payments and up to several hundred Euros for the entire treatment (including surgical intervention). People under social assistance are exempted from payment. Other patients who cannot pay will delay their treatment or will use less advanced services. This will reflect negatively in their condition and complications. Overall, a major part of advanced treatment and rehabilitation is done in private clinics in which patients pay out-of-pocket or though private health insurance plan.

In Macedonia, the costs of tests and treatment are mostly in correlation with the type of fracture. All citizens with health insurance have also to pay a participation fee, which varies between 0.5% up to 20% of the national gross monthly wage (in February 2013). The official payments cover all services: doctor/ specialists, nurses or other medical staff, laboratory tests, clinical medication, proper care and accommodation. If the patient cannot pay, she or he will nevertheless receive medical treatment. The payment process is separated from the medical services and doctors taking care of patient's health, especially in emergencies such are injuries. When the patient is stabilized, the administration continues with regulation of the payment. Co-payments are also necessary for rehabilitation (about 1% of the national gross monthly wage per day) and especially for medicines (ranging between 0.2% and 10% of the national gross monthly wage, in February 2013).

In Moldova, patients' experience throughout the entire process, from occurrence of trauma to post-trauma rehabilitation (according to accounts made by doctors and health officials) highlights the existence of financial barriers to accessing health-care. Thus, the need at the level of the public health system for conditional direct payments for proper health-care has been reported. Direct informal payments are widespread at the stage of hospital care and are destined for medical investigations, doctors, nurses and other medical personnel with a view to receiving proper care and treatment. Thus, depending on the type of fracture and hospital, payments made for investigations and establishment of diagnosis amount to € 3-300: for orthopaedic treatment - € 10–150, and for surgical treatment - € 190-1,000.[154] Such payments have been identified as a financial barrier for patients, because they exceed the financial possibilities of large segments of the population.

Montenegro did not report any out-of-pocket payments (formal or informal) for people covered by compulsory health insurance.

In Romania, the individual witnesses declared small out-of-pocket payments both formal, for medication (other than those received at the emergency unit), and informal, to secure 'best care'. Knowledgeable observers emphasized that costs are relatively high for patients that need more complex interventions. Many

[154] At an exchange rate of 15.9967 MDL = 1 EURO, as at December 2012, http://www.curs.md/

Table 17. The critical out-of-pocket payments (formal and informal) in injuries in SEE region

	Diagnosis (tests)	Treatment	Monitoring, rehabilitation	Medication and medical devices	Transport to doctor or health facility
Bulgaria				High quality	
Croatia				High quality	
Kosovo		(as gratitude)			
Macedonia					
Montenegro					
Moldova		(conditioned)			
Romania	***	(as gratitude)		Medical devices	
Serbia				Medical devices	

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Note: *** Only when CT, NMR or similar tests are needed.

of the state-of-the-art tests and treatments (CT, NMR etc.) are not covered by the National Insurance Fund, which equates to costs in between € 50 and € 250 official payments.[155] These costs are more likely to increase if septic complications occur after surgery or if the patient needs prosthesis, which often are very expensive and are not covered by insurance.

In Serbia, the treatment of injuries (including fractures) is covered by the Health Compulsory Fond. The exception to this is medication, which has to be paid for out of pocket, after discharge from the hospital. Pain-killers could be in a part reimbursed by the Health Compulsory Fund, but due to relatively low costs most patients pay out of pocket (up to € 10 per month). Similar is the situation with some specific devices like plastic plaster, modern stabilizing orthosis, and other devices that are not available in public hospitals and are not covered by the Health Compulsory Fond. Modern devices are designed to improve quality of life, and improve overall quality of care, but do not influence the end result of the treatment in the sense of disability. Average payment for a modern orthosis is between € 70 and € 100.

Table 17 shows that, regarding injuries, only out-of-pocket payments for medication, medical devices and transportation are critical to equity in funding in some of the eight SEE countries included in the study. Informal payments have remained a major problem in Moldova for this health problem too.

(C) Availability of services and geographical access for injuries patients

The majority of health professionals and officials (80%) interviewed within our study appreciate that state-of-the-art treatment for injuries is available in their country, for all types of fractures.[156] The negative answers are more numerous among representatives from Moldova as well as among general practitioners from rural areas.

National guidelines for treatment of injuries and protocols approved by the Ministry of Health are in place in Croatia, Kosovo and Macedonia.

Health-care services for injured people are available in most health facilities across the eight selected countries. Nevertheless, as we

[155] At an exchange rate of 4.456 RON = 1 EURO, 2012 average, http://cursvalutar.dailybusiness.ro/curs-valutar-mediu-lunar

[156] A total of 193 valid answers.

have mentioned, state-of-the-art treatment for injuries is concentrated in specialized Orthopaedics and Traumatology hospitals or in departments of bigger hospitals. Consequently, geographic access represents a major problem in all countries. Generally, within the public system, Orthopaedics are very good in National and University hospitals; the services are available in the District or County hospitals, they are rare in Municipality hospitals and are missing from rural areas. In specialized health institutions state-of-the-art treatment is the standard of care, but most general hospitals don't have high performance equipment in order to deliver state-of-the-art surgeries or treatment. So, as for any other health condition, a patient needs to travel to the closest National or University hospital to receive state-of-the-art care. This means that access is dependant upon the availability of Emergency services or other kinds of transportation.

In Moldova, the treatment of fractures according to the latest standards is not delivered in all public health institutions, due to insufficient medical technologies and low quality of health-care services. It is available only in public specialized institutions and private hospitals from the Chisinau municipality. In these circumstances, there is limited access to state-of-the-art treatment, which is determined by such factors as the long distance to respective health-care institutions, waiting lists and informal payments.

Emergency services are available and have good coverage in all countries. However, according to our interviews, in most cases, emergency medical assistance is only sought when there it is impossible to travel by oneself to the health-care institution. The main reasons for this are to reduce the time taken to arrive at the medical institution and to obtain care much faster.

Availability of rehabilitation services in the public system is limited in the region, particularly in Kosovo, Macedonia and Moldova. In Kosovo, major sections of advanced treatment and rehabilitation is done in private clinics. In Moldova, rehabilitation services for post-traumatic conditions, delivered in line with the standard of care, are not available; they include only physiotherapy provided in public hospitals and centres of family physicians. The private health sector has not developed these kind of services. As such, patients reported on being monitored only by the orthopedic physician and on the conduct of recovery measures in home settings (curative gymnastics, etc.) as indicated. In Serbia, the availability and access to rehabilitation services was better rated, but poor accommodation and food was mentioned as unsatisfactory by some individual witnesses.

In the entire region, the population from large urban areas with higher socio-economic standards of living are much more likely to be treated at a specialized institutions, benefitting from state-of-the-art treatments.

(D) Health-care providers in injuries

Orthopaedics and Traumatology services are available both in public and private facilities and are covered by health insurance in all countries with the exception of Kosovo.

(E) Waiting lists and other aspects of system organization that can result in barriers to access

The concentration of specialized Orthopaedics and Traumatology services in some facilities, as well as the insufficient number and capacity of rehabilitation services in the public sector, lead to some areas with considerable waiting times as shown in table 18. For example, in Croatia, few cases of long waiting times for diagnosis were reported, but this phenomena seems rather linked to the level of professionalism of certain medical staff. At the same time, long waiting times for getting into rehabilitation were mentioned by patients with less severe injuries. In Kosovo, the waiting time for being received into rehabilitation facilities, as well as for receiving medication, can be very long; treatment and rehabilitation are characterized by long waiting times in the public sector and by limited resources and quality of care in both sectors. So, in order to receive fast service, one has to use the private sector. In Macedonia, among

access barriers, a small part of patient sample mentioned waiting time to be received by a doctor or to rehabilitation centre, while few health professionals declared the waiting time to getting medication as being too long.

Other aspects of system organization that result in barriers of access to state-of-the-art treatment relate to in-patient budget restraints, which result in poor equipment in clinic/hospitals and limited amounts of drugs and medical materials. From the health professional perspective, this interferes with the quality of medical services. This is the case particularly in smaller health facilities and rehabilitation units, in all eight countries. So, in the region, the availability of health-care services for injured persons (persons with fractures) is good, but the quality of service is medium.

However, nearly all interviewed patients declared satisfaction with the diagnosis and treatment process and most health professionals considered that the population trusts the public health-care system with regard to fractures and other injuries.

(F) Groups with limited access to health-care services for injuries

According to patients' experience and doctors' accounts, there is a sufficient level of public information on the prevention of traumas, correct reproduction of symptoms and medical assistance-seeking behaviour. However, poor knowledge and levels of information among the general population was seen as a problem in Croatia, Kosovo and Serbia. In addition, in the entire region, there is a low level of public knowledge concerning first aid in the case of fractures.

The main group with a disproportionate risk of fracture, mentioned by medical professionals from all studied countries, refers to elderly people. Other groups with higher risk include people suffering of osteoporosis, but also the young; due to violent fighting or risk behaviours; i.e. males who work on construction sites, people from lower economic backgrounds (as they tend to work later hours), and children unsupervised in school or at home.

The population of rural areas constitutes the main group with limited access to quality health-care in the public system, due to a combination of geographical and socio-economic factors.

3.5.4 Main access barriers in injuries

Table 19 sums up the access barriers discussed in the previous chapter. In relation to injuries (fractures), four major obstacles need to be surmounted in order to achieve universal coverage in the public health sector. Firstly, the quality (or effectiveness) of medical services, mainly in relation to shortages of medical materials and drugs, especially the high quality ones, needs to be improved. Secondly, treatment according to the latest standards is not delivered in all public health institutions due to insufficient medical technologies, particularly poor equipment of clinic/hospitals. Thirdly, the poor availability of doctors or medical services in rural (particularly remote) areas results in inequity in access. Fourthly, rehabilitation services need to be developed in order to shorten waiting times in the recovery phase. The development of private health providers has improved access of general population to state-of-the-art services, but does not represent an alternative for people with low socio-economic status.

Table 18. Waiting times for treatment in injuries

	Direct access to specialist	Treatment	Rehabilitation services	Getting medication
Bulgaria				
Croatia			Less severe injuries	
Kosovo				
Macedonia				
Montenegro				
Moldova				
Romania				
Serbia				

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Notes: Red cells indicate long or very long waiting times, light orange cells show a intermediate situation, and green cells point out the areas with no problems in terms of waiting times.

Table 19. Main access barriers in public health-care to state-of-the-art treatment for injuries (fractures)

Access barriers	BG		HR		RKS		MK		MD		ME		RO		SRB	
Poor knowledge and levels of information of the population. Preventive health related behaviour is uncommon.				x		x										x
Doctor or medical services are not available in some areas		x				x	x	x		x				x		x
Rehabilitation units/services are not available/enough in some areas					x	x		x		x				x		
Pharmacies are not available in some areas								x								x
Emergency services are not available in some areas or are underdeveloped							x	x								
Transport services are underdeveloped or too costly		x				x				x				x		
Distance from home to a hospital/clinic is too large and/or too costly	x				x		x			x			x	x		
The waiting time for being received by a specialist is very long						x			x	x						
The waiting time for getting medication is very long								x								
The waiting time for rehabilitation services is very long				x	x	x	x									
Lack of interest or unprofessionalism of the doctor or medical staff							x	x					x			x
Lack of trust in doctors, nurses or medical staff							x									
Lack of humanness of the staff	x												x		x	
Lack of money for out-of-pocket payments						x			x	x						
Low quality and effectiveness of medical services				x	x	x	x	x	x	x				x	x	x
High costs of medication				x	x	x	x									
Poor equipment in public clinics/ hospitals					x	x	x			x				x	x	x
Lack of accessibility and continuity of care					x								x		x	

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Notes: Lack of humanness of the staff: not treated well, disrespectful, not provided with explanations about disease and treatment. Low quality and effectiveness of services: inappropriate waiting times, laboratory tests not reported promptly and correctly, poor working equipment, unclean and untidy hospital/clinic. Lack of accessibility and continuity of care: inappropriate number of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

3.6 DIABETES (TYPE 2)

3.6.1 General situation

Diabetes is among the most widespread non-communicable diseases in the world and the numbers of those newly diagnosed is growing rapidly. Estimates from the International Diabetes Federation (IDF, 2013) show that globally, by 2035, the number of people with diabetes will double.[157] Although the highest incidence rates are registered in developed countries, the largest increase of the number of people with diabetes is expected in the developing countries, generating changes in the structure of morbidity, disability and premature mortality, as well as increasing the financial pressure on the public budget.[158]

In 2013, about 2.7 million adults (20-79 years) were suffering from diabetes in the studied countries.[159] The highest national prevalence of diabetes in adults was registered in 2013 in Montenegro (12.5%), Serbia (12.4%) and Macedonia (11.8%). Moldova registers the lowest prevalence of diabetes; however the IDF estimates that these figures are not exactly in line with national statistics. According to local research and analyses, the number of persons with "latent" diabetes is 2-3 times higher than the estimated number of people with diabetes.

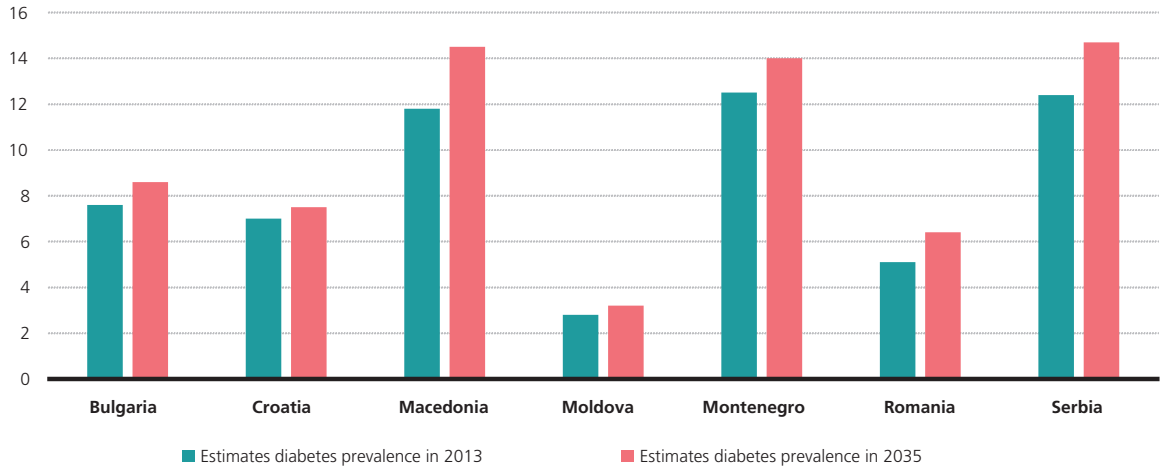
There is little gender difference in the global numbers of people with diabetes. There are about 14 million more men than women with diabetes (198 million men versus 184 million women). This difference is expected to increase to 15 million (303 million men versus 288 million women) by 2035, according to IDF estimations. Although at global level, diabetes slightly affects more men, in the studied countries, 57% of diabetes patients are females. With no exception, in all eight countries, type 2 diabetes is slightly more often diagnosed in females. For example, in Romania, 61% of total diabetes patients are females.

[157] In 2013, 381 million people around the world were suffering from diabetes.

[158] According to the International Diabetes Federation (2013), in Europe, the costs for prevention and treatment for diabetes accounted, in 2013, for more than 147 billion dollars.

[159] Data for Kosovo is not available.

Figure 34. Estimated national diabetes prevalence in the adult population (20-79 years) in 2013 and 2035



Data: International Diabetes Federation (2013). Notes: Data not available for Kosovo.

Diabetes is not so rare even in young people, obese children and adolescents (due to mild symptoms) often pass unnoticed for years. This means that a large number of people with diabetes are not known to be ill, and sometimes for every one ill person there is another who does not know they have diabetes.

Diabetes is a leading cause of death in most developed countries. Mortality caused by diabetes is equal or higher than the EU-28 average for most studied countries, except in Romania and Moldova. The highest mortality rate caused by diabetes was recorded in Macedonia, while the lowest was in Romania.

Diabetes mortality rates are higher for men than for women. In most cases, the higher mortality rate among men can be explained by the greater prevalence of risk factors. Also, screening programmes, as well as proper disease management protocols are used and respected to a lower extent by men than women.

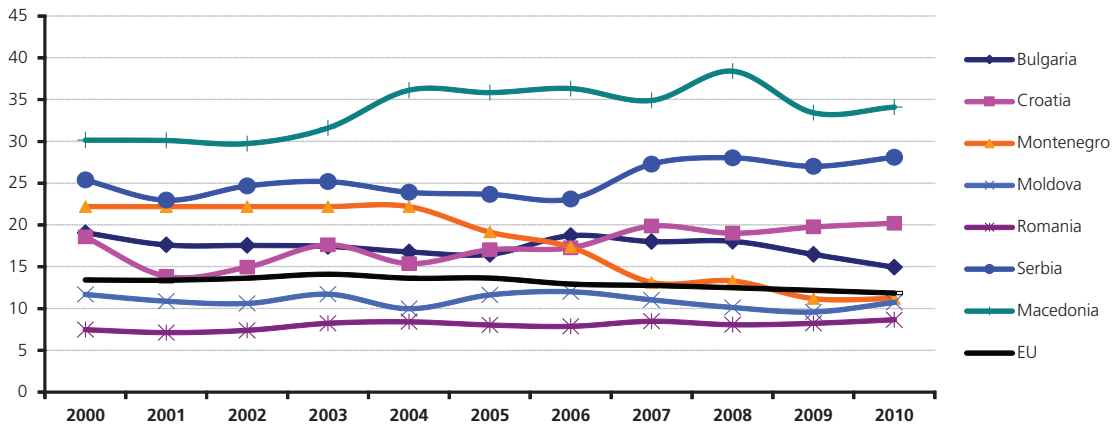
National institutional arrangements and policies

National Registries or National Programmes for people affected by diabetes are available in Croatia, Macedonia, Moldova, Romania and Serbia. In Montenegro a National Commission for Diabetes that will implement the measures defined by the National Strategy for Healthcare of People Living with Diabetes is about to be established.

In Bulgaria and Kosovo there is no National Registry, Programme or Strategy addressing the situation of people affected by diabetes. This fact implies a lack of reliable statistics regarding the prevalence of the disease. In Kosovo, patients with type 2 diabetes are treated in all three levels of care: primary, regional hospitals (secondary) and tertiary.

In Croatia, starting in 2000 there is in place a National Diabetes Registry and since 2008 a National Programme of Diabetes. The Croatian National Diabetes Registry was created with the aim of improving health-care of persons with diabetes mellitus by assessing the prevalence and incidence of the disease (and its acute and chronic complications) and monitoring morbidity, mortality and other

Figure 35. Standardized death rate due to diabetes



Data: WHO (2013b) and WHO/Europe, European HFA Database, July 2013. Data not available for Kosovo.

clinical care quality indicators on a national level. Since 2004, registration has been mandatory for all general practitioners and hospital physicians treating persons with diabetes mellitus. The overall number of patients registered in the CroDiab registry is 109,109, of which, more than 90% suffer from type 2 diabetes. Also, for diabetes treatment, more specialized care is available in Zagreb, at the National Centre for Diabetes (the Institute for Diabetes).

A National Diabetes Mellitus Registry and a National Diabetes Programme have been in place in Macedonia since 1996. Throughout the National Programme the Ministry of Health provides financial resources to assure patients free of charge treatment with insulin. Health-care for patients with diabetes in Macedonia is organized at primary, secondary and tertiary levels. Theoretically, at the primary care level, general practitioners should provide preventive check-ups of glucose, inform patients about healthy food and the importance of physical activity. If preventive actions fail, patients are sent to secondary level-dispensers, where specialists take additional tests that can confirm the diagnosis. Across Macedonia there are 37 specialized dispensers for diagnosis and treatment of patients with diabetes. Those dispensers are also places where patients receive insulin therapy, take control of glucose tests and are under the supervision of a specialist. The diabetes patients who suffer complications are transferred to the Clinic for endocrinology at the Clinical Centre Skopje.

Moldova started the implementation of a National Diabetes Control Programme in the mid 90's. At the present moment, the National Programme on Diabetes Prophylaxis and Control for 2011-2015 is in force. Its objective is to ensure the increase of diabetes early detection rate by 30% among people with risk factors, and the reduction of the mortality rate caused by diabetes and its late complications by about 5-10% by 2015 compared to the level registered in 2010. Specific objectives of the National Programme aim at the prevention of diabetes, early detection of diabetes, specialized diagnosis and treatment and scientific research and medical staff training. The implementation of certain specific actions of the National Programme, which lay the foundation for the achievement of estimated outcomes, is difficult due to the fact that there isn't a strict record of the number of patients with diabetes. Moldova lacks a National Register of people with diabetes, consequently, the estimation of needs for medication, medical devices and health-care services, is based on historical experience rather than on the real situation.

The Moldovan Ministry of Health has attributed diabetes control a public health priority status and has developed necessary public policies in the field covering all levels of health service delivery, except for rehabilitation services. The spread of diabetes in the population of Moldova is acknowledged by health officials and endocrinologists but family physicians have a scarce knowledge of the diabetes situation, which makes the implementation of diabetes prevention and early detection measures difficult.

Box 10. Diabetes control policies in Montenegro (by Agima Ljaljevic)

In Montenegro, the Government adopted a National Strategy for Health-care of People Living with Diabetes that should provide primary prevention, risk reduction, effective and high quality treatment of diabetes as well as the required levels of research, and effective partnership working between public and private health-care systems, NGOs, patients and their families. The National Strategy and the guidelines for treatment of diabetes are in accordance with the guidelines for the Development of National Diabetes Programmes of the WHO, carried out in collaboration with the International Diabetes Federation (IDF) and in accordance with the EU Vienna Declaration on diabetes. In order to implement the measures defined in the Strategy, a National Commission for Diabetes will be established.

In Montenegro, the overall organization of the health-care of people with diabetes is based on a model of three-dimensional networks of functionally related organizations in order to optimally provide the activities of primary, secondary and tertiary prevention. Constantly open communication at all three levels of health-care, with teams of selected doctors, as the basis of the system, provides a continuous process in line with the secondary level of general hospitals, and the entire structure is covered by subspecialist activities of the Clinical Centre. The model is complemented by activities of the Institute of Public Health, NGOs and patient organizations who implement measures to promote health and prevent disease. Future work will be targeted to promote prevention and early detection of diabetes, as well as towards the most effective ways to influence the course of disease; health education of the population, especially those subgroups that are at increased risk of disease, giving particular attention to the provision of adequate health and educational strategies; training of teams of family doctors; practical implementation of the Guide for the treatment of diabetes, as an important element to improve the quality of services to people living with diabetes; monitoring and control of health-care for persons with diabetes at all levels of prevention and all organizational levels; the establishment of mandatory referent values for all mandatory parameters important for diabetes relevant to all laboratories.

Research such as the Living Standard Measurement Study provides data on the behaviour and nutritional status of the population with high levels of risk factors for diabetes. The network of health institutions within their jurisdiction provides services for its beneficiaries in the field of health-care for persons with diabetes. In reformed primary health-care centres, counselling for diabetes type 2, has been established, which provides health and educational services for persons suffering from diabetes and measures for health promotion and prevention of this disease. Hospitals provide inpatient health-care related to the treatment of diabetes and complications of the disease, while all the cases that could not be resolved at the secondary level are referred to the Clinical Centre for providing subspecialist care. The Institute of Public Health registers all services provided in health-care facilities, creates preventive and other programmes of health-care and will lead the national register for diabetes.

Since 2006, in Romania has implemented the National Diabetes Programme[160] which aims to improve health, increase life expectancy of patients with diabetes, as well as to ensure fair access to treatment for the patients enrolled in the Programme. The Romanian National Diabetes Programme includes three components: (i) Prevention and control of diabetes and other diseases of nutrition, (ii) Insulin treatment of patients with diabetes and (iii) Oral anti diabetic treatment of patients with diabetes. The Programme is fully financed by the Ministry of Public Health by direct transfer from the state budget to the budget of the National Fund of Health Insurance. Patients included in the National Programme can access free of charge specialized treatment at county level, including in Bucharest.

Starting with 2011 a National Register for diabetes patients is also in place. The Ro Diab Diabetes - Patient Management System software functions in all health units that is part of the National Diabetes Programme in Romania. The aim of the Registry is to correctly assess and register the needs of the diabetes population in order to implement the objectives and activities of the National Programme. In the medium and long term, the utilization of the Registry is expected to lead to: an increase of the efficient use of resources, greater transparency in public spending and higher control of costs in the National Diabetes Programme. The software application interconnects all health-care providers who implement the National Diabetes Programme; improving the population's health by assuring a more accurate and detailed monitoring of patients with diabetes.

In Serbia, there has been in place a Diabetes Registry since 1980. On the basis of the national importance of the Diabetes Registry and statutory regulations, in the course of 2006 a team of experts initiated its reorganization. There is a Republic Expert Committee and Guideline for the diagnosis and treatment of Diabetes, but not a National Programme for type 2 diabetes. Due to the fact that there is no National Programme for diabetes patients, the NGOs active in the field are trying to fill in the major gaps of the public health system.

[160] Ministry of Public Health, Ordinul Nr. 1061/31.08.2006 / National Fund of Health Insurance Ordinul Nr. 425/04.09.2006

Box 11. Diabetes risk factors in Serbia (by Milos Bjelovic)

According to the Serbian Diabetes Registry the main risk factors associated with type 2 diabetes are: obesity, smoking and physical inactivity.

Diet and obesity

In 2006 three main meals were regularly consumed by 56.6% of adults in Serbia, which was an improvement in comparison with 2000 when only 52.8% had them. More than three quarters (77.6%) of the Serbian population had a regular breakfast. The oldest, the poorest and those living in non-urban settlements had their meals more regularly than those that were better off and lived in cities.

The use of animal lard to prepare meals was reduced in 2006 (33.8%) in comparison with 2000 (41.0%). Animal fats were mostly used to prepare meals in Western Serbia (44.5%) and Vojvodina (43.8%) and least in Belgrade (14.2%). The use of animal fats was most prevalent among the poorest (58.3%) and poorer (44.7%) population, and it gradually fell with the rise of wealth index, so that only 9.0% of the richest used this type of fat to prepare their meals. Over half of the population (57.2%) used predominantly white bread, and 14.8% of adults used whole grain, rye and similar types of bread.

In 2006 in Serbia 48.7% of the population ate fish less than once a week. The population of Belgrade and Vojvodina, the richest and those living in urban settlements had fish in their diet more frequently.

In 2006 fresh vegetables were eaten daily by 54.8% of adults, which was significantly more than in 2000 when only 42.4% did so. Fresh fruits were a part of the everyday diet of 44.0% of the population. The richer and richest people used fresh fruits and vegetables more often.

Leisure, exercises and sport

In 2006 two thirds of the population of Serbia (67.7%) spent their free time mainly in a sedentary manner. In 2006 the percentage of adults who exercised more than 3 times a week intensively, i.e. sweating and breathing faster, reached 25.5% which was significantly more than in 2000 when only 13.7% did so.

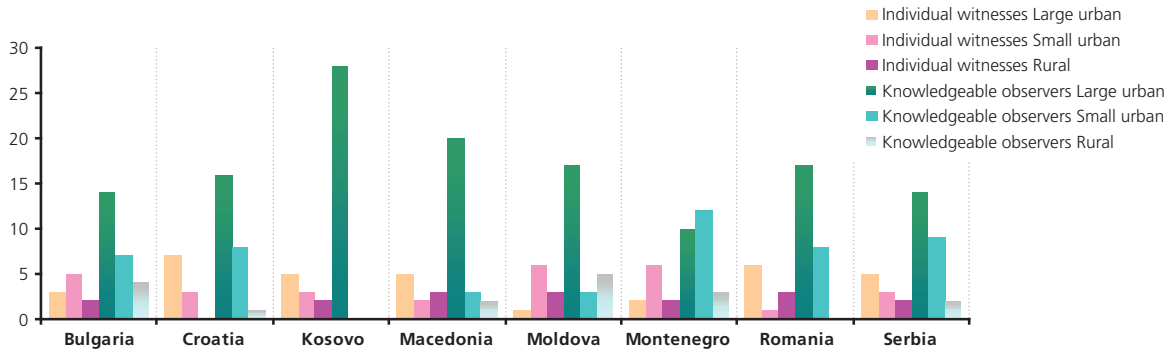
In 2006 one third of the employed population in Serbia (31.1%) had a sedentary type of work: one quarter of men (25.4%) and two fifths of women (40.6%). The percentage of employees with a sedentary type of work was significantly increased in comparison with 2000 when it was only 25.2%. The number is the highest among the richest (49.7%) and tends to fall with the wealth index, reaching the lowest value with the poorest, i.e. only 12.0%.

3.6.2 Interviewees on diabetes

In all 8 countries a total number of 283 interviews on diabetes (type 2) were realized, of which 80 were individual witnesses and 203 knowledgeable observers.

The study covered, in each country, various regions including large cities (170 interviews), small urban (79) as well as rural (34) areas. The knowledgeable observers interviewed for diabetes from large urban areas represent the largest group of interviewees on the topic (48% of the total interviewees on diabetes).

Figure 36. Diabetes: Distribution of the sample by interviewee's type by area and by country (number of interviews)



Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Note: Types of areas (rural or urban) according to the national administrative definitions.

Interviews were carried out both on with women and men. The female interviewees represented 59% of individual witnesses and 63% of knowledgeable observers. Only in Montenegro the number of male knowledgeable observers interviewed is higher than in the other countries.[161]

Individual witnesses who participated in the study were mainly patients diagnosed during the period 1st of January 2010 - 31st of December 2011, aged between 27 and 81 years old (with an average age of 57), from a range of ethnic groups,[162] with various levels of education[163] and with diverse occupations.[164]

Knowledgeable observers are medical representatives, aged between 24 and 78 years old (with an average age of 43 years). The interviewees include specialists (84 interviews), general practitioners (61), hospital representatives (21), public health representatives (12), pa-

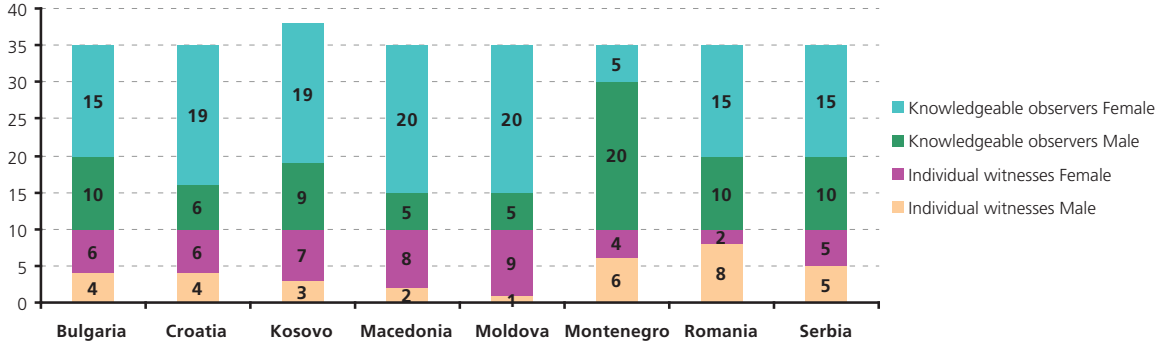
[161] In Montenegro there were interviewed 20 male knowledgeable observes, compared to 10 in Bulgaria, Romania and Serbia, 9 in Kosovo, 6 in Croatia and 5 in Macedonia and Moldova.

[162] Bulgarians, Croatians, Kosovars, Albanians, Macedonians, Montenegrins, Romanians, Moldovans, Roma, Ukrainians, Russians, etc.

[163] Were interviewed 13 with elementary education, 35 with high school, 22 with college or more. For Kosovo data regarding the level of education of the interviewees is not available.

[164] Employed (30 interviews), pensioners (35%) or other economically inactive persons (15).

Figure 37. Diabetes: Distribution of the sample by interviewee's type and gender and by country (number of interviews)



Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*.

tients' organizations (8), NGOs (6), emergency centres representatives (5) and others (6).

The main characteristics of the sample on diabetes, regarding both individual witnesses and knowledgeable observers, are presented in tables A.11 and A.12 in the Annex.

3.6.3 Accessibility to state-of-the-art treatment in diabetes

This section analyzes the actual access of diabetes patients to state-of-the-art diagnosis, treatment, monitoring and rehabilitation based on the interviews with knowledgeable observers and individual witnesses from the eight selected SEE countries. The analysis is organized according to the adjusted 6-access-steps model presented in subchapter 3.1.1.

(A) Content of the national benefits packages

National programmes for management and treatment of diabetes have been developed and implemented, or are in the process of being implemented, in all studied countries, except Bulgaria and Kosovo.

Health-care services for patients with diabetes are included in the universal coverage of health and are supported by the national insurance funds. In most countries, the tests and diagnosis, the treatment itself including drugs, the work of specialists, doctors, nurses, laboratory tests are free of charge by law, being covered by compulsory health insurance. However, there were reported shortages in the number of insulin stripes covered by the insurance fund (patients have to buy an extra amount on a monthly basis in Croatia) or limitation of free of charge treatment to a restricted list of drugs, covering in most cases only insulin therapy and/or oral mono-therapy (Bulgaria, Kosovo, Serbia).

In Moldova, under the National Programme for Prevention and Control of Diabetes for 2011-2015 and the Mandatory Health Insurance Unique Programme, early detection, diagnosis and treatment of diabetes, as well as diabetes control and secondary prophylaxis, are covered by mandatory health insurance funds. Also, oral hypoglycemic agents for outpatient treatment and insulin medicines are covered by the state budget, being centrally purchased by the Ministry of Health. Type 1 diabetes patients receive devices to monitor glucose levels in blood, as well free insulin treatment. Type 2 diabetes patients have to buy devices for monitoring glucose and receive 90% compensated medication. Although hospital treatment for diabetes is also covered by health insurance, it does not include most of the complex treatments of complications[165] – diabetic foot, retinopathy, diabetic nephropathy and renal insufficiency.

For uninsured patients, health-care services for diabetes delivered at the level of pre-hospital emergency health assistance and primary health assistance, including prescription of compensated drugs, are covered by the Health Insurance Fund,[166] whereas at the level of specialized outpatient care, only insulin therapy is covered. An uninsured person can obtain an outpatient consultation by the endocrinologist and benefit from laboratory medical services prescribed by the specialist, as well as hospital treatment, all of which must be paid for in accordance with the Unified catalogue of charges for services provided by public medical institutions.

(B) Formal and informal out-of-pocket payments

Although free of charge services for diabetes patients are covered by the universal insurance funds, formal and informal out-of-pocket payments were reported in interviews across all studied countries.

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[165] In 2013, the laser treatment of diabetic retinopathy was included in the List of medical maneuvers specific for some specialties/surgical services, performed in the context of outpatient specialized health assistance included in the Unique Programme.

[166] Order of the Ministry of Health and the National Health Insurance Company No.348/56-A of 29.04.2011 on the approval of methodological norms for implementation in 2011 of the Unique Programme of Mandatory Health Insurance

In Bulgaria, tests, diagnoses and some types of treatment are free of charge, being covered by the compulsory health insurance. Diabetes patients reported only formal co-payments for mono-therapy treatment, about € 25[167] per month. Insulin therapy is 100% covered by the Insurance Fund.

In Croatia, the health insurance fund totally covers tests and diagnosis. Most of the patients that had to take regular medicine declared that insulin treatment was free of charge; a few mentioned some official payments for combined oral therapy (€ 13[168] per month) and for oral mono therapy (€ 15 per month). For most patients on oral medicine, the insulin stripes covered by health insurance are insufficient and they have to purchase them, paying out-of-pocket (€ 25 per month).

In Kosovo, the required tests (blood tests, oral glucose tolerance test) and treatment (if covered in the essential list of drugs) for diabetes patients are free of charge in the public sector. However, the health system's shortages impose a series of co-payments, some in the private sector, of about € 50 - 100 per month, for treatment and monitoring. These costs are high if we consider that this condition is chronic and income levels in the country are quite low. In case a patient cannot pay the demanded amount for the treatment s/he would either be released from the payment, or would receive whatever treatment is available for free, if any. There are cases when patients remain untreated, a situation with negative impact on the future course of the health condition. In the private sector, patients have to pay the total amount of services, which is considered a significant burden on their budgets.

In Macedonia, persons diagnosed with type 2 diabetes that are registered in National Registry receive insulin therapy for free. For other types of medicine, patients have to pay a participation fee varying between € 5 and 25,[169] which accounts for 1%-3% of the official average monthly gross wage per employee in February, 2013. Also, for other services such as laboratory tests, medication, proper care, doctor/specialists, nurses or other medical staff, patients pay between € 1 and 25. Free transportation services are available only in emergency cases.

In Moldova, despite the fact that the diagnosis of diabetes is free of charge for all persons, regardless of their insurance status, both doctors and patients acknowledge the existence of additional payments. Thus, for the entire volume of clinical and laboratory investigations required for establishing the diagnosis, patients additionally pay between € 5[170] and € 75 (formal payments). For outpatient treatment, the official spending on diabetes medication and insulin accounts monthly to around € 5-40. For the full set of monitoring tests, both doctors and patients state that out-of-pocket formal payments are required of between € 30 and 100. The need for additional payments, both formal and informal, is specific to hospital services. Thus, formal payments are made by patients for drugs (mostly insulin) that are missing or are ineffective, and amount to € 25. Informal payments are made to doctors and nurses for proper care. According to doctors' estimations, the patient must formally pay between € 125 and 200 for the hospital treatment of type 2 diabetes with complications.

In Romania, according to the National Diabetic Programme, all tests and treatments for diabetes are free of charge. All insulin dependent patients receive also free of charge 100 glycemic tests every three months. Additional payments were reported by the hospitalized diabetes patients, who declared that they felt like paying informal money to medical staff as a sign of gratitude for good care received.

In Serbia, the services received at the clinic/hospital, including payments of the medical staff, laboratory tests, proper care or medications for patients with type 2 diabetes are covered by the Health Compulsory Fund so

[167] At an exchange rate of 1.95583 BGN= 1 EURO.

[168] At an exchange rate of 0.13071 KN= 1 EURO.

[169] At an exchange rate of 61.76220 MKN= 1 EURO.

[170] At an exchange rate of 15.9967 MDL = 1 EURO, as at December 2012, http://www.curs.md/

Table 20. The critical out-of-pocket payments (formal and informal) for diabetes patients in SEE region

	Diagnosis (tests)	Treatment	Monitoring, rehabilitation	Medica-tion	Transport to doctor or health facility
Bulgaria					
Croatia				(devices)	
Kosovo					
Macedonia					(except emergencies)
Montenegro					
Moldova					
Romania		(as gratitude)			
Serbia				(high quality)	

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*.

patients do not have to pay (formally or informally). However, due to long waiting lists, about 30% of patients (3 out of 10 individual witnesses) take part of the tests in private laboratories. The average fee for the glucose level is € 2, and for HbA1c € 10. Regarding treatment, standard oral mono-therapy and insulin therapy is free of charge, being covered by the Health Compulsory Fund. However, modern treatment options are not covered by the Health Compulsory Fund. This kind of treatment cost between € 50 and 100 per month.

In conclusion, in the case of diabetes, out-of-pocket payments are critical in Macedonia and Moldova, as they present at all stages in the process of health-care delivery. For most countries out-of-pocket payments limit access to modern, more advanced treatment.

(C) Availability of services and geographical access for diabetes (type 2) patients

The majority of health professionals and officials (70%) interviewed within our study appreciate that state-of-the-art treatment in diabetes is available in their country.[171]

Health-care services for diabetes patients are generally available in the public health-care systems across the eight selected countries. The treatment provided in the public sector was overall rated well and the general opinions are that the level on which care is provided is state-of-art in Bulgaria, Croatia and Macedonia, although in Croatia delays and long waiting lists were mentioned.

In Romania, respondents rated the services received as state-of-the-art. However, no patient or medical representative talked about new technologies or modern treatments for diabetes beyond standard. For most respondents standard treatment for diabetes (in most cases insulin therapy) is regarded as being similar to state-of-the-art treatment.

In Serbia, although the general opinion is that the availability and quality of health-care services for patients with diabetes is good, modern treatment options, like Incretin therapy (DPP4 inhibitors and GLP analogues), are not covered by the universal coverage and need to be paid out-of-the-pocket.

In Kosovo and Moldova, the great majority of respondents consider that state-of-art treatment of diabetes is not delivered in all public health institutions and that universal coverage of the state-of-art treatment for diabetic patients is only theoretical. In Moldova, treatment of patients with diabetes is done in outpatient and inpatient settings. However, regu-

[171] A total of 202 valid answers.

lar administration of medication by patients in ambulatory settings is dependent upon access to medicines. Despite the fact that diabetes medication is provided by the government, patients report situations when they couldn't find the prescribed medication and had to order them from abroad. On the other hand, patients mention that when the prescribed medication is available, it is only partly free of charge, whereas for some types of medication, especially insulin, payment is required in full.

In all studied countries, state-of-the-art treatment for diabetes is more likely to be available in the larger cities. Consequently, geographic access, especially for rural residents, is considered a problem in all countries. Generally, within the public health-care system, services for diabetes are available in District or County hospitals, they are rare in Municipality hospitals and are missing from rural areas. In Bulgaria, Macedonia, Moldova and Serbia, large parts of the respondents mentioned geographic disproportion in the availability of specialists and health-care for diabetes. In Romania, in order to receive the needed medication (insulin therapy), a registered diabetic patient has to visit the specialist every 3 months. In many regions of the country, specialists are available only at county level, thus forcing patients to travel distances of between 5 and 60 km. For those patients, costs of transportation are mentioned as a barrier ito accessing proper care.

In Kosovo, most respondents reported that all health-care services needed during the treatment and monitoring period were present at the nearest clinic or hospital. This improved situation is as a result of the primary care network that was developed after the war. Some reported that they had to visit different doctors located in various places, but travel distances were considered acceptable. Specialists or medical services for diabetes are available in the proximity of patients and are easy to access. The exceptions are patients from remote villages that have to go to nearby cities to receive proper care. They need to find transportation by themselves, and related expenses can become a serious burden for patients and their families.

In the entire region, most health officials and physicians report a good availability of health services for diabetes, but their accessibility is classified as medium or in some cases low, despite the fact that there is a universal coverage for this type of services. The imbalance between availability and accessibility proves the existence of certain barriers in the health system. Thus, populations from large urban areas and with higher socio-economic standards are more likely to receive specialized treatment for diabetes.

(D) Health-care providers in diabetes

In all eight countries, health-care services for diabetes are provided in both public and private facilities, but tend to be concentrated in the public sector. In Bulgaria, Croatia, Macedonia, Moldova, Montenegro and Romania most respondents declared that they used mainly the public facility services for diabetes diagnosis, treatment and monitoring. However, in order to avoid waiting lists for diagnosis tests and examinations, referrals to the private facilities were mentioned by patients in Kosovo and Serbia. In Serbia one patient reported that the same physicians working in both sectors conditioned the patient to receive the treatment in a private facility, thus necessitating payment for the care received.

(E) Waiting lists and other aspects of system organization that can result in barriers to access

In accessing state-of-the-art health-care services for diabetes, respondents from all eight studied countries mentioned as barriers the long waiting time to be received by a specialist, but also some other organizational aspects.

The concentration of specialized diabetes services correlated with the insufficient number of specialists translates into long waiting times to be diagnosed and to receive proper care; a fact identified by both patients and medical representatives. Long waiting times were reported for: tests and receiving the diagnosis in Croatia; to be seen by a specialist (routine consult) or to receive medication in Kosovo, Montenegro, Moldova and Romania. In Serbia the long waiting lists for the diagnosis tests and examinations influenced patients to look for care in the private sector.

Table 21. Waiting times for treatment in diabetes

	Direct access to specialist	Treatment	Rehabilitation services	Getting medication
Bulgaria				
Croatia				
Kosovo				
Macedonia				
Montenegro				
Moldova				
Romania				
Serbia				

Data: FES (2012-2013) *Performance of the Public Health-care Systems in SEE countries*. Notes: Red cells indicate long or very long waiting times, light orange cells show a intermediate situation, and green cells point out the areas with no problems in terms of waiting times.

The high number of patients per specialist is highly acknowledged in all studied countries, especially in Romania, where, in some counties one or two specialists have to cover the specific needs of more than 17,000 diabetes patients. In this context, both patients and medical representatives consider that some improvements regarding the almost non-existent non-pharmacological part of the therapeutic scheme (information about proper diet, lifestyle) are necessary.

In Bulgaria, patients complained about communication difficulties with medical specialists. Most of them declared that they were not provided with enough information about the disease, about the treatment and about the consequences of the illness, being forced instead to search for information from other people with diabetes or on the Internet.

In Moldova, neither the non-pharmacological treatment (diet) nor the oral diabetes medications or insulin therapy where complemented by appropriate training regarding the management of treatment, that should be delivered by the family physician or by the endocrinologist. According to the National Clinical Protocol "Uncomplicated Diabetes", patient training represents a mandatory step in the management of the diabetic patient. Insufficient quantitative and qualitative coverage with training services, especially at the outpatient stage, leads to partial treatment compliance and self-monitoring of disease evolution. As a negative result, patients with diabetes report benefitting from a very limited range of monitoring tests (4-5 out of 13 tests), compared to the ones stipulated in the National Clinical Protocol "Uncomplicated Diabetes"; the cause of this situation is the insufficient knowledge about screening measures and their periodicity. Thus, patients report only having their blood glucose evaluated monthly or every 2-3 months during their visit to the family physician/endocrinologist, whereas the protocol stipulates daily (3-4 times/day) self-monitoring of this parameter.

In Serbia, patients also mentioned the lack of interest of the doctors in public sector. All interviewed patients started the treatment with the advice about non-pharmacologic treatment (lifestyle optimization: diet, physical exercises, weight loss, quitting smoking, cessation of alcohol consumption), followed by mono oral pharmacologic treatment (Metformin). However, half of them received insufficient information about how to correctly put in practice non-pharmacologic treatments or how to administer pharmacological treatments.

In all eight countries, routine and preventive consultations as well as systematic screenings are rare. The lack of active work of health institutions in health education is an element of concern in all countries, especially in Kosovo, Moldova and Romania.

Box 12. Weak prevention action in diabetes in Moldova (by Andrei Mecineanu)

According to the National Programme and the Mandatory Health Insurance Unique Programme, the role of health-care is to implement diabetes prevention and early detection measures. In reality, the identification of persons with risk factors is achieved in only 20% of cases, the screening by oral glucose tolerance test – 20%, and early detection of diabetes – 15% of cases.[172] One cause of the given situation is the reduction of categories of persons with risk factors for diabetes. Thus, family physicians include in the risk group only persons suffering from obesity, hypertension and are sedentary.

Population coverage with information, education and communication materials on risk factors and methods of preventing diabetes is extremely low in Moldova. According to Ministry of Health data, only 20% of the required measures are implemented. The result of this study confirms this situation, pointing to a worrying phenomenon. Thus, patients diagnosed with diabetes rarely receive information and prevention measures in the health system, obtaining information from relatives and acquaintances or media sources that have addressed the issue of diabetes outside certain cooperation measures with health authorities. The existence of this phenomenon leads to the conclusion that the first link in the management of diabetes – primary health-care – has a high degree of inefficiency.

This situation creates a vicious chain in the diagnosis and treatment of a diabetic patient. Therefore, in the Moldovan health system, the diagnosis of diabetes may be made long after the onset of symptoms, the patients not being able to attribute them to this disease, or the patient is diagnosed with diabetes while being admitted to hospital with another health condition.

The exclusion of a family physician consultation at the stage of diabetes diagnosis is a persistent phenomenon with patients choosing to visit directly the endocrinologist. Additionally, patients opt for medical consultation and/or admission into tertiary health institutions in Chisinau municipality. The first visit to the family physician or the specialist, at the place of residence or in Chisinau municipality, is not conditioned by the area of residence or financial status. The pros for one option or another lie in the confidence in the health-care provider, or in recommendations from reliable persons.

All these deficiencies existing in the health system at the stage of diabetes prevention and detection create a false satisfaction of patients in relation to delivered health services. Patient satisfaction is determined only by the establishment of diabetes diagnosis, which acquires negative aspects when the patient has information about the disease, prevention measures and timely diagnosis.

It is not only the case that specialist diabetes treatment is insufficient but there are some opinions that the qualification/interest of specialists and general practitioners regarding diabetes patients is limited. In Croatia there is a lack of education among rural and small urban general practitioners who often do not attend extra trainings about diabetes. As a result, they do not take seriously enough testing for blood sugar and many patients consider that their treatment was delayed only because of the subjective attitude of doctors. In Macedonia a few patients complained that the doctors that took no action even though blood tests for glucose level were high in that year. In Moldova and Serbia it was mentioned that some general practitioners were not aware of the prevalence of diabetes, did not know the risk factors, and did not understand the importance of preventive actions.

Regarding the satisfaction with the health-care services received, although the interviewed patients could not tell whether they

[172] The National Programme on Diabetes Prophylaxis and Control for 2011-2015, Government Decision No. 549 of 21.07.2011

received health-care services at the state-of-the-art level, they were generally satisfied with what they got. The great majority of patients consider that the diagnosis was performed in a professional and timely manner and it did not affect in any negative sense their health condition, although some delays in diagnosis were registered.

(F) Groups with limited access to health-care services in diabetes (type 2)

In all eight studied countries the highest risks to developing diabetes and to not being able to access proper diagnosis and treatment were visible in the elderly and the economically disadvantaged groups. For the second category the risk is highly associated with poor nutrition, unhealthy lifestyle, low health culture, working conditions, stress and limited access to information and care.

In addition to poverty, the geographic dimension of accessibility was mentioned in: Croatia, Romania and Serbia. The fact that specialists are not available in the localities of residence is a factor that delays or prevents access to diagnosis and treatment.

3.6.4 Main access barriers in diabetes

Five major access barriers to state-of-the-art treatment in diabetes are common to nearly all countries included in the study: (i) Poor knowledge and low levels of public information; uncommon preventive health related behaviour; (ii) Long waiting times to be received by a specialist; (iii) Doctor or medical services are not available in some areas; (iv) Poor equipment at clinics/hospitals; (v) Low quality (low effectiveness) of medical services.

In all countries, interviews revealed that insufficient knowledge, low levels of information and the lack of preventive health-related behaviour represent the main factors that hamper access to quality health-care. Health systems in the region have a reduced capacity to ensure the implementation of policies on the prevention and control of diabetes, although specific programmes are in place in almost all studied countries. In the majority of cases, the participation of family doctors and diabetes specialists in the provision of health-care services commences at the stage of administrating the standard treatment, with no additional patient education, although the existing National Protocols provide guidelines in this respect. In these circumstances, patients report the absence or inadequate delivery of information and prevention services. This is a highly relevant indicator that the first link in the management of diabetes – primary health-care – is in most cases ineffective. As National reports state; the failure of the national programmes in preventing diabetes is reflected by the lack of initiative among patients who usually neglect the first symptoms of the disease and become "an active side" only after the diabetes had been diagnosed.

The long waiting times to be received by a specialist, availability of doctors, medical services only in some areas, poor medical equipment and low quality (low effectiveness) of medical services are mentioned both by patients and medical representatives as barriers in accessing state-of-the-art treatment in diabetes in most countries, and represent shortages in the health systems which translate into inequity in access.

Table 22. Main access barriers to health-care in type II Diabetes

Access barriers	BG		HR		RKS		MK		MD		ME		RO		SRB	
Delayed first contact with a doctor							x		x	x			x			
Poor knowledge and level of information of population. Preventive health related behaviour is uncommon.	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x
Doctor or medical services are not available in some areas		x				x		x	x	x			x	x		x
Transport services are underdeveloped or too costly						x										
Distance from home to a hospital/ clinic is too large and/or too costly													x		x	
The waiting time for being received by a specialist is very long			x		x				x	x	X	x	x		x	x
The waiting time for getting treatment or medication is very long			x	x	x											
Lack of interest or unprofessionalism of the doctor or medical staff	x		x			x							x		x	x
Discriminatory or inappropriate behaviour of medical staff						x										
Lack of money to pay the needed tests										x						
Lack of trust in doctors, nurses or medical staff						x			x	x						
Lack of humanness of the staff																
Low quality (low effectiveness) of medical services				x		x	x	x	x	x					x	x
High costs of medication			x				x		x	x						
Poor equipment of clinic/hospital						x	x	x		x					x	x
Specialists of certain subspecialties are missing or insufficient										x				x		
Others, please give details		x														

Data: FES (2012-2013) *Performance of the Public Health-care System*. Notes: Lack of humanness of the staff: not treated well, disrespectful, not provided with explanations about disease and treatment. Low effectiveness of services: inappropriate waiting time, laboratory tests not reported promptly and correctly, poor working equipment, unclean and untidy hospital/clinic. Lack of accessibility and continuity of care: inappropriate number of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit. Others: socio-economic factor like weak health culture and incomplete living conditions. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

4. MAIN CONCLUSIONS: Major areas of reform in public health-care in SEE countries

The study *Performance of the Public Health-care System* analyzes the performance of the public health-care systems in South-East Europe, focusing on the needs of patients in relation to five health problems: Myocardial infarction, Stroke, Cancer, Injuries and Diabetes (type 2).

The objective of this empirical comparative study was to provide qualitative insights about the *expected* versus the *actual* performance of the public health-care systems with the aim to indicate the major areas that need interventions both at National and European levels. The research has been designed with a view to providing information on topics and issues that are difficult to capture through quantitative research methods. Thus, the study relied on qualitative research techniques and gathers both the perspective of knowledgeable observers (1,006 interviews) and of individual witnesses (432 interviews).

The report provides an analysis based on a common analytical framework for all eight countries and compiles many types of sources: WHO European HFA Database, European statistical data, drawn from various Eurostat databases, World Bank - World Development Indicators; national statistical data; national information, provided by country studies.

4.1 KEY FINDINGS

Socio-demographic aspects

The study covers eight European countries out of which three are EU member states and five are candidate countries in early stages of the accession process.

Although, most developments have been country-specific due to differing pre-transition starting points and different approaches and efforts (political as well as economic) invested in social policies, the studied countries share some common features and areas for intervention.

Figure 38. Socio-demographic trends in eight SEE countries

	BG	HR	RKS	MK	MD	ME	RO	SRB
Population at 1 Jan 2013 (in 1,000 persons)	7,285	4,262	1,794	2,062	3,559	623	20,057	7,182
Children <15 years trend	▼	▼	▲	▼	▼	▼	▼	▼
Children <15 years in total population	13%	15%	28%	17%	16%	19%	15%	14%
Population growth*	▼	▼	▲	▲	▼	▲	▼	▼
Fertility rate (after 1990)	▼	▼	▼	▼	▼	▼	▼	▼
Crude death rate (after 2000)	▲	▲	=	▲	▼	▲	▲	▲
Premature mortality rate	▲	▲	▲	▲	▲	=	▲	▲
Infant mortality (after 2000)	▼	▼	▼	▼	▼	▼	▼	▼
Life expectancy (after 1990)	▲	▲	=	▲	▲	▼	▲	▲
GDP per capita (after 2000)	▲	▲	▲	▲	▲	▲	▲	▲
GDP per capita compared to EU	47%	61%		35%	10%	43%	49%	35%
Human Development Index	High	Very high	High	High	Medium	High	High	High

Legend: Red cells indicate negative trends. Green cells indicate positive trends. Grey cells indicate stability. Up arrows indicate increase, while downs arrow indicate decrease. Note: *Kosovo population growth was positive until 2011 when the population registered a significant decline from 2,208 to 1,799 thousand persons.

In all eight countries included in the present study, the general standard of living, measured as GDP per capita, has constantly increased since 1990, yet has remained fairly below the EU-28 level. According to the broader definition of well-being (which measures the average achievement in three basic dimensions of human development - a long and healthy life, knowledge and a decent standard of living) most of the studied countries belong to the group of countries with high human development. Only Croatia is rated 'very high' and Moldova 'medium'.

After 1990, all SEE countries experienced tremendous social changes linked to the transition to democracy and market economy and/or to war. Changes in socioeconomic conditions have affected population health both directly and through psychosocial factors (Marmot and Wilkinson, 1999). As in most countries of the former Soviet Union, all countries included in the study experienced a mortality crisis in the early 1990s. Since 2000, the share of children under 15 years has decreased in all studied countries except Kosovo. In 2012, children under 15 years represent between 13% of the total population in Bulgaria to 19% of the total population in Montenegro.

The population growth rate registered negative values in Bulgaria, Croatia, Moldova, Romania and Serbia, while in Kosovo, Macedonia and Montenegro it has been positive. The negative natural population growth is mainly the result of a long-term decline in fertility together with an increase in mortality. In all eight countries the fertility rate decreased since 1980; the largest drop being registered by Moldova, while in Montenegro the fertility rate has been stable since 2000. All countries face high mortality rates and an increase in premature mortality rates (except Montenegro).

Overall population health has improved since the 1970s in the region, as life expectancy has increased in six out of the eight studied countries. In the last twenty years in almost all studied countries life expectancy at birth increased by values ranging between less than one year, in Moldova, and almost four years, in Romania. Nonetheless, the gap between the EU and these countries has remained significant.

As in the other European countries, women on average live longer than men. In 2011, the gap was as large as eight years, in Moldova, seven years in Bulgaria and Romania, compared with four years in Kosovo and Macedonia. In most countries, men not only have a shorter life expectancy, but also shorter expected lifespan in good health than women. However, in all selected countries the average number of years spent in good health is far below the EU-15 average of more than 70 years.

Infant mortality rates are decreasing since the 1970s. Nonetheless, in all studied countries infant mortality rates register values higher than the EU average. In 2011, only Montenegro and Croatia (with rates of 4.4, respectively 4.7 per 1000) registered infant mortality rates comparable with the EU-28 average (3.9 per 1000). For the other six countries infant mortality rates were much larger, particularly in Kosovo (13.1 per 1000) and Moldova (11 per 1000).

Main causes of death

In the SEE countries under study, as in the entire European region, communicable diseases have low prevalence due to the constant improving of the surveillance systems and good immunization coverage. Among the studied countries only in Moldova, did communicable diseases such as HIV and tuberculosis (TB) still represent major causes of morbidity and mortality due to the insufficient capacity of the system to detect and respond to outbreaks.

By contrast, non-communicable diseases (NCDs) - cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases and diabetes - account for the largest share of mortality globally: about 80% of deaths. In Europe, in 2009, diseases of the circulatory system accounted for nearly 50% of all deaths, with higher rates among men than women, followed in frequency by cancer (neoplasm), with 20% of deaths, and external causes of injury and poisoning, representing 8% of all deaths. (WHO, 2013a)

The studied SEE countries (no data available for Kosovo) follow the European pattern. Circulatory diseases and neoplasm represent the first two major causes of death in all eight countries. The third major cause of death varies across countries from external causes of injury and poisoning, in Bulgaria and Croatia, to diseases of the respiratory system, in Bulgaria, Montenegro and Serbia, respectively diseases of the digestive system, in Moldova and Romania. In all eight countries, the burden of non-communicable diseases has been increasing.

The high burden of NCDs is directly related to a high prevalence of risk-factors. Tobacco use, physical inactivity, unhealthy diet and the harmful use of alcohol increase the risk of or cause most NCDs. 'For the major groups of diseases causing high mortality, morbidity and disability (...), two main risk factors contribute to multiple disease outcomes and thus remain a priority to tackle: tobacco smoking and harmful alcohol consumption. From a European perspective, their prevalence and levels remain high across all populations, in spite of the knowledge and technology available to address both.' (WHO, 2013a, p. 40-41)

Inequalities in health

Regarding inequalities in health and fair access to health-care services, factors such as income, education and job status have a high influence on health status, mortality and risk factors among EU countries (e.g. Mladovsky et al., 2009). In the eight studied countries, the major inequities in health relate to poverty, financial barriers, ethnicity (Roma), geographical barriers (in particular rural areas but also some regions) and migration.

Financing the health system

Total health spending varies significantly between a low 3% of GDP in Kosovo and 5.8% in Romania[173] to 10.4% in Serbia and a of 11.4% in Moldova (against the EU-28 average of 9.6% of GDP, data for 2011). Thus, Moldova appears to be the highest spender. However, due to the level of GDP, in absolute terms, total health expenditure per capita in Moldova is the lowest (no data for Kosovo), almost two times lower than in Macedonia and Romania, about three times lower than in Bulgaria, Montenegro and Serbia and approximately four times less compared to Croatia (the highest spender) and representing only 12% of the EU-28 average. This substantial variation in health spending translates into great variation in the coverage of the population's benefits and, as a result, into great variation in health outcomes.

The fiscal context[174] represents the main driver of the relatively low health spending, since most studied countries have overall government spending levels lower than 40% of GDP as against an EU-28 average of 47.9% of GDP (exceptions are Montenegro and Serbia; no data for Kosovo). The second factor of the relatively low health spending in the region is the priority that the governments accord to the health sector. Government health spending accounts for only 8% of total government expenditure in Kosovo and less than 15% in Romania compared with 19-21% in Bulgaria, Croatia, Macedonia and Montenegro (the EU-28 average), and with almost 23% in Serbia and as much as 29% in Moldova.

In most studied countries, the majority of expenditure on health (as a proportion of GDP) is generated publicly. Nonetheless, out-of-pocket payments for health services exceed 40% of total health expenditure in Moldova, Bulgaria and Kosovo.

In the entire region, achievement of universal coverage for marginalized poor populations, Roma, internally displaced persons or persons returned through the re-admission process from EU countries has remained a major chal-

[173] Romania decreased its health spending to only 4% of GDP in 2012, hence registering one of the lowest health expenditure in Europe.

[174] The fiscal context refers to the current and expected capacity to spend of a government. Richer countries tend to be more effective at mobilizing tax revenues and so to have higher levels of public spending as a share of GDP, whereas more limited fiscal space is associated with low government spending, including on health.

lenge. In some countries, such as Bulgaria, Macedonia, Romania and Serbia, difficulties in obtaining identity documents and registering with the insurance scheme have systematically discriminated against the already severely disadvantaged Roma population. (e.g. Zoon, 2001; Figueras and McKee, 2012) Long-term care and home-care are funded from EU funds (such as in Bulgaria) or from donations (as in Romania) and remain a challenge not yet consistently addressed in the studied countries. (Genet et al., ed., 2012)

For ensuring financial sustainability under pressure of fiscal constraints, most countries have sought to shift the burden from collective financing to the individual, whether through encouragement of private, voluntary insurance (though the private market remains limited) and/or through increased co-payments and deductibles and no-claim bonuses.

Health-care delivery

Regarding governance and organization, in all studied countries with the exception of Kosovo, the health systems are organized according to the principles of universal access to basic health services, equity and solidarity in health-care financing. The health systems include a mix of public and private medical facilities, as well as public agencies and authorities involved in the provision, financing, regulation and administration of health services. Regulatory functions are centralized in the Ministries of Health that also collect and analyse data and generate relevant information to contribute to the development of evidence-based policies. Nearly all selected countries promote the principle of Health in All Policies through multi- and inter-sectoral collaboration, the Ministry of Health ensuring the coordination of public health activities within the sector and beyond it.

The health-care provision system is organized along three levels: primary, secondary and tertiary.[175] Both public and private health-care providers may be directly contracted by the National Health Insurance bodies for the provision of medical services under mandatory health insurance.

The rationalization of hospital stock and introduction of new management structures in hospitals have been on the reform agenda in Bulgaria, Croatia, Kosovo, Moldova and Romania. Most selected countries inherited numerous facilities and health-care personnel from the communist era. Infrastructure has been significantly reduced but in some countries there is still an oversupply of beds. In the entire region, the hospital services are concentrated in some areas, especially in the larger cities and in capitals. Besides the large regional disparities, the problem comes from an inadequate structure of hospital capacities that is not adjusted to the needs of population in particular territories.

In most studied countries, the pharmaceutical supply network was almost entirely privatized. There is an oversupply of pharmacies in urban areas, whereas in rural areas shortages are still a problem although the situation has gradually improved.

The Euro Health Consumer Index 2013 indicates that all SEE countries need to improve the performance of their health systems in all considered areas: patients rights and information, accessibility (waiting times for treatment), outcomes, range and reach of services provided, prevention, as well as pharmaceuticals deployment.

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[175] The primary care system is the network of family medicine facilities. Public medical facilities at secondary levels provide specialized care to the community and belong to local public authorities. Medical facilities at the tertiary level include research and teaching institutions that provide also specialized and highly specialized medical care for the whole population. A large number of parallel health-care services are also provided through public medical institutions belonging to other branches of government, which are financed from the state budget through the respective ministries but can also contract with the National Health Insurance bodies.

Perceived performance of SEE public health-care systems

The dominant opinion about the performance of the health systems in the SEE region is rather a matter of controversy among health professionals. First, the dominant opinion varies widely from one country to another. In Croatia and Montenegro, most health professionals tend to consider that the national health systems perform well in terms of accessibility, availability and quality of services and are invested with trust by the population. By contrast, in Kosovo, Moldova and Romania, health professionals divide almost equally between positive and negative assessments.

Secondly, in the entire region, health professionals from rural areas tend to assess the system performance as being much weaker than in urban areas. This opinion reflects the urban - rural gap, which is highly visible in statistics and indicators on health status and health-care provision.

Thirdly, the performance of health systems in the SEE region are significantly lower in relation to certain groups of disease, such as cancer.

Fourthly, the assessment depends also on the profile of the evaluator. Thus, patient organizations tend to be very critical, NGOs are rather neutral (or almost equally split between positive and negative attitudes), whereas specialist doctors and management representatives (from regional and national areas of public health) are the most positive regarding the system's performance. This gap between the patient organizations and the system representatives is particularly accentuated in the case of terminal diseases (such as cancer). The patient organizations mainly focus on 'desperate cases'; the poor, Roma or other vulnerable people who need help and support in order to access appropriate health services. By contrast, the system representatives tend to focus on success stories, on health professionals who strive to provide state-of-the-art services under severe constraints of all kinds or on efforts to provide minimal conditions in a context of significant cuts and budgetary shortages.

Tackling the five selected health problems in the SEE region

Circulatory diseases (including myocardial infarction and strokes) and neoplasms (cancer) are the main causes of death in the SEE countries under study. The age-standardized death rates from myocardial infarction have registered a decline in recent years, yet have remained higher than the European average in Croatia, Romania and especially in Moldova. Mortality from cerebrovascular diseases have registered a decline in recent years, yet have remained higher than the European average in all eight studied countries.

Between 1990 and 2010, cancer incidence rose significantly across all selected countries for which data is available (WHO data). There are large variations in rates of cancer across SEE countries, both in men and women. Cancer incidence is higher than the EU-27 average in Croatia for men (462 per 100,000 inhabitants) and in Serbia (data includes Kosovo) for women (330 per 100,000 inhabitants). The other six countries recorded lower cancer incidence in men as well as in women, with the lowest rates registered in Moldova (323 for men and 229 for women per 100,000 inhabitants). Nonetheless, mortality from cancer was equal or higher than the EU-27 average in all studied countries.

Fatality rates due to injuries have registered a decline in recent years, but have remained higher than the EU-28 average in Croatia, Romania and especially Moldova. In countries for which data are available, suicides, road accidents and falls are the three main causes of fatal injuries. Mortality caused by diabetes is equal or higher than the EU-28 average for most studied countries, except in Romania and Moldova. The highest mortality rate caused by diabetes was recorded in Macedonia, while the lowest in Romania.

National institutional arrangements and policies for tackling all five diseases are in place in almost all countries. The availability of protocols and guides for management of the disease, national programmes and or national strategies by country and health problem is shown in the table below with a 'x' tick.

	BG	HR	RKS	MK	MD	ME	RO	SRB
Myocardial infarction			x	x		x	x	x
Stroke			x	x		x	x	x
Cancer	x	x		x	x		x	x
Injuries	x	x	x	x	x	x	x	x
Diabetes		x		x	x		x	x

In the case of circulatory diseases (myocardial infarction and strokes), protocols and guides for the management of disease, national programmes and or national strategies are established in Kosovo, Macedonia, Montenegro, Romania and Serbia. In Moldova there is a lack of coherent and financially sustainable policies on prevention, detection, diagnosis and treatment of myocardial infarction and since 2002, Moldova hasn't approved or implemented National Programmes for control of cardiovascular diseases.

National Cancer Registries are available in Bulgaria, Croatia, Macedonia, Moldova, Romania, Serbia, and are under development in Montenegro. Only in parts of these countries are these registers integrated in larger oncologic programmes. However, all countries (except for Kosovo) have adopted strategic documents and laws for the control of tobacco, alcohol and drugs abuse as well as on food safety (regulating maximum amounts of sugar, salt, saturated fat and various additives in industrially produced foods, as well as more accurate labeling of food composition), which are important for the prevention of carcinoma and have the ultimate goal of reducing morbidity and mortality as consequences of the devastating impact of risk behaviours. Public information, prevention and early detection however are still insufficiently developed in the region.

In all countries, the responsibility for injury prevention is quite dispersed over a variety of policy sectors - depending on the setting in which they occur and the circumstances (at home, at workplace, in leisure and sport activities, on roads, etc.). In the studied countries, Governments adopted strategies for chronic non-communicable diseases, which covers the area of injury, due to the importance that injuries have and make to national pathologies. In addition, all countries have developed national strategies and legislation for road safety and/or for prevention of drug abuse, including alcohol and tobacco, which address the influence of risk factors on the increase in the incidence and prevalence of injuries. However, in many countries, law enforcement is rather poor.

National Registries or National Programmes for people affected by diabetes are available in Croatia, Macedonia, Moldova, Romania and Serbia. In Montenegro a National Commission for Diabetes that will implement the measures defined by the National Strategy for Healthcare of People Living with Diabetes is about to be established.

Main access barriers in public health-care to state-of-the-art treatment

There are four aspects of the health-care systems that were mentioned as major barriers in accessing state-of-the-art treatment, for all selected health problems, in all countries:

(1) Poor knowledge and low level of information and the lack of preventive health-related behaviour.

The national studies report a rather high incidence of risk factors for myocardial infarction, stroke, cancer or diabetes. Due to low levels of available information many patients do not recognize their symptoms on time. Thus, a large number of patients remain undiagnosed until a fatal life threatening situation occurs (myocardial infarction, stroke) or the disease is advanced with complications (cancer, diabetes), when the possibility of receiving proper medical treatment does not give positive results.

(2) Doctor or medical services are not available in some areas

Rural areas and remote areas (such as the islands in Croatia or the mountain villages in Kosovo and Romania) were reported in all countries as being at a disadvantage with respect to access to basic medical services. In these areas, pharmacies may also be missing or not sufficiently stocked with more advanced medication. However, the low access to pharmacies was much less mentioned as an access barrier.

(3) Low quality and effectiveness of medical services, in particular related to (a) long waiting times and (b) poor equipment in public clinics/hospitals

While individual witnesses tend to focus on inappropriate waiting times for various healthcare services, especially for being received by a specialist, the knowledgeable observers tend to emphasize the insufficient and/or obsolete working equipment.

(4) Specialized services are available only in some areas, while emergency services are not sufficiently developed in five of the eight countries

Insufficient access to specialized services was mentioned as a barrier in relation to three health conditions: myocardial infarction, strokes and cancer.

These barriers indicate the need for better financing of the health system: for more medical staff, for extending the existing network of public facilities, for better equipment and also for better geographical coverage of the specialized medical services.

Table 23. Access barriers in public health-care to state-of-the art treatment by health problem and respondent

Respondents: IW – individual witnesses and KO – knowledgeable observers

The table presents the number of countries in which the given aspect was mentioned as access barrier in relation to the specific health problem.

	Myocardial Infarction		Stroke		Cancer		Injuries		Diabetes	
Access barrierS	**IW**	**KO**	**IW**	**KO**	**IW**	**KO**	**IW**	**KO**	**IW**	**KO**
Delayed first contact with a doctor		3		4	6	5			3	1
Poor knowledge and level of information of the population. Preventive health related behaviour is uncommon		7		7	4	8		3	8	8
Doctor or medical services are not available in some areas	2	6	2	6	3	6	1	6	2	6
Specialized services are available only in some areas	1	4	4	6	6	7				
Specialized services are available mainly in private hospital/clinics or out of the country					1	1				
Rehabilitation units/ services are not available/ enough in some areas	1	4	1	6			1	4		
Pharmacies are not available in some areas	1	2	1	1		5		1		
Emergency services are not available in some areas or are underdeveloped	1	5	2	5			1	2		
Transport services are underdeveloped or too costly		2	2	2	3	3		4		1
Distance from home to a hospital/clinic is too large and/or too costly					4	3	4	2	2	
The waiting time for being received by a specialist is very long	4	4	4	2	4	5	1	2	6	3
The waiting time for getting treatment or medication is very long	2	1	1	1	2	4		1	2	1
The waiting time for rehabilitation services is very long	1	2	2	2			2	2		
Insufficient competence of nurses or other medical staff						2				
Lack of interest or unprofessionalism of the doctor or medical staff		1	2			1	2	2	4	2
Discriminatory or inappropriate behaviour of medical staff										1
Lack of trust in doctors, nurses or medical staff		1	2	1	2	4	1		1	2
Lack of humanness of the staff	2		3	2	6		3			
Lack of money to pay the doctor	1	1	1	1	2					
Lack of money to pay the needed tests			4	2	2	2				1
Lack of money for out-of-pocket payments	1	4	4	3	2	2	1	2		
Low quality and effectiveness of medical services	5	4	4	5	2	2	4	6	3	5
High costs of medication	6	2	2	1		3	2	2	3	1
Poor equipment of public clinics/hospitals		4	3	3	4	6	3	4	2	4
Lack of accessibility and continuity of care	2		4	1	1	2	3			
Specialists of certain subspecialties are missing or insufficient		1		2		2				2

	Myocardial Infarction		Stroke		Cancer		Injuries		Diabetes	
Access barrierS	IW	KO	IW	KO	IW	KO	IW	KO	IW	KO
Low clinic/hospital capacity						2				
Others, please give details										1

Data: FES (2012-2013) *Performance of the Public Health-care System*. Notes: Lack of humanness of the staff: not treated well, disrespectful, not provided with explanations about disease and treatment. Low effectiveness of services: inappropriate waiting time, laboratory tests not reported promptly and correctly, poor working equipment, unclean and untidy hospital/clinic. Lack of accessibility and continuity of care: inappropriate number of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit. Others: socio-economic factor like weak health culture and incomplete living conditions. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

4.2 SIX MAJOR POLICY REFORM AREAS

Building on the research results four major policy reform areas can be identified for improving the performance of the public health-care system.

The need to better define, and evaluate, the costs of benefit packages

All eight countries provide, by the national law, comprehensive packages of health-care services. The major problem is that none of the studied health systems has the capacity to ensure the universal provision of such services. So, there is a need for more realistic packages of services. '(…) *defining a more realistic benefits package* will be a key strategy in ensuring financial sustainability. The commitment to fund both universal coverage and a truly comprehensive benefits package is unrealistic and unsustainable in many countries in the region. Despite political and technical difficulties and concerns about equity, countries may need to consider explicitly defining more limited entitlements to ensure that public revenues are targeted at the most cost-effective interventions and the poorest segments of society and protect public health.' (Figueras et al., 2004, p.15)

The need to develop prevention services

In most countries, there have been preventive programmes or singular preventive actions but their results have failed to meet the needs of the populations, therefore there is still much preventive work to do. The participation of the family doctors and specialists in the provision of the prevention services commences in most cases at the stage of administrating treatment, with no consideration to patient education.

The community nursing system, considered to be the most powerful "equalizer" in the health system is still largely unutilized in most countries. Despite efforts to develop primary care, access to adequate and holistic community health-care remains a challenge for certain segments of the population (low-income groups, residents of rural areas and small towns, Roma etc.).

The development of prevention services is even more necessary given the high level of avoidable mortality in the region. Patterns of preventable mortality call for strengthening of policies and their implementation (particularly for women) especially the continued development of both tobacco and alcohol policies. Thus, considerable progress could be made in reducing mortality further in these countries by targeting health-care services. By targeting we mean not only financing better the health system but also modernizing and enhancing the quality of health-care services.

The need to develop rehabilitation, palliative and long-term care services

Palliative, long-term and rehabilitation care are not sufficiently developed as parts of the health-care systems in the region. Most long-term care is provided in the family, and there are few resources available for informal carers.

The need to improve the financing of the public health-care systems

Public health-care systems in the region are underfinanced, primarily as a result of fiscal constraints. However, in some countries at least, under-financing is linked to the low priority that the governments accord to the health sector. So, political will is a major factor for improving the performance of public health-care systems.

The study shows that financing should not be only greater, but also better oriented towards capital investments in equipment and technology. The capital investment in secondary and tertiary care provision has varied from country to country, but generally has been lower compared with the investment that has taken place in primary care. As a general rule, high-technology equipment is available only in larger centres, whereas everyday low-technology medical equipment is missing or outdated in many areas, particularly in smaller medical facilities. Information technology is developing, but it is fragmented and uncoordinated in most studied countries.

The need for an effective human resource policy in health

In nearly all studied countries, the availability of all types of medical professionals is well below the European average. Planning of human resources has become a priority only in recent years, particularly in relation to mass out-migration of medical professionals. Many doctors and nurses have left medicine, and often the country, in search of better pay, working conditions and/or social recognition. The mobility of health professionals is a matter of concern, particularly because the most economically deprived regions were most affected by outflows.

However, the problem of shortages is not just related to the absolute number of doctors, but also their profile. In the deprived rural areas, the departure of even a few specialist doctors can produce a substantial effect on service delivery. Given that family medicine is one of the most demanded specialties in some EU countries, it is most likely that access inequalities to primary care services will increase even further if the emigration of family doctors continues and/or increases. Also, some specialties and skills at hospital level might be adversely affected.

Shortages of some specialties and skills are also reported in the studied countries - Croatia, Macedonia, Kosovo, Moldova, and are not necessarily related to health professional mobility.

The need to address informal payments in the public health-care system

The study shows that informal payments still represent an access barrier to state-of-the art treatment in particular in relation to chronic diseases. Thus, addressing informal payments must be a priority. Data on out-of-pocket payments suggest that they are widespread in both ambulatory and hospital care and in some countries they constitute a large source of funding. Informal payments are linked to cultural and historical factors, but primarily they represent a response to the poor capacity of the public health-care system to provide adequate access to basic services.

4.3 PËRFUNDIMET KRYESORE: FUSHAT MË TË RËNDËSISHME TË REFORMËS NË KUJDESIN SHËNDETËSOR PUBLIK NË VENDET E EJL

Studimi *"Performanca e Sistemit të Kujdesit Publik Shëndetsor"* analizon performancën e sistemit publik shëndetësor në Europën Juglindore, duke u përqendruar në nevojat e pacientëve në lidhje me pesë probleme shëndetësore: Infarkti i miokardit, Pika në tru, Kanceri, Plagët dhe Diabeti (tipi.2)

Objektivi i këtij studimi krahasues empirik ishte të ofronte disa pikëpamje cilësore mbi performancën e *pritshme* kundrejt asaj *aktuale* të sistemit publik shëndetësor me synimin për të nxjerrë në pah zonat kryesore të cilat kanë nevojë për ndërhyrje, në nivel Kombëtar dhe Europian. Studimi u përpilua me qëllimin për të ofruar infomacion mbi çështjet dhe temat që janë të vështira të identifikohen nëpërmjet metodave kërkimore cilësore. Si rrjedhojë, studimi mbështetet në teknikat e kërkimit cilësor dhe bashkon perspektivat e vëzhguesve të informuar në këtë fushë (1,006 intervista) dhe dëshmitarëve individualë (432 intervista).

Raporti përcjell një analizë të bazuar në kornizën e përbashkët analitike për të gjitha tetë vendet dhe përmbledh disa burime: OBSH, European HFA Database, të dhëna statistikore europiane, të marra nga databaza e Eurostat, Banka Botërore- Treguesit Botërorë të Zhvillimit; të dhëna kombëtare statistikore; informacione kombëtare të ofruara nga studimet e vendeve përkatëse.

4.3.1 Gjetjet kryesore

Aspektet social-demografike

Studimi mbulon tetë vende Europiane, tre nga të cilat janë vende anëtare të Bashkimit Europian dhe pesë të tjerë janë vende kandidate në fazat e hershme të procesit të anëtarësimit.

Megjithëse shumica e zhvillimeve kanë qenë specifike në varësi të këtyre shteteve për shkak të pikave të ndryshme të fillimit para tranzicionit, dhe qasjeve e përpjekjeve të ndryshme (politike si dhe ekonomike) mbi politikat sociale, vendet e përfshira në studim ndajnë disa tipare të përbashkëta dhe fusha ku nevojitet ndërhyrje.

Figura 38. Trendet social-demografike në tetë vendet e EJL

	BG	HR	RKS	MK	MD	ME	RO	SRB
Population at 1 Jan 2013 (in 1,000 persons)	7,285	4,262	1,794	2,062	3,559	623	20,057	7,182
Children <15 years trend	▼	▼	▲	▼	▼	▼	▼	▼
Children <15 years in total population	13%	15%	28%	17%	16%	19%	15%	14%
Population growth*	▼	▼	▲	▲	▼	▲	▼	▼
Fertility rate (after 1990)	▼	▼	▼	▼	▼	▼	▼	▼
Crude death rate (after 2000)	▲	▲	=	▲	▼	▲	▲	▲
Premature mortality rate	▲	▲	▲	▲	▲	=	▲	▲
Infant mortality (after 2000)	▼	▼	▼	▼	▼	▼	▼	▼
Life expectancy (after 1990)	▲	▲	=	▲	▲	▼	▲	▲
GDP per capita (after 2000)	▲	▲	▲	▲	▲	▲	▲	▲
GDP per capita compared to EU	47%	61%		35%	10%	43%	49%	35%
Human Development Index	High	Very high	High	High	Medium	High	High	High

Legjenda: Qelizat e kuqe tregojnë një trend negativ. Qelizat e gjelbërta tregojnë trendet pozitive. Qelizat me ngjyrë gri tregojnë qëndrueshmëri. Shigjetat me drejtim lart tregojnë rritjen, ndërsa ato me drejtim poshtë tregojnë uljen. Shënim:* Rritja e popullësisë së Kosovës ishte pozitive deri në vitin 2011 kur popullësia shënoi një rënie domethënëse nga 2,208 në 1,799 njerëz.

Në tetë vendet e përfshira në studim, standardi i përgjithshëm i jetesës i përllogaritur si PBB për frymë është rritur në mënyrë konstante që nga viti 1990, megjithatë ka mbetur mjaft poshtë nivelit të 28 vendeve anëtare të BE-së. Në bazë të një përkufizimi më të gjerë të mirëqenies (që mat arritjet mesatare në tre dimensione bazë të zhvillimit njerëzor- një jetë e gjatë dhe e shëndetshme, njohuri dhe një standard i përshtatshëm i jetesës) pjesa më e madhe e vendeve të analizuara i përkasin grupit të vendeve me një zhvillim të lartë njerëzor. Vetëm Kroacia vlerësohet me një nivel 'shumë të lartë' dhe Moldavia me një nivel 'mesatar'.

Pas vitit 1990, të gjitha vendet e Europës Juglindore përjetuan ndryshime të mëdha sociale të lidhura me tranzicionin në demokraci dhe ekonominë e tregut dhe/ose në luftë. Ndryshimet në kushtet social ekonomike kanë ndikuar në shëndetin e popullësisë në mënyrë të drejtpërdrejtë dhe nëpërmjet faktorëve psiko-socialë (Marmot dhe Wilkinson, 1999). Si në të gjitha vendet e ish Bashkimit Sovjetik, edhe vendet e përfshira në studim, përjetuan një krizë vdekshmërie në fillim të viteve 90-të. Që nga viti 2000, numri i fëmijëve nën moshën 15 vjeç ka rënë në të gjitha vendet e studiuara me përjashtim të Kosovës. Në vitin 2012, fëmijët nën moshën 15 vjeç përfaqësojnë 13% të popullësisë totale në Bullgari dhe 19% të popullatës totale të Malit të Zi.

Ritmet e rritjes së popullësisë shënuan vlera negative në Bullgari, Kroaci, Moldavi, Rumani dhe Serbi ndërkohë që në Kosovë, Maqedoni dhe Mal të Zi këto ritme kanë qenë positive. Rritja negative natyrale e popullësisë vjen kryesisht si rezultat i një rënieje afat-gjatë të fertilitetit dhe një rritje të nivelit të vdekshmërisë. Në të gjitha tetë vendet në studim, niveli i fertilitetit ka rënë që nga viti 1980; pika më e ulët është regjistruar në Moldavi, ndërkohë që në Malin e Zi, niveli i fertilitetit ka qenë i qendrueshëm që nga viti 2000. Të gjitha vendet përballen me nivele të larta të vdekshmërisë dhe një rritje të vdekshmërisë së parakohshme (përveç Malit të Zi).

Shëndeti i popullësisë në rajon në përgjithësi është përmirësuar që nga vitet 1970, ndërsa pritshmëria e jetëgjatësisë është rritur në gjashtë nga tetë vendet e përfshira në studim. Në 20 vitet e fundit, në pothuaj të gjitha vendet në studim, pritshmëria e jetëgjatësisë në lindje është rritur në vlera mes më pak se një vit në Moldavi, dhe me të paktën katër vjet në Rumani. Sidoqoftë, hendeku mes Bashkimit Europian dhe këtyre vendeve mbetet domethënës.

Si në vende të tjera Europiane, gratë jetojnë mesatarisht më gjatë se meshkujt. Në vitin 2011, hendeku ishte pothuaj 8 vjet, në Moldavi, 7 vjet në Bullgari dhe Rumani krahasuar me katër vjet në Kosovë dhe Maqedoni. Në shumë prej këtyre vendeve, meshkujt jo vetëm që kanë një pritshmëri të ulët të jetëgjatësisë, por jetëgjatësi më shëndet-pakët se femrat, Megjithatë në të gjitha vendet e përzgjedhura, numri mesatar i viteve të kaluara në shëndet të mirë është ndjeshëm më poshtë mesatares prej 70 vjetësh të 15 vendeve Europiane.

Nivelet e vdekshmërisë foshnjore janë në rënie që nga vitet 70. Megjithatë, në të gjitha vendet e përfshira në studim, nivelet e vdekshmërisë foshnjore kanë regjistruar vlera më të larta se mesatarja Europiane. Në vitin 2011, vetëm Mali i Zi dhe Kroacia (me një nivel prej respektivisht 4.4 dhe 4.7 për 1000 lindje) regjistruan nivele të vdekshmërisë foshnjore të krahasueshme me mesataren e Bashkimit Europian (3.9 për 1000). Në të gjashtë vendet e tjera, vdekshmëria foshnjore ishte më e larta, vecanërisht në Kosovë (13.1 per 1000 lindje) dhe Moldavia (11 për 1000 lindje).

Shkaqet kryesore të vdekjeve

Në vendet e Europës Juglindore të përfshira në studim, si dhe në të gjithë rajonin e Europës, sëmundjet infektive kanë një prevalencë të ulët për shkak të përmirësimit të vazhdueshëm të sistemit të vëzhgimit dhe të mbulimit të mirë të vaksinimit. Nga të gjitha vendet në studim, vetëm në Republikën e Moldavisë, sëmundjet infektive si HIV dhe tuberkulozi (TB) akoma përfaqësojnë shkaqet kryesore të sëmundshmërisë dhe vdekshmërisë për shkak të kapacitetit të pamjaftueshëm të sistemit për të identifikuar apo kundërpërgjigjurshpërthimit të sëmundjeve. Nga ana tjetër, sëmundjet jo

infektive (SJI) - sëmundjet kardiovaskulare (si pika në tru dhe ataku kardiak) tumorët, sëmundjet kronike respiratore dhe diabeti- përbëjnë pjesën më të madhe të vdekshmërisë globale: rreth 80% të vdekjeve. Në Europë, në vitin 2009 sëmundjet e sistemit të qarkullimit të gjakut përbëjnë pothuajse 50% të vdekjeve, në nivele më të larta tek meshkujt se femrat, ndjekur nga sëmundjet e kancerit (neoplazma) që përbëjnë 20% të vdekjeve, dhe shkaqe të jashtme të lëndimeve dhe helmimeve që përfaqësojnë 8% të vdekjeve. (OBSH, 2013a)

Vendet e Europës Juglindore të përfshira në studim (nuk ka të dhëna për Kosovën) ndjekin modelin Europian. Sëmundjet e qarkullimit të gjakut dhe neoplazma përfaqësojnë dy shkaqet kryesore të vdekjeve në të gjitha vendet në studim. Shkaku i tretë i vdekjeve për nga rëndësia ndryshon në bazë të vendeve duke nisur që nga shkaqe të jashtme të lëndimeve dhe helmimeve, në Bullgari dhe Kroaci, duke vazhduar me sëmundjet në sistemin respirator, në Bullgari, Mali i Zi dhe Serbi, dhe më pas me sëmundjet në sistemin tretës, në Moldavi dhe Rumani. Në të tetë vendet e EJL, barra e sëmundjeve jo infektive është shtuar.

Niveli i lartë sëmundjeve jo infektive është drejtpërdrejtë i lidhur me prevalencën e lartë të faktorëve të rrezikut. Përdorimi i duhanit, mungesa e aktivitetit fizik, dietë jo e shëndetshme ushqimore dhe përdorimi i dëmshëm i alkolit rrisin rrezikun ose shkaktojnë shumicën e SJI-ve.' Në shumicën e grupeve të sëmundjeve që shkaktojnë nivel të lartë të vdekshmërisë, sëmundshmërisë dhe paaftësisë (...) dy janë faktorët kryesore të rrezikut që kontribuojnë në rritjen e nivelit të sëmundjeve dhe duhen trajtuar me prioritet: duhanpirja dhe konsumi i dëmshëm i alkolit. Në perspektivën Europiane, prevalenca dhe nivelet e tyre mbeten të larta në të gjitha popullësitë, pavarësisht njohurive dhe teknologjive në dispozicion për të trajtuar të dyja' (OBSH, 2013a, fq. 40-41)

Pabarazitë në shëndetësi

Për sa i përket pabarëzive në shëndetësi dhe aksesit të barabartë në shërbimet e kujdesit shëndetësor, faktorët si të ardhurat, arsimi dhe statusi i punës kanë një impakt të lartë në statusin shëndetësor, vdekshmërinë dhe faktorët e rrezikut mes vendeve të Bashkimit Europian (Mladovsky et al., 2009). Në tetë vendet e studiuara, pabarazitë më të mëdha të shëndetit kanë lidhje me varfërinë, pengesat financiare, etniciteti (Rom) pengesat gjeografike ((në vecanti në disa zona rurale por edhe në disa rajone) dhe migrimi.

Financimi i sistemit shëndetësor

Shpenzimet e përgjithshme në shëndetësi variojnë nga 3% e PBB-së në Kosovë dhe 5.8% në Rumani[176] në 10.4% në Serbi dhe 11.4% në Republikën e Moldavisë (kundrejt mesatares të 28 vendeve Europiane prej 9.6% të PBB-së, sipas të dhënave të vitit 2011). Duket qartë që Moldavia, është vendi që shpenzon më shumë në këtë fushë. Megjithatë, për shkak të nivelit të PBB-së në terma absolutë, shpenzimet totale të shëndetësisë për frymë në Moldavi janë më të ulëtat (nuk ka të dhëna për Kosovën), pothuaj dy herë më të ulëta se në Maqedoni dhe Rumani, tre herë më të ulëta se në Bullgari, Mali i Zi dhe Serbi, dhe pothuaj katër herë më pak krahasuar me Kroacinë (shpenzuesi më i madh) duke përfaqësuar vetëm 12% të mesatares së 28 vendeve të Bashkimit Europian.

Ky variacion thelbësor në shpenzimet për shëndetësinë përkthehet në një ndryshim akoma më të madh në mbulimin e popullësisë me përfitime dhe, si rrjedhorë në një ndryshim më të madh të rezultateve në shëndetësi.

Konteksti fiskal[177]përfaqëson faktorin kryesor pas shpenzimeve të ulëta shëndetësore, duke qenë se shumica e vendeve në studim kanë nivele të përgjithshme shpenzimesh qeveritare më të ulëta se 40% e PBB-së kundrejt 47.9%

[176] Rumania reduktoi shpenzimet në shëndetësi në 4% të PBB-së në 2012, duke regjistruar kështu shpenzimin më të ulët në shëndetësi në të gjithë Europën

[177] Konteksti fiscal i referohet kapacitetit aktual dhe të pritshëm të shpenzimit të një qeverie. Vendet më të pasura kanë tendencën të jenë më efektive në mobilizimin e të ardhurave nga taksat dhe kështu kanë nivele më të larta të shpenzimeve publike në raport me PBB-në, ndërkohë që hapësira fiskale e kufizuar shoqërohet me shpenzimeve të ulëta qeveritare, edhe në shëndetësi.

e PBB-së së mesatares së Bashkimit Europian (me përjashtim të Malit të Zi dhe Serbisë ndërkohë që nuk ka të dhëna për Kosovën). Faktori i dytë për nga rëndësia i shpenzimeve të pakëta shëndetësore në rajon është prioriteti që qeveritë caktojnë për sektorin shëndetësor. Shpenzimet qeveritare në shëndetësi përbëjnë vetëm 8% të shpenzimeve totale qeveritare në Kosovë dhe më pak se 15% në Rumani krahasuar me 19-21% në Bullgari, Kroaci, Maqedonia and Mali i Zi (mesatarja e 28 vendeve Europiane), dhe pothuaj 23% në Serbi dhe deri në 29% në Moldavi.

Në shumicën e vendeve të përfshira në studim, pjesa më e madhe e shpenzimeve në shëndetësi (në raport me PBB-në) gjenerohet publikisht. Megjithatë, pagesat nga xhepi për shërbime shëndetësore tejkalojnë 40% të shpenzimeve totale shëndetësore në Moldavi, Bullgari dhe Kosovë.

Në të gjithë rajonin, arritja e një mbulimi universal për popullatat e margjinalizuara dhe të varfra, Romët, personat e zhvendosur brenda vendit apo njerëzit e rikthyer nërpërmjet një procesi ri-pranimi nga vendet e BE-së vazhdon të mbetet një sfidë kryesore. Në disa vende si Bullgaria, Maqedonia, Rumania dhe Serbia, vështirësitë e pajisjes me dokumenta identiteti dhe regjistrimi në një skemë sigurimi janë subjekt diskriminimi edhe ndaj popullësisë Rome tashmë në disavantazh të thellë (Zoon, 2001; Figueras dhe McKee, 2012). Kujdesi afatgjatë dhe kujdesi shëndetësor në shtëpi financiohen nga fonde të Bashkimit Europian (si në Bullgari) ose nga kontribute (si në Rumani) dhe mbeten një sfidë akoma e pa trajtuar në vendet e përfshira në studim (Genet et al., ed., 2012)

Në mënyrë që të sigurojnë qëndrueshmëri financiare nën presionin e pengesave fiskale, shumë prej vendeve synojnë ta kalojnë barrën në fjalë nga financim kolektiv në atë individual, edhe nërpërmjet inkurajimit të sigurimit privat vullnetar (edhe pse tregjet private mbeten të kufizuara) dhe/ose nëpërmjet rritjes së bashkë-pagesave, shpenzimeve të reduktueshme dhe shpërblimevetë pakërkuara.

Ofrimi i Kujdesit Shëndetësor

Për sa i përket qeverisjes dhe organizimit, në të gjitha vendet e studiuara me përjashtim të Kosovës, sistemet shëndetësore janë të organizuara në bazë të principeve të qasjes universal ndaj shërbimeve bazë, barazisë dhe solidaritetit në financimet e kujdesit shëndetësor. Sistemet shëndetësore përfshijnë një pëzierje të faciliteteve mjekësore publike dhe private, agjensi publike dhe autoritete të angazhuara në ofrim, financim, rregullim dhe administrim të shërbimeve shëndetësore. Funksionet rregulluese janë të përqendruara në Ministritë e Shëndetësisë të cilat në të njëjtën kohë mbledhin dhe analizojnë të dhëna dhe përcjellin informacione relevante duke kontribuar në zhvillimin e politikave të bazuara në fakte. Pothuaj të gjitha vendet e përzgjedhura promovojnë principin e Shëndetit në të Gjitha Politikat nëpërmjet bashkëpunimeve multi dhe ndër-sektoriale ndërkohë që Ministria e Shëndetësisë siguron koordinimin e aktiviteteve publike shëndetësore brenda dhe përtej sektorit.

Sistemi i ofrimit të sistemit të kujdesit shëndetësor organizohet nëpërmjet tre nivele: parësor, sekondar dhe terciar.[178]Ofruesit publikë dhe privatë të kujdesit shëndetësor publik dhe privatë mund të kontraktohen nga organizmat e Sigurimit Kombëtar Shëndetësor për ofrimin e shërbimeve mjekësore nën siguracionin shëndetësor të detyrueshëm.

Racionalizimi i stokut spitalor dhe prezantimi i strukturave të reja të menaxhimit në spitale kanë qenë pjesë e agjendës së reformave në Bullgari, Kroaci, Kosovë, Moldavi dhe Rumani. Shumë prej vendeve të përzgjedhura kanë trashëëguar objekte të shumta dhe personel të kujdesit shëndetësor nga epoka komuniste.

178 Sistemi i kujdesit parësor është rrjeti i objekteve të mjekësisë familjare. Objektet shëndetësore publike në nivel dytësor ofrojnë kujdes të specializuar në komunitet dhe i përkasin autoriteteve lokale. Objektet shëndetësore në nivel terciar përfshijnë instituticione kërkimore dhe mësimore që ofrojnë kujdes mjekësor të specializuar për të gjithë popullësinë. Një numër i lartë i shërbimeve paralele të kujdesit shëndetësor ofrohen gjithashtu nëpërmjet institucioneve publike mjekësore që i përkasin degëve të tjera qeveritare të financuara si nga buxheti i shtetit nërpërmjet ministrive respective, por mund të kontraktohen nëpërmjet organizmave të Sigurimit Shëndetësor Kombëtar.

Infrastruktura është reduktuar ndjeshëm, por në disa vende regjistrohen akoma një tepricë shtretërish. Në të gjithë rajonin, shërbimet spitalore janë të përqendruara në disa zona të caktuara, vecanërisht në qytete të mëdha dhe në kryeqytete. Përveç pabarazive të mëdha rajonale, problemi vjen nga një strukturë e papërshtatshme e kapaciteteve spitalore që nuk përputhet me nevojat e popullësisë në disa prej territoreve.

Në shumicën e vendeve të përfshira në studim, rrjeti i furnizimit farmaceutik ishte pothuaj i privatizuar plotësisht. Ekziston një mbipopullim të farmacive në zonat urbane ndërkohë që në zonat rurale, shënohet një mangësi farmacish ndonëse situate po përmirësohet në mënyrë graduale.

Indeksi Europian Shëndetësor i Konsumatorit 2013 tregon që vendet e Europës Juglindore kanë nevojë të përmirësojnë performancën e sistemeve të tyre shëndetësore në të gjitha fushat e studiuara: të drejtat e pacientëve dhe informimi, aksesi (kohët e pritjes për trajtim) rezultatet, gama dhe arritja e shërbimeve të ofruara, parandalimi si dhe shpërndarja e objekteve farmaceutike.

Perceptimi mbi performancën e sistemeve publike të kujdesit shëndetësor të EJL

Opinioni dominues mbi performancën e sistemeve shëndetësore në rajonet e Europës Juglindore është çështje polemikash mes profesionistëve në fushën e shëndetësisë. Së pari, opinioni dominues ndryshon gjërësisht nga një vend në tjetrin. Në Kroaci dhe Mali i Zi, shumica e ekspertëve të fushës së shëndetësisë janë të mendimit se sistemet kombëtare të shëndetësisë kanë një performancë të mirë sa i perket aksesibilietit, disponibilitetit dhe cilësisë së shërbimeve dhe kanë besimin e popullatës. Situata është e ndryshme në Kosovë, Moldavi dhe Rumani ku ekspertët në fushën e shëndetësisë janë të ndarë mes vlerësimeve negative dhe pozitive.

Së dyti, në të gjithë rajonin profesionistët e fushës së shëndetësisë nga zonar rurale e vlerësojnë performancën e sistemit si më të dobët se në zonat urbanë. Ky mendim reflekton edhe hendekun mes zonave urbale dhe rurale që është i dukshëm në statistikat dhe treguesit e gjendjes shëndetësore dhe ofrimit të kujdesit shëndetësor.

Së treti, performanca e sistemeve shëndetësore në rajonin e Europës Juglindore është ndjeshëm më e ulët në lidhje me disa grupe sëmundjes sic është kanceri.

Së katërti, vlerësimi varet nga profili i vlerësuesit. Si rrjedhojë, grupet e pacientëve janë shumë kritike, OJQ-të janë disi neutral (ose të ndara në mënyrë të barabartë mes qasjeve pozitive dhe negative), ndërkohë që mjekët specialist dhe përfaqësuesit e administrative (nga zonat kombëtare dhe rajonale të shëndetit publik) janë shumë pozitivë në vlerësimin e tyre ndaj performancës së sistemit. Ky hendek mes grupit të pacientëve dhe përfaqësuesve të sistemit është vecanërisht i nënvizuar në rastin e sëmundjeve terminale (siç është kanceri). Grupet e pacientëve përqendrohen më shumë në 'rastet e dëshpëruara'; të varfërit, komuniteti Rom ose grupe të tjera të ndjeshme të popullësisë të cilët kanë nevojë për ndihmë dhe mbështetje për të pasur qasje ndaj shërbimeve të përshtatshme shëndetësore. Krejt ndryshe mendojnë përfaqësuesit e sistemit të cilët përqendrohen në historitë e suksesit, tek profesionistët e fushës të cilët përpiqen të ofrojnë shërbimet më cilësore pavarësisht të gjitha pengesave serioze të të gjitha llojeve ose në përpjekjet për të ofruar kushtet minimale në kushtet e shkurtimeve domethënëse në personel dhe reduktimeve buxhetore.

Trajtimi i pesë problemeve të përzgjedhura shëndetësore në rajonin e EJL.

Sëmundjet e qarkullimit të gjakut (përfshirë infarktin e miokardit dhe pika në tru) dhe neoplazmat (kanceri) janë shkaqet kryesore të vdekjeve në vendet e EJL nën studim. Shkalla e vdekjeve nga infarkti i miokardit shënoi një rënie gjatë viteve të fundit, megjithatë mbetet më e lartë se mesatarja Europiane në vende si Kroacia, Rumania dhe vecanërisht në Moldavi. Vdekjet nga sëmundjet cerebrovaskulare kanë shënuar rënie gjatë viteve të fundit, por mbeten më të larta se mesatarja Europiane në tetë vendet e përfshira në studim.

Mes vitit 1990 dhe 2010, incidenca e kancerit u rrit ndjeshëm në të gjitha vendet e zgjedhura për të cilat ka të dhëna (nga OBSH). Ka ndryshime të mëdha në shkallën e përhapjes së kancerit në të gjitha vendet e EJL mes femrave dhe meshkujve. Incidenca e kancerit është më e lartë se mesatarja e 27 vendeve të BE-së, për meshkujt në Kroaci (462 për 100.000 banorë) dhe në Serbi (të dhënat përfshijnë Kosovën) për femrat (330 për 100.000 banorë). Gjashtë vendet e tjera regjistruan një incidencë në ulje të kancerit tek meshkujt dhe femrat, me nivelin më të ulët të regjistruar në Moldavi (323 përmeshkujtdhe 229 për femrat për 100,000 banorë). Megjithatë, vdekshmëria nga kanceri në të gjitha vendet e studiuara është e barabartë ose më e lartë se mesatarja e 27 vendeve të BE-së.

Shkalla e fatalitetit për shkak të lëndimeve shënoi ulje në vitet e fundit, por mbetet më e lartë se mesatarja e 28 vendeve të BE-së, në Kroaci, Rumani dhe vecanërisht në Moldavi. Në vendet për të cilat ekzistojnë të dhëna, vrasjet, aksidentet rrugore dhe rëniet janë tre shkaqet kryesore për plagë fatale. Vdekshmëria e shkaktuar nga diabeti është e barabartë ose më e lartë se mesatarja e 28 vendeve të BE-së, për shumë nga vendet e përfshira në studimme përjashtim të Rumanisë dhe Moldavisë. Shkalla më e lartë e vdekshmërisë e shkaktuar nga diabeti u regjistrua në Maqedoni, ndërkohë që më e ulëta u shënua në Rumani.

Politikat dhe Marrëveshjet Institucionale Kombëtare për trajtimin e pesë sëmundjeve janë aprovuar në pothuaj të gjitha vendet. Disponibiliteti i protokolleve dhe guidave për administrimin e sëmundjes, programeve kombëtare dhe/ose strategive kombëtare për secilin shtet ose problem shëndetësor tregohet në tabelën më poshtë me një "x"

Në rastin e sëmundjeve të qarkullimit të gjakut (infarkti i miokardit dhe pika në tru) në Kosovë, Maqedoni, Mali i Zi, Rumani dhe Serbi janë vendosur protokolle dhe guida për menaxhimin e sëmundjeve si dhe janë ngritur programme kombëtare ose strategji kombëtare. Në Republikën e Moldavisë ka një mungesë të politikave koherente dhe të qëndrueshme nga ana financiare për parandalimin, zbulimin, diagnostifikimin dhe trajtimin e infarktit të miokardit. Madje, që nga viti 2002, Moldavia nuk ka aprovuar ose zbatuar Programet Kokmbëtare për kontrollin e sëmundjeve kardiovaskulare.

Në Bullgari, Kroaci, Maqedoni, Moldavi, Rumani dhe Serbi janë ngritur Regjistra Kombëtarë për Kancerin ndërkohë që në Malin e Zi ato janë në fazën e zhvillimit. Vetëm në disa zona të këtyre shteteve, regjistrat në fjalë janë të integruar në programe më të zgjeruara onkologjike. Sidoqoftë, të gjitha shtetet (me përjashtim të Kosovës) kanë aprovuar dokumenta dhe ligje strategjike për kontrollin e duhanit, alkolit dhe abuzimit me drogat si dhe për sigurinë ushqimore (duke rregulluar sasitë maksimale të sheqerit, kripës, yndyrave të ngopura dhe aktivitete të ndryshme për ushqimet e prodhuara në mënyrë industrial, si dhe etiketimin e saktë të përbërjes ushqimore), të cilët janë të rëndësishme për parandalimin e karcinomës dhe kanë synimin kryesor për të reduktuar sëmundshmërinë dhe vdekshmërinë si rezultat i impaktit shkatërrimtar të sjelljeve të rrezikut. Informacioni publik, parandalimi dhe zbulimi i hershëm janë gjithsesi të zhvilluara në mënyrë të pamjaftueshme në rajon.

Në të gjitha shtetet, përgjegjësia për parandalimin e lëndimeve është e shpërndarë mbi një sërë sektorë politikash- në varësi të mjedisit ku ndodhin dhe rrethanave (në shtëpi, në vendin e punës, gjatë aktiviteteve të kohës së lirë dhe sporteve, në rrugë etj). Në vendet

	BG	HR	RKS	MK	MD	ME	RO	SRB
Infarkti i Miokardit			x	x		x	x	x
Pika në tru			x	x		x	x	x
Kancer	x	x		x	x		x	x
Lendimet	x	x	x	x	x	x	x	x
Diabeti		x		x	x		x	x

e përfshira në studim, Qeveritë kanë adoptuar strategji për sëmundjet kronike jo infective që mbulon zonën e lëndimit për shkak të rëndësisë që kanë këto lëndime duke u kthyer në pas në patologji kombëtare. Për më tepër, të gjitha shtetet kanë zhvilluar strategji kombëtare dhe strategji për sigurinë rrugore dhe/ose për parandalimin e përdorimit të drogës, përfshirë alkolin dhe duhanin, të cilat trajtojnë influencën e faktorëve të rrezikut në rritjen e incidenteve dhe prevalencës së lëndimeve. Megjithatë, në shumë prej vendeve, zbatimi i ligjit është i pakët.

Regjistrat Kombëtarë ose Programet Kombëtare për njerëzit e prekur nga diabeti gjenden në Kroaci, Maqedoni, Moldavi, Rumani dhe Serbi. Mali i Zi po themelon një Komision Kombëtar për Diabetin që do të zbatojë masat e nënvizuara në Strategjinë Kombëtare për Kujdesin Shëndetësor për Njerëz që Jetojnë me Diabetin.

Pengesat kryesore në qasjen e kujdesit publik shëndetësor dhe një trajtimi më cilësor

Katër janë aspektet e sistemeve të kujdesit shëndetësor që u përmenden si pengesa kryesore nëpasjen e një trajtimi cilësor për të gjitha problemet shëndetësore në të gjitha vendet:

(1) Njohuri e pakët dhe nivel i ulët informacioni si dhe mungesa e sjelljes parandaluese në lidhje me shëndetin.

Studimet kombëtare raportojnë një rënie të madhe të faktorëve të rrezikut për infarktin e miokardit, goditjen në tru, kancerin apo diabetin. Për shkak të nivelit të ulët të informacionit në dispozicion, shumë prej pacientëve nuk arrijnë të identifikojnë simptomat në kohë. Si rezultat, një numër i madh pacientësh mbeten të padiagnostikuar deri në një situatë fatale dhe të rrezikshme për jetën (infarkti i miokardit, pika në tru) apo sëmundja avancon me komplikacione (kancer, diabeti), në një kohë kur mundësia e marrjes së një trajtimi të përshtatshëm mjekësor nuk jep rezultate pozitive.

(2) Mjekët ose shërbimet mjekësore mungojnë në disa zona.

Zonat rurale apo të largëta (siç janë ishujt në Kroaci, apo fshatet malore në Kosovë dhe Rumani) në të gjitha vendet kanë një disavantazh në lidhje me qasjen ndaj shërbimeve shëndetësore bazë. Në këto zona, farmacitë mungojnë ose nuk kanë furnizime të mjaftueshme me medikamentet më të avancuara. Megjithatë, qasja e ulët ndaj farmacive është përmendur pak si një pengesë.

(3) Cilësia dhe efektiviteti i ulët shërbimeve mjekësore, në lidhje veçanërisht me (a) kohët e gjata të pritjes dhe (b) aparatura të pakëta në klinikat/spitalet publike.

Dëshmitarët individualë përpiqen të fokusohen në kohën e papërshtatshme të pritjes për disa shërbime të kujdesit shëndetësor, veçanërisht për tu takuar me një specialist. Vëzhguesit e informuar nga ana tjetër vënë theksin tek aparaturat e pamjaftueshme apo të vjetra.

(4) Shërbimet e specializuara janë të disponueshme vetëm në disa zona, ndërkohë që shërbimet e emergjencës nuk janë të zhvilluara mjaftueshëm në pesë nga tetë vende.

Qasja e pamjaftueshme ndaj shërbimeve të specializuara është përmendur gjithashtu si një pengesë në lidhje me tre probleme shëndetësore: infarkti i miokardit, pika në tru dhe kanceri.

Këto pengesa tregojnë nevojën për një financim më të mirë të sistemit shëndetësor: për më shumë staf mjekësor, zgjerim të rrjetit ekzistues të qendrave publike, aparatura më të mira dhe për mbulim më të gjërë gjeografik të shërbimeve mjekësore të specializuara.

Tabela 23. Pengesat në qasje në sistemin publik të kujdesit shëndetësor dhe trajtimin më të mirë sipas problemeve shëndetësore dhe të anketuarëve

Të anketuarit: DI – dëshmitarë individualëdheVI – vëzhgues të informuar

Tabela më poshtë paraqet numrin e vendeve ku elementët e mëposhtëm janë përmendur si pengesa në lidhje me një problem specifik shëndetësor.

	Infarkti i Miokar-dit		Pika në tru		Kancer		Plagët		Diabeti	
Pengesat në qasje	**IË**	**KO**	**IË**	**KO**	**IË**	**KO**	**IË**	**KO**	**IË**	**KO**
Vonesa në kontaktin e parë me një mjek.		3		4	6	5			3	1
Nivel informacioni dhe njohuri e pakët e popul-lësisë. Sjellja shëndetësore parandaluese është e rrallë		7		7	4	8		3	8	8
Mjekët ose shërbimet mjekësore mungojnë në disa zona.	2	6	2	6	3	6	1	6	2	6
Shërbimet e specializuara ofrohen vetëm në disa zona	1	4	4	6	6	7				
Shërbimet e specializuara gjenden kryesisht në spitale/klinika private ose jashtë shtetit.					1	1				
Njësitë/shërbimet e rehabilitimit mungojnë ose janë të pamjaftueshme në disa zona.	1	4	1	6			1	4		
Në disa zona nuk ka farmaci.	1	2	1	1		5		1		
Shërbimet e emergjencës nuk ofrohen në disa zona, ose janë të pazhvilluara.	1	5	2	5			1	2		
Shërbimet e transportit janë të pazhvilluara ose tepër të kushtueshme.		2	2	2	3	3		4		1
Distanca nga shtëpia tek spitali/klinika është shumë e madhe dhe/ose shumë e kushtueshme					4	3	4	2	2	
Koha e pritjes për të takuar një specialist është shumë e gjatë	4	4	4	2	4	5	1	2	6	3
Koha e pritjes për të marrë trajtim ose mjekim është shumë e gjatë	2	1	1	1	2	4		1	2	1
Koha e pritjes për shërbimet e rehabilitimit është shumë e gjatë.	1	2	2	2			2	2		
Kompetenca të pamjaftueshme të infermiereve apo stafit mjekësor.						2				
Mungesë interesi ose joprofesionalizëm të mjekëve ose stafit mjekësor		1	2			1	2	2	4	2
Sjellje diskriminuese ose e papërshtatshme e stafit mjekësor										1
Mungesa e besimit tek mjekët, infermieret dhe stafi mjekësor.		1	2	1	2	4	1		1	2
Mungesa e ndjenjës njerëzore tek stafi	2		3	2	6		3			
Mungesa e parave për të paguar doktorin.	1	1	1	1	2					
Mungesa e parave për të paguar analizat e nevojshme.			4	2	2	2				1
Mungesa e parave për pagesat nga xhepi	1	4	4	3	2	2	1	2		
Cilësi dhe efektivitet i ulët i shërbime mjekë-sore.	5	4	4	5	2	2	4	6	3	5
Kosto të larta mjekimi	6	2	2	1		3	2	2	3	1
Aparatura të pakëta të klinikave/spitaleve pub-like		4	3	3	4	6	3	4	2	4
Mungesja e qasjes dhe vazhdueshmërisë së kujdesit.	2		4	1	1	2	3			
Specialistë të disa nën-specialiteteve mungojnë ose janë të pamjaftueshëm		1		2		2				2
Kapacitet i ulët në klinika/spitale						2				
Të tjera, jep detaje										1

Të dhëna: FES (2012-2013) Performanca e Sistemit Publik të Kujdesit Shëndetësor.Shënime: Mungesa e ndjenjës njerëzore të stafit: trajtim jo i mirë, pa respekt, mos ofrimi i shpjegimeve për sëmundjen dhe trajtimin. Efektivitet i ulët i shërbimeve: kohë e papërshtatshme pritjeje, testet laboratorike nuk raportohen në mënyrë korrekte dhe me shpejtësi, aparatura jo funksionale, klinika/spitale të papastra dhe të çrregullta. Mungesa e qasjes dhe vazhdimësisë së kujdesit: numër i papërshtatshëm karrigesh në dhomë e pritjes, disponueshmërisë së shërbimeve të nevojshme në çdo orë, numri i stafit që performon të gjitha detyrat e nevojshme në çdo vizitë. Të tjera: faktorë social-ekonomikë si kulturë e pakët shëndetësore dhe kushte jetese jo të plota. Akronimet e shteteve: BG - Bullgaria, HR - Kroacia, RKS - Kosova, MK - Maqedonia, MD - Moldavia, ME –Mali i Zi, RO - Rumania, SRB - Serbia.

4.3.2 Gjashtë fusha kryesore tëpolitikave të reformave

Në bazë të rezultateve të kërkimit, gjashë janë fushat kryesore ku nevojiten politikat e reformave për të përmirësuar sistemin publik të kujdesit shëndetësor.

Nevoja për të përkufizuar dhe vlerësuar më mirë, kostot e paketave përfituese.

Tetë vendet në studim ofrojnë me ligj, paketa gjithëpërfshirëse të shërbimit të kujdesit shëndetësor. Problemi kryesor është se asnjë prej sistemeve shëndetësore në studim nuk ka kapacitetin për të siguruar ofrimin universal të shërbimeve të tilla. Ndaj, ekziston nevoja për paketa më realiste shërbimi. '(…) *përkufizimi i një pakete realiste përfitimesh* do të jetë një strategji kyçe në sigurimin e qëndrueshmërisë financiare. Angazhimi për të financuar mbulimin universal dhe një paketë me të vërtetë gjithëpërfshirëse nukështë realist dhe i qëndrueshëm në shumë vende të rajonit. Pavarësisht vështirësive politike dhe teknike si dhe shqetësimeve për pabarazinë, këto vende mund të kenë nëvojë të marrin në konsideratë përkufizimin eksplicit të të drejtave të kufizuara për të siguruar që të ardhurat publike shënjestrohen nëpërmjet ndërhyrjeve më të mira dhe efektive nga ana e kostove dhe nga segmentet më të varfëra të shoqërisë, si dhe për të mbrojtur shëndetin publik' (Figueras et al., 2004, f.15)

Nevoja për të zhvilluar shërbimet e parandalimit

Në shumicën e vendeve, ka patur programme parandalimi ose veprime parandaluese, por rezultatet e tyre nuk plotësuan nevojat e popullësisë, si rrjedhojë ka nevojë për më shumë punë parandaluese. Pjesëmarrja e mjekëve të familjes dhe ekspertëve në ofrimin e shërbimeve të parandalimit nis në fazën e administrimit të trajtimit, pa marrë në konsideratë arsimin e pacientit.

Sistemi i infermierisë së komunitetit, që konsiderohet si "barazuesi' më i fuqishëm në sistemin shëndetësor nuk është akoma në përdorim të gjërë në shumë vende. Pavarësisht përpjekjeve për të zhvilluar kujdesin parësor, qasja ndaj një kujdesi të përshtatshëm dhe holistik shëndetësor të komunitetit mbetet një sfidë për disa prej segmenteve të popullësisë (grupeve më të ardhura të pakëta, banorët e zonave rurale dhe qyteteve të vogëla, komunitetit Rom etj.).

Zhvillimi i shërbimeve të parandalimit është akoma më i nevojshëm duke konsideruar nivelin e lartë të vdekshmërisë së shmangshme në rajon. Modelet për shmangien e vdekshmërisë kanë nevojë për politika të forta dhe të zbatueshme (veçanërisht për gratë) dhe kryesisht për zhvillimin e vazhdueshëm të politikave kundër duhanit dhe alkolit. Në këtë mënyrë, mund të ketë progres të konsiderueshëm në reduktimin e mëtejshëm të vdekshmërisë në këto vende duke targetuar shërbimet e kujdesit shëndetësor. Me 'targetuar' nënkuptojmë jo vetëm financime më të mira të sistemit shëndetësor por edhe modernizim dhe zgjerim të cilësisë së shërbimeve të kujdesit shëndetësor.

Nevoja për të zhvilluar shërbimet e rehabilitimit, kujdesit paliativ dhe afatgjatë shëndetësor.

Kujdeset paliative, afatgjatë dhe të rehabilitimit nuk janë mjaftueshëm të zhvilluara si pjesë e sistemeve publike të kujdesit shëndetësor në

rajon. Shumë prej kujdesit afatgjatë ofrohet në familje, dhe personat që e ofrojnë atë kanë qasje të limituar të burimeve të nevojshme.

Nevoja për të përmirësuar financimin e sistemeve publike të kujdesit shëndetësor.

Sistemet publike të kujdesit shëndetësorë në rajon janë të financuara pak, si rezultat i pengesave të shumta fiskale. Megjithatë, të paktën në disa vende, nënfinancimi është i lidhur me prioritetet e ulëta që qeveritë vendosin ndaj sistemit shëndetësor. Ndaj, vullneti politik është një faktor kryesor për përmirësimin e sistemeve publike të kujdesit shëndetësor.

Studimi tregon se jo vetëm që financimi duhet të jetë më i madh, por edhe më i orientuar drejt investimeve kapitale në aparatura dhe teknologji. Investimi kapital në ofrimin e kujdesit sekondar dhe terciar varion nga vendi në vend, por në përgjithësi ka qenë më i ulët në krahasim me kujdesin parësor shëndetësor. Sipas një rregulli të përgjithshëm, aparaturat e teknologjisë së lartë gjenden në qendra të mëdha, ndërkohë që aparaturat mjekësore të një teknologjie më tëvjetër me përdorim të përditshëm mungojnë ose janë të vjetra, sidomos në subjekte më të vogla mjekësore.

Teknologjia e informacionit është në zhvillim, por në shumicën e vendeve të studiuara ajo është e fragmentuar dhe e pakoordinuar.

Nevoja për një politikë efektive të burimeve njerëzore në shëndetësi

Në pothuaj të gjitha vendet nën studim, qasja ndaj të gjithë mjekëve profesionistëve është nën mesataren europiane. Planifikimi i burimeve njerëzore është kthyer në prioritet vetëm gjatë viteve të fundit, veçanërisht në lidhje migrimin masiv të punonjësve profesionistë të mjekësisë. Shumë mjekë dhe infermiere janë larguar nga fusha e mjekësisë, por edhe nga vendi në kërkim të pagave më të mira, kushteve më të mira të punës dhe/ose njohjes sociale. Lëvizja e profesionistëve të shëndetësisë, është një çështje që shkakton shqetësim, veçanërisht sepse shumë prej rajoneve të privuara nga ana ekonomike janë më të ndikuar nga ky megrim.

Megjithatë, problemi i mangësive të profesionistëve të fushës nuk ka lidhje vetëm me numrin absolute të mjekëve por edhe me profilin e tyre. Në zonat e privuara rurale, largimi qoftë i vetëm disa specialistëve mund të ketë një impakt thelbësor në ofrimin e shërbimeve mjekësore. Duke qenë se mjekësia e familjes është një nga specialitetet më të kërkuara në disa prej vendeve të Bashkimit Europian, ka shumë gjasa që pabarazitë në qasjen ndaj shërbimeve të kujdesit parësor do të shtohen më tej nëse migrimi i mjekëve të familjes vazhdon dhe/ose rritet. Për më tepër, disa specialitete dhe aftësi në nivel spitalesh mund të përballen gjithashtu me një efekt negativ.

Mungesat e disa specialiteteve apo aftësive të fushës janë raportuar në vendet në studim –Kroacia, Maqedonia, Kosova, Moldavia dhe nuk janë domosdoshmërisht të lidhura me lëvizshmërinë e specialistëve shëndetsor.

Nevoja për të adresuar pagesat informale në sistemin publik të kujdesit shëndetësor.

Studimi tregon se pagesat informale akoma përfaqësojnë një pengesë në qasjen ndaj një trajtimi të mirë shëndetësor në lidhje me sëmundjet kronike. Si rrjedhojë, çështja e pagesave informale duhet të jetë një prioritet. Të dhëna mbi pagesat nga xhepi tregojnë se ato janë të përhapura gjerësisht në kujdeset spitalore dhe ambulatore dhe në shumë vende përbëjnë një burim të madh financimi. Pagesat informale janë të lidhura me faktorë kulturorë dhe historikë, por kryesisht përfaqësojnë një përgjigje ndaj kapacitetit të pakët të sistemit publik të kujdesit shëndetësor për të ofruar akses të përshtatshëm ndaj shërbimeve bazë.

4.4 NAJVAŽNIJI ZAKLJUČCI: OSNOVNE OBLASTI REFORME U SISTEMU JAVNOG ZDRAVLJA U ZEMLJAMA JUGOISTOČNE EVROPE

Studija Funkcionisanje sistema javnog zdravlja analizira funkcionisanje sistema javnog zdravlja u jugoistočnoj Evropi, fokusirajući se na potrebe pacijenata kada je reč o pet zdravstvenih tegoba: srčanom udaru, moždanom udaru, kanceru, povredama i dijabetesu (tip 2).

Cilj ove empirijske komparativne studije bio je da obezbedi kvalitativna saznanja o odnosu između očekivanog i stvarnog funkcionisanja sistema javnog zdravlja, sa ciljem da ukaže na osnovne oblasti koje zahtevaju intervencije kako na nacionalnom, tako i na evropskom nivou. Istraživanje je osmišljeno sa namerom da obezbedi informacije o temama i problemima koje je teško sagledati na osnovu kvantitativnih istraživačkih metoda. Ova studija se shodno tome oslanja na kvalitativne tehnike istraživanja i sažima stanovišta kako stručnih posmatrača (1.006 intervjua), tako i pojedinačnih svedoka (432 intervjua).

Izveštaj sadrži analizu zasnovanu na uobičajenom analitičkom okviru za svih osam zemalja i u skladu je sa različitim vrstama izvora: SZO, Evropska HFA baza podataka, evropski statistički podaci sakupljeni iz raznih baza podataka Eurostata, Svetske banke – indikatori svetskog razvoja; nacionalni statistički podaci; nacionalne informacije obezbeđene na osnovu studija u predmetnim zemljama.

4.4.1 Ključna otkrića

Sociodemografski aspekti

Studija pokriva osam evropskih zemalja, od kojih su tri članice Evropske unije, a pet su zemlje kandidati, koje se nalaze u ranim fazama procesa pridruživanja.

Iako je veći deo razvoja specifičan za svaku pojedinačnu zemlju usled različitih startnih pozicija u momentu započinjanja procesa tranzicije i različitih pristupa i napora (političkih i ekonomskih) koji su uloženi u socijalnu politiku, ispitane zemlje imaju neke zajedničke karakteristike i oblasti u kojima je potrebna intervencija.

Slika 38. Sociodemografski trendovi u osam zemalja jugoistočne Evrope

	BG	HR	RKS	MK	MD	ME	RO	SRB
Broj stanovnika 01.01.2013. (u 1.000)	7,285	4,262	1,794	2,062	3,559	623	20,057	7,182
Deca <15 godina trend	▼	▼	▲	▼	▼	▼	▼	▼
Deca <15 godina u ukupnoj populaciji	13%	15%	28%	17%	16%	19%	15%	14%
Porast broja stanovnika*	▼	▼	▲	▲	▼	▲	▼	▼
Stopa fertiliteta (posle 1990)	▼	▼	▼	▼	▼	▼	▼	▼
Opšta stopa mortaliteta (posle 2000)	▲	▲	=	▲	▼	▲	▲	▲
Stopa prevremene smrtnosti	▲	▲	▲	▲	▲	=	▲	▲
Stopa smrtnosti odojčadi (posle 2000)	▼	▼	▼	▼	▼	▼	▼	▼
Očekivani životni vek (posle 1990)	▲	▲	=	▲	▲	▼	▲	▲
BDP po glavi stanovnika (posle 2000)	▲	▲	▲	▲	▲	▲	▲	▲
BDP po glavi stanovnika u poređenju sa EU	47%	61%		35%	10%	43%	49%	35%
Indeks ljudskog razvoja	High	Very high	High	High	Medium	High	High	High

Legenda: Crvena polja označavaju negativne trendove. Zelena polja označavaju pozitivne trendove. Siva polja označavaju stabilnost. Strelice koje pokazuju naviše označavaju rast, dok strelice koje pokazuju naniže označavaju pad. Napomena: *Rast broja stanovnika Kosova bio je pozitivan do 2011, kada je zabeležen značajan pad broja stanovnika sa 2.208 na 1.799 hiljada stanovnika.

U svih osam zemalja koje su uključene u ovu studiju, opšti standard života, meren kao BDP po glavi stanovnika, je konstantno bio u porastu od 1990. godine, pri čemu je ostao značajno ispod nivoa zemalja EU-28. Prema široj definiciji dobrobiti (gde se mere prosečna dostignića u tri osnovne dimenzije ljudskog razvoja – dug i zdrav život, znanje i pristojan životni standard), većina zemalja u kojima je vršeno istraživanje, spada u grupu zamalja sa visokim ljudskim razvojem. Jedino je Hrvatska rangirana kao zemlja sa vrlo visokim, a Moldavija kao zemlja sa srednjim nivoom ljudskog razvoja.

Posle 1990. godine su sve zemlje jugoistočne Evrope iskusile značajne društvene promene povezane sa tranzicijom ka demokratiji i tržišnoj ekonomiji i/ili sa ratom. Promene u društveno-ekonomskim uslovima uticale su na zdravlje stanovništva bilo direktno bilo kroz psihosocijalne faktore (Marmot i Vilkinson, 1999). Kao i u većini zemalja bivšeg Sovjetskog Saveza sve zemlje uključene u ovu studiju iskusile su ranih devedesetih godina krizu u mortalitetu. Počev od 2000. godine udeo dece ispod 15 godina starosti opao je u svim zemljama u kojima je vršeno istraživanje, osim na Kosovu. U 2012. godini broj dece ispod 15 godina starosti činio je između 13% ukupnog broja stanovnika u Bugarskoj i 19% ukupnog broja stanovnika u Crnoj Gori.

Stopa rasta broja stanovnika je registrovala negativne trendove u Bugarskoj, Hrvatskoj, Moldaviji, Rumuniji i Srbiji, dok je na Kosovu, u Makedoniji i Crnoj Gori trend bio pozitivan. Negativan prirodni priraštaj je uglavnom rezultat dugoročnog opadanja fertiliteta uz istovremeni porast mortaliteta. U svih osam zemalja stopa fertiliteta je opadala od 1980. godine; najveći pad je registrovan u Moldaviji, dok je u Crnoj Gori stopa fertiliteta stabilna od 2000. Sve zemlje se suočavaju sa visokim stepenom mortaliteta i porastom stope prevremene smrtnosti (osim u Crnoj Gori).

Opšte zdravlje stanovnika u regionu se poboljšalo od sedamdesetih godina, pošto je očekivani životni vek porastao u šest od osam zemalja u kojima je vršeno istraživanje. U poslednjih dvadeset godina u skoro svim zemljama je očekivani životni vek u trenutku rođenja porastao u vrednostima koje se kreću od manje od jedne godine u Moldoviji do skoro četiri godine u Rumuniji. Uprkos tome, jaz između Evropske unije i ovih zemalja ostao je i dalje značajan.

Kao i u drugim evropskim zemljama, žene u proseku žive duže od muškaraca. U 2011. godini razlika je iznosila čak osam godina u Moldaviji, sedam godina u Bugarskoj u Rumuniji, u poređenju sa četiri godine na Kosovu i u Makedoniji. U većini zemalja muškarci ne samo da imaju kraći očekivani životni vek, već i kraći očekivani život u dobrom zdravlju, nego što je to slučaj kod žena. Ipak, u svim odabranim zemljama prosečan broj godina provedenih u dobrom zdravlju je daleko ispod proseka u zemljama EU-15, gde iznosi preko 70 godina života.

Stopa smrtnosti odojčadi se smanjuje od 1970-tih godina. Ipak, u svim zamljama u kojima je vršeno istraživanje, stopa smrtnosti odojčadi ukazuje na veće vrednosti nego što iznosi prosek Evropske unije. U 2011. godini je samo u Crnoj Gori i Hrvatskoj (sa stopama od 4,4 odnosno 4,7 na 1000) zabeležena stopa smrtnosti odojčadi, koja može da se poredi sa prosekom zemalja EU-28 (3,9 na 1000). Stopa smrtnosti odojčadi je kod ostalih šest zemalja bila mnog viša, naročito na Kosovu (13.1 na 1000) i u Moldaviji (11 na 1000).

Glavni uzroci smrti

U zemljama jugoistočne Evrope, koje su predmet ove studije, zarazne bolesti su malo zastupljene zahvaljujući neprestanom poboljšanju sistema kontrole i dobroj pokrivenosti imunizacijom. Među ispitanim zemljama samo su u Republici Moldaviji zarazne bolesti kao što su HIV i tuberkuloza i dalje reprezentativni uzroci oboljevanja i smrtnosti usled nedovoljnih kapaciteta sistema da otkrije i reaguje na njihovu pojavu.

Nasuprot njima, nezarazne bolesti – kardiovaskularne bolesti (kao što su srčani udar i moždani udar), kanceri, hronične respiratorne bolesti i dijabetes – zaslužne su za najveći udeo u globalnoj smrtnosti: one su uzrok smrti u skoro 80% slučajeva. U Evropi su u 2009.

godini bolesti kartiovaskularnog sistema bile uzrok 50% svih smrtnih slučajeva, gde je udeo muškaraca veći nego udeo žena, a njih prate kancer (neoplazme), kao uzročnik 20% svih smrtnih slučajeva, i eksterne povrede i trovanja, koji čine 8% svih smrtnih slučajeva. (SZO, 2013a)

Ispitane zemlje jugoistočne Evrope (nema dostupnih informacija za Kosovo) prate evropski šablon. Bolesti kardiovaskularnog sistema i neoplazme predstavljaju dva glavna uzročnika smrti u svih 8 zemalja. Treći glavni uzročnik smrti varira od zemlje do zemlje i kreće se od eksternih povreda i trovanja u Bugarskoj i Hrvatskoj do bolesti respiratornog sistema u Bugarskoj, Crnoj Gori i Srbiji, odnosno bolesti digestivnog trakta u Moldaviji i Rumuniji. U svih osam zemalja teret nezaraznih bolesti je sve teži.

Veliki teret nezaraznih bolesti je direktno povezan sa zastupljenošću faktora rizika. Uživanje duvana, fizička neaktivnost, nezdrava ishrana i štetno korišćenje alkohola povećavaju rizik za oboljevanje od nezaraznih bolesti ili predstavljaju direktni uzrok oboljevanja od njih. "Kada je reč o najvećim grupama bolesti koje su uzročnik visoke smrtnosti, oboljevanja i invaliditeta (...), dva glavna faktora rizika doprinose izbijanju više bolesti i stoga je potrebno prvenstveno se baviti njima: pušenje duvana i štetna konzumacija alkohola. Iz evropske perspektive njihova zastupljenost i nivo ostaju visoki u svim populacijama uprkos dostupnom znanju i tehnologiji koji su na raspolaganju za borbu protiv oba faktora" (SZO, 2013a, str. 40-41)

Nejednakosti koje vladaju u zdravstvu

Po pitanju nejednakosti koje vladaju u zdravstvu i ravnopravnog pristupa zdravstvenim uslugama, u zemljama Evropske unije faktori kao što su prihodi, obrazovanje i poslovni status imaju veliki uticaj na zdravstveno stanje, smrtnost i faktore rizika (npr. Mladovski i drugi, 2009). U svih osam izučavanih zemalja većina dispariteta u zdravstvu povezana je sa siromaštvom, finansijskim barijerama, etnicitetom (Romi), geografskim barijerama (prvenstveno u ruralnim područjima, ali i u drugim regionima) i migracijom.

Finansiranje zdravstvenog sistema

Ukupna odvajanja za zdravstvo značajno variraju između 3% BDP na Kosovu i 5,8% u Rumuniji[179] do 10.4% u Srbiji i 11.4% u Republici Moldaviji (u poređenju sa prosekom zemalja EU-28 koji iznosi 9,6% BDP, podaci za 2011). Prema ovim podacima izgleda da Moldavija najviše troši. Ipak, imajući u vidu BDP u apsolutnim iznosima, ukupna potrošnja na zdravstvo po glavi stanovnika je u Moldaviji najniža (bez podataka za Kosovo), i to skoro dva puta niža nego u Makedoniji i Rumuniji, skoro tri puta niža nego u Bugarskoj, Makedoniji i Srbiji, zatim skoro četiri puta niža nego u Hrvatskoj (gde se najviše troši), a predstavlja samo 12% proseka u zemljama EU-28. Ove suštinske varijacije u izdvajanju sredstava za zdravstvo za posledicu imaju velike varijacije u pokrivanju zdravstvenih usluga stanovništva i rezultiraju značajnim varijacijama u rezultatima u zdravstvu.

Fiskalni kontekst[180] je glavni uzročnik relativno niskih izdataka za zdravstvo, jer su u većini proučavanih zemalja ukupni državni izdaci manji od 40% BDP u poređenju sa prosekom u zemljama EU-28, koji iznosi 47,9% BDP (izuzeci su Crna Gora i Srbija; nema podataka za Kosovo). Drugi faktor za relativno mala odvajanja za zdravstvo u regionu je stepen prioriteta koji vlade dodeljuju zdravstvenom sektoru. Na izdvajanja za zdravstvo otpada samo 8% ukupnih vladinih izdataka na Kosovu i manje od 15% u Rumuniji, u poređenju sa 19-21% u Bugarskoj, Hrvatskoj, Makedoniji i Crnoj Gori (prosek EU-28), i skoro 23% u Srbiji, a čitavih 29% u Moldaviji.

U većini proučavanih zemalja, najveći deo izdataka za zdravstvo (posmatrano u odnosu na BDP) se javno obezbeđuje. Uprkos tome, pla-

[179] Rumunija je smanjila odvajanja za zdravstvo na samo 4% BDP 2012. godine i stoga spada među zemlje koje najmanje troše na zdravstvo u Evropi.

[180] Fiskalni kontekst se odnosi na trenutni i očekivani kapacitet potrošnje neke vlade. bogatije zemlje su najčešće efikasnije u mobilisanju prihoda od poreza i stoga imaju viši nivo javne potrošnje, posmatran kao udeo u BDP, dok je ograničeniji fiskalni prostor povezan sa manjim nivoom potrošnje vlade, uključujući i potrošnju za zdravstvo.

ćanja iz džepa za zdravstvene usluge prelaze 40% ukupnih izdataka za zdravstvo u Moldaviji, Bugarskoj i na Kosovu.

Univerzalna briga o marginalizovanoj siromašnoj populaciji, Romima, interno raseljenim licima ili licima koja su tokom procesa readmisije vraćena iz Evropske unije i dalje predstavlja glavni izazov u čitavom regionu. U nekim zemljama, kao što su Bugarska, Makedonija, Rumunija i Srbija, teškoće u dobijanju ličnih dokumenata i pri registraciji za zdravstveno osiguranje sistematski su diskriminisale Rome koji se već nalaze u izuzetno nepovoljnom položaju. (npr. Zoon, 2001; Figueras i Mekki, 2012) Dugotrajna nega i kućna nega se finansiraju iz fondova Evropske unije (kao što je slučaj u Bugarskoj) ili iz donacija (kao što je slučaj u Rumuniji) i predstavljaju i dalje izazov sa kojim se proučavane zemlje još nisu dosledno suočile. (Genet i drugi, ed, 2012)

U cilju obezbeđivanja finansijske održivosti pod pritiskom budžetskih prepreka većina zemalja je pokušala da prebaci teret sa kolektivnog finansiranja na indivudualno, bilo ohrabrivanjem privatnog dobrovoljnog osiguranja (iako privatno tržište ostaje ograničeno) i/ili povećanjem iznosa participacija i odbitaka, kao i bonusa kada ne dolazi do osiguranog slučaja.

Obezbeđivanje zdravstvenih usluga

S obzirom na upravljenje i organizaciju, u svim proučavanim zemljama, bez Kosova, zdravstveni sistem je organizovan po principu opšte dostupnosti osnovnih zdravstvenih usluga, jednakosti i solidarnosti u finansiranju zdravstva. Zdravstveni sistem uključuje mešavinu javnih i privatnih medicinskih ustanova, kao i javnih agencija i institucija, koje su uključene u pružanje, finansiranje, regulisanje i administriranje zdravstvenih usluga. Regularne funkcije su centralizovane u Ministarstvu zdravlja, koje takođe prikuplja i analizira podatke i generiše relevantne informacije, kako bi doprinelo razvoju politike zasnovane na podacima. Skoro sve odabrane zemlje promovišu princip "zdravlje u svim politikama" putem saradnje između i unutar sektora, a Ministarstvo zdravlja obezbeđuje koordinaciju aktivnosti iz oblasti javnog zdravlja unutar sektora i izvan njega.

Obezbeđivanje zdravstvenih usluga je organizovano u tri nivoa: primarnom, sekundarnom i tercijarnom.[181] Da bi pružali medicinske usluge koje pokriva obavezno zdravstveno osiguranje, i javni i privatni pružaoci zdravstvenih usluga moraju direktno da sklope ugovore sa nacionalnim organizacijama zdravstvenog osiguranja.

Racionalizacija bolničkih ustanova i uvođenje novih struktura upravljanja u bolnicama predmet je reformskih planova u Bugarskoj, Hrvatskoj, Moldaviji, Rumuniji i na Kosovu. Većina odabranih zemalja je nasledila brojne ustanove i zdravstvene radnike iz komunističke ere. Infrastruktura je značajno redukovana, ali u nekim zemljama i dalje postoji prevelika ponuda bolničkih ležajeva. U čitavom regionu su bolničke usluge koncentrisane u pojedinim regionima, naročito u većim gradovima i prestonicama. Osim zbog velike regionalne neujednačenosti problem postoji zbog neadekvatne strukture bolničkih kapaciteta, koja nije prilagođena potrebama stanovništva na pojedinačnim teritorijama.

U većini proučavanih zemalja mreža snabdevanja lekovima je skoro potpuno privatizovana. Postoji prevelika ponuda lekova u urbanim područjima, dok su u ruralnim područjima nestašice i dalje problem, iako se situacija vremenom poboljšala.

Evropski indeks kvaliteta rada zdravstvene službe u 2013. godini govori da sve zemlje jugoistočne Evrope treba da poprave rad svojih zdravstvenih sistema u svim posmatranim oblastima: prava pacijenata i pružanje infor-

[181] Primarni sistem zdravstvenih usluga čini mreža porodičnih medicinskih ustanova. Javne medicinske ustanove na sekundarnom nivou pružaju specijalizovane usluge društvu i pripadaju lokalnim javnim ustanovama. Medicinske ustanove na tercijarnom nivou uključuju istraživačke i obrazovne institucije koje pružaju i specijalizovanu i visokospecijalizovanu medicinsku negu čitavoj populaciji. Veliki broj paralelnih zdravstvenih usluga se obezbeđuje i preko javnih medicinskih institucija koje pripadaju drugim delovima vlade i finansiraju se iz državnog budžeta preko nadležnih ministarstava, ali mogu da imaju i ugovor sa nacionalnim organizacijama zdravstvenog osiguranja.

macija, dostupnost (vreme čekanja na medicinski tretman), ishodi, obim i domet pruženih usluga, prevencija, kao i distribucija lekova.

Percepcija funkcionisanja sistema javnih zdravstvenih usluga u jugoistočnoj Evropi

Dominantno mišljenje o funkcionisanju zdravstvenih sistema u regionu jugoistočne Evrope je protivrečno među zaposlenima u zdravstvu. Kao prvo, dominantno mišljenje veoma varira od zemlje do zemlje. U Hrvatskoj i Crnoj Gori većina zdravstvenih radnika naginje ka konstataciji da nacionalni sistemi zdravstva dobro funkcionišu po pitanju dostupnosti i kvaliteta usluga i da uživaju poverenje stanovnika. Nasuprot tome, na Kosovu, u Moldaviji i Rumuniji zdravstveni radnici su skoro podjednako podeljeni u pozitivnim i negativnim ocenama.

Kao drugo, u čitavom regionu zdravstveni radnici iz ruralnih područja uglavnom smatraju da sistem slabije funkcioniše nego u urbanim područjima. Ovo mišljenje reflektuje jaz koji postoji između ruralnih i urbanih oblasti, koji je vrlo uočljiv u statistikama i indikatorima zdravstvenog stanja i pružanja zdravstvenih usluga.

Kao treće, funkcionisanje zdravstenih sistema u regionu jugoistočne Evrope je značajno slabije kada su u pitanju određene grupe bolesti, kao što je kancer.

Kao četvro, procena zavisi i od profila procenitelja. Organizacije pacijienata imaju tendenciju da budu vrlo kritički nastrojene, nevladine organizacije su više neutralne (ili su skoro podjednako podeljena pozitivna i negativna stanovišta), pri čemu lekari specijalisti i predstavnici uprave (iz regionalnih i nacionalnih oblasti javnog zdravstva) imaju najpozitivniji stav po pitanju funkcionisanja sistema. Ovaj nesklad između organizacija pacijenata i predstavnika sistema je posebno izražen u slučaju terminalnih bolesti (kao što je kancer). Organizacije pacijenata se uglavnom fokusiraju na "beznadežne slučajeve"; siromašne Rome ili druge ranjive grupe ljudi, kojima je potrebna pomoć i podrška kako bi imali pristup odgovarajućim zdravstvenim uslugama. Nasuprot njima predstavnici sistema naginju ka tome da se fokusiraju na uspešno okončane slučajeve, na profesionalce u zdravstvu koji teže ka tome da pruže najsavremenije usluge pod teškim okolnostima najrazličitijih vrsta ili na napore u obezbeđivanju minimalnih uslova u situaciji značajnih rezova i restrikcija u budžetu.

Suočavanje sa pet odabranih zdravstvenih problema u regionu jugoistočne Evrope

Kardiovaskularne bolesti (uključujući srčane i moždane udare) i neoplazme (kancer) su glavni uzročnici smrti u zemljama jugoisočne Evrope, koje su bile predmet ove studije. Starosno standardizovana stopa smrtnosti od srčanih udara zabeležila je pad proteklih godina, pri čemu je ona i dalje iznad evropskog proseka u Hrvatskoj, Rumuniji, a pogotovo u Moldaviji. Smrtnost prouzrokovana kadriovaskularnim bolestima opala je proteklih godina, ali je u svih osam proučavanih zemalja i dalje veća od evropskog proseka.

Između 1990. i 2010. godine slučajevi kancera su značajno porasli u svim odabranim zemljama, za koje su postojali dostupni podaci (podaci SZO). Postoje velike varijacije u stopama kancera u zemljama jugoistočne Evrope, kako kod muškaraca, tako i kod žena. Slučajevi kancera su češći nego što iznosi prosek zemalja EU-27 i to u Hrvatskoj za muškarce (462 na 100.000 stanovnika), a u Srbiji (podaci uključuju Kosovo) za žene (330 na 100.000 stanovnika). U ostalih šest zemalja je zabeležen manji broj slučajeva kancera kako kod muškaraca, tako i kod žena (323 kod muškaraca i 229 kod žena na 100.000 stanovnika). Smrtnost od kancera je, međutim, u svim proučavanim zemljama bila ista ili viša od proseka zemalja EU-27.

Stopa povreda sa fatalnim ishodom zabeležila je pad proteklih godina, ali je u Hrvatskoj, Rumuniji, a posebno u Moldaviji i dalje viša od proseka zemalja EU-28. U zemljama za koje su podaci stajali na raspolaganju, samoubistva, saobraćajne neuzgode i padovi predstavljaju tri glavna uzroka povreda sa fatalnim ishodom. Smrtnost prouzrokovana dijabetesom je ista ili viša od proseka zemalja EU-28, osim u Rumuniji i Moldaviji. Najviša stopa smrtnosti prouzrokovana dijabetesom zabeležena je u Makedoniji, a najniža u Rumuniji.

	BG	HR	RKS	MK	MD	ME	RO	SRB
Srčani udar			x	x		x	x	x
Moždani udar			x	x		x	x	x
Kancer	x	x		x	x		x	x
Povrede	x	x	x	x	x	x	x	x
Dijabetes		x		x	x		x	x

Nacionalni institucionalni sporazumi i politika suzbijanja svih pet bolesti postoje u skoro zvim zemljama. Dostupnost protokola i uputstava za upravljanje ovim bolestima, nacionalnim programima ili nacionalnim strategijama po zemljama s obzirom na zdravstvene probleme prikazana je u donjoj tabeli i označena sa 'x'.

U slučaju kardiovaskularnih bolesti (srčani udar i moždani udar) protokoli i uputstva za upravljanje bolestima, nacionalni programi i/ili nacionalne strategije postoje na Kosovu, u Makedoniji, Crnoj Gori, Rumuniji i Srbiji. U Republici Moldaviji postoji manjak koherentne i finansijski održive politike prevencije, otkrivanja, dijagnostifikovanja i tretiranja srčanog udara, a od 2002. godine, Moldavija nije odobrila ili implementirala nacionalne programe kontrole kardiovaskularnih bolesti.

Nacionalni registri kancera su dostupni u Bugarskoj, Hrvatskoj, Makedoniji, Moldaviji, Rumuniji i Srbiji, a trenutno se razvijaju u Crnoj Gori. Samo u nekim delovima ovih zemalja ti su registri integrisani u šire onkološke programe. Ipak su sve zemlje (osim Kosova) usvojile strateška dokumenta i zakone o kontroli duvana, zloupotrebi alkohola i droga, kao i o bezbednosti namirnica (reguliše se maksimalna količina šećera, soli, zasićenih masti i različitih aditiva u industrijski proizvedenim namirnicama, kao i preciznije navođenje sastava namirnica na etiketama), što je važno za prevenciju karcinoma i ima ultimativni cilj da smanji stopu oboljevanja i smrtnosti kao posledice razornog uticaja rizičnog ponašanja. Informacije dostupne javnosti, prevencija i rano otkrivanje su ipak i dalje nedovoljno razvijeni u regionu.

U svim zemljama je odgovornost za prevenciju povreda rasuta na mnoštvo političkih sektora – u zavisnosti od okruženja i okolnosti u kojima se pojavljuju (kod kuće, na radnom mestu, tokom sportskih aktivnosti i aktivnosti u slobodno vreme, na putevima, itd). U proučavanim zemljama vlade su usvojile strategije za hronične nezarazne bolesti, koje pokrivaju oblast povreda, u zavisnosti od značaja samih povreda i njihove važnosti za nacionalnu patologiju. Osim toga sve zemlje su razvile nacionalne strategije i zakone o bezbednosti na putevima i/ili prevenciji zloupotrebe droga, uključujući alkohol i duvan, a koje su orijentisane ka uticaju faktora rizika na povećanje broja povreda i njihove zastupljenosti. U mnogim zemljama je, međutim, sprovođenje zakona prilično slabo.

Nacionalni registri ili nacionalni programi za osobe obolele od dijabetesa postoje u Hrvatskoj, Makedoniji, Moldaviji, Rumuniji i Srbiji. U Crnoj Gori treba da se ustanovi Nacionalna komisija za dijabetes koja će implementirati mere definisane nacionalnom strategijom za zdravstvenu brigu o ljudima obolelim od dijabetesa.

Glavne prepreke u javnom zdravstvu savremenom načinu lečenja

Za sve odabrane zdravstvene probleme u svim zemljama je navedeno da postoje četiri aspekta sistema zdravstva, koji predstavljaju glavne prepreke primeni savremenog načina lečenja:

(1) Nedovoljno znanje, nizak nivo obaveštenosti i nedostatak preventivnog zdravstvenog ponašanja.

Nacionalne studije izveštavaju o prilično visokom prisustvu faktora rizika za srčani udar, moždani udar, kancer ili dijabetes. Usled niskog nivoa dostupnosti informacija mnogi pacijenti ne prepoznaju svoje simptome na vreme. Zbog toga veliki broj pacijenata ostaje bez dijagnoze, sve dok ne dođe do situacije opasne po život (srčani udar, moždani udar) ili dok bolest ne uznapreduje sa komplikacijama (kancer, dijabetes), i do momenta kada mogućnost do-

bijanja odgovarajućeg medicinskog tretmana više ne donosi pozitivne rezultate.

(2) Lekar ili medicinske usluge nisu dostupni u nekim područjima

Ruralna područja i udaljeni regioni (kao što su ostrva u Hrvatskoj ili planinska sela na Kosovu i u Rumuniji) su u svim zemljama navedeni kao oblasti koje se nalaze u lošijem položaju s obzirom na pristup osnovnim medicinskim uslugama. Može da se desi da u ovim oblastima nema ni apoteka ili one nisu dovoljno snabdevene naprednijim terapijama. U svakom slučaju, nedovoljna dostupnost apoteka je mnogo ređe spominjana kao barijera.

(3) Loš kvalitet i efikasnost medicinskih usluga, posebno s obzirom na (a) dugo vreme čekanja i (b) lošu opremljenost javnih klinika/bolnica

Dok individualni svedoci naginju ka tome da se fokusiraju na neprimereno vreme čekanja na razne zdravstvene usluge, pogotovo kada se radi o prijemu kod lekara specijaliste, stručnjaci su skloni da naglasak stave na nedovoljna i/ili zastarela sredstva za rad.

(4) Specijalizovane usluge dostupne su samo u nekim oblastima, dok hitne usluge nisu dovoljno razvijene u pet od osam zemalja

Nedovoljan pristup specijalizovanim uslugama spomenut je kao barijera kada su u pitanju tri zdravstvena stanja: srčani udar, moždani udar i kancer.

Ove barijere govore o potrebi za boljim finansiranjem zdravstvenog sistema: za većim brojem medicinskog osoblja, za proširenjem postojeće mreže zdravstvenih ustanova, za boljom opremljenošću i takođe boljom geografskom pokrivenošću specijalizovanih medicinskih usluga.

Tabela 23. Barijere u javnom zdravstvu za pristup savremenim načinima lečenja po zdravstvenom problemu i ispitaniku

Ispitanici: IS – individualni svedoci i SP – stručni posmatrači

Tabela predstavlja broj zemalja u kojima su dati aspekti bili navedeni kao barijera za pristup s obzirom na specifičan zdravstveni problem.

	Srčani udar		Moždani udar		Kancer		Pov-rede		Dijabe-tes	
Barijera za pristup	**IS**	**SP**	**IS**	**SP**	**IS**	**SP**	**IS**	**SP**	**IS**	**SP**
Zakasneli prvi kontakt sa lekarom		3		4	6	5			3	1
Slabo znanje i loša informisanost stanovništva. Preventivno zdravstveno ponašanje nije uobičajeno.		7		7	4	8		3	8	8
Lekar ili medicinske usluge nisu dostupne u nekim oblastima	2	6	2	6	3	6	1	6	2	6
Specijalne usluge su dostupne samo u nekim područjima	1	4	4	6	6	7				
Specijalizovane usluge su dostupne uglavnom u privatnim bolnicama/klinikama ili izvan zemlje					1	1				
Institucije/usluge rehabilitacije nisu dostupne/ nema ih dovoljno u nekim područjima	1	4	1	6			1	4		
Apoteke nisu dostupne u nekim područjima	1	2	1	1		5		1		
Usluge za hitne slučajeve nisu dostupne u nekim područjima ili su nedovoljno razvijene	1	5	2	5			1	2		
Usluge transporta nisu dovoljne razvijene ili su previše skupe		2	2	2	3	3		4		1
Razdaljina od kuće do bolnice/klinike je prevelika i/ili previse košta					4	3	4	2	2	
Vreme čekanja na prijem kod specijaliste je vrlo dugo	4	4	4	2	4	5	1	2	6	3
Vreme čekanja na medicinski tretman ili lek je vrlo dugo	2	1	1	1	2	4		1	2	1
Vreme čekanja na usluge rehabilitacije je vrlo dugo	1	2	2	2			2	2		
Nedovoljna kompetentnost medicinskih sestara ili drugog medicinskog osoblja						2				
Nedostatak interesa ili neprofesionalnost lekara ili medicinskog osoblja		1	2			1	2	2	4	2
Diskriminatorsko ili neprilično ponašanje medicinskog osoblja										1
Nedostatak poverenja u lekare, medicinske sestre ili medicinsko osoblje		1	2	1	2	4	1		1	2
Nedostatak humanosti kod osoblja	2		3	2	6		3			
Nedostatak novca za plaćanje lekara	1	1	1	1	2					
Nedostatak novca za plaćanje potrebnih testova			4	2	2	2				1
Nedostatak novca za plaćanje iz džepa	1	4	4	3	2	2	1	2		
Loš kvalitet i efikasnost medicinskih usluga	5	4	4	5	2	2	4	6	3	5
Visoki troškovi lekova	6	2	2	1		3	2	2	3	1
Loša opremljenost javnih klinika/bolnica		4	3	3	4	6	3	4	2	4
Loša dostupnost i kontinuiranost zdravstvene nege	2		4	1	1	2	3			
Nedostaju specijalisti za određene subspecijalizacije ili ih nema dovoljno		1		2		2				2
Nedovoljan kapacitet klinika/bolnica						2				
Ostalo, molimo navedite detalje										1

Podaci: Fondacija Fridrih Ebert (2012-2013) Funkcionisanje sistema javnog zdravlja. Napomene: Nedostatak humanosti kod osoblja: nisu dobro tretirani, bez poštovanja, bez objašnjenja o bolesti i tretmanu. Loša efikasnost usluga: neprimereno vreme čekanja, laboratorijski testovi nisu izdavani promptno i pravilno, loša sredstva za rad, prljava i neuredna bolnica/klinika. Nedostatak dostupnosti i kontinuiranosti zdravstvene nege: nedovoljan broj stolica u čekaonici, dostupnost neophodnih usluga u svako doba dana, broj osoblja za obavljanje svih neophodnih zadataka prilikom posete. Ostalo: socioekonomski faktor kao što je loša zdravstvena kultura i nekompletni uslovi života. Skraćenice za države: BG - Bugarska, HR - Hrvatska, RKS - Kosovo, MK - Makedonija, MD - Moldavija, ME – Crna Gora, RO - Rumunija, SRB - Srbija.

4.4.2 Šest glavnih oblasti koje treba reformisati

Imajući u vidu rezultate istraživanja moguće je identifikovati šest oblasti u kojima je potrebno poboljšati funkcionisanje javnog zdravstvenog sistema.

Potreba za boljim definisanjem i procenjivanjem troškova paketa zdravstvenih usluga

Svih osam zemalja u skladu sa nacionalnim zakonodavstvom obezbeđuje sveobuhvatne pakete zdravstvenih usluga. Najveći problem je taj što nijedan od proučavanih zdravstvenih sistema nema dovoljno kapaciteta koji bi osigurali opšte obezbeđivanje tih usluga. Tako da postoji potreba za realističnijim paketima zdravstvenih usluga. '(…) definisanje realističnijih paketa zdravstvenih usluga predstavljaće ključnu strategiju u obezbeđivanju finansijske održivosti. Obavezivanje na finansiranje kako univerzalne pokrivenosti tako i zaista sveobuhvatnih paketa zdravstvenih usluga je nerealistično i neodrživo u mnogim zemljama regiona. Uprkos političkim i tehničkim teškoćama, kao i zabrinutosti zbog finansijskih sredstava, zemlje bi možda trebalo eksplicitno da definišu veća ograničenja prava, kako bi obezbedile da javni prihodi budu usmereni ka intervencijama kod kojih je odnos između troškova i efekta najbolji, kao i najsiromašnijim segmentima društva u cilju zaštite javnog zdravlja.' (Figueras i drugi, 2004, str. 15)

Potreba za razvojem preventivnih usluga

U mnogim zemljama postoje preventivni programi ili pojedinačne preventivne akcije, ali njihovi rezultati nisu odgovorili na potrebe stanovništva, tako da i dalje postoji velika potreba za preventivnim aktivnostima. Angažovanje porodičnih lekara i specijalista u obezbeđivanju preventivnih usluga u najvećem broju slučajeva započinje u fazi prepisivanja terapije, bez obzira na obrazovanje pacijenta.

Sistem zdravstvene nege u društvu, koja se smatra najmoćnijim "balansom" u zdravstvenom sistemu se u mnogim zemljama i dalje u velikoj meri ne koristi. Uprkos naporima da se razvije primarna zdravstvena zaštita, pristup adekvatnoj i holističkoj zdravstvenoj nezi i dalje ostaje izazov za pojedine segmente populacije (grupacije sa niskim primanjima, stanovnici ruralnih oblasti i malih gradova, Romi itd.).

Još je važnije pokloniti veliki značaj razvoju preventivnih usluga zbog visokog nivoa smrtnosti u regionu, koji bi se mogao izbeći. Modeli smrtnosti koja bi se mogla predupredити nalažu jačanje politike i njene implementacije (u prvom redu za žene), a pogotovo kontinuirani razvoj politike prema duvanu i alkoholu. Na taj način bi bilo moguće napraviti značajan progres u daljem smanjivanju mortaliteta u ovim zemljama, usmeravajući se na usluge zdravstvene zaštite. Kada govorimo o usmeravanju ne mislimo samo na bolje finansiranje zdravstvenog sistema, već i na modernizovanje i poboljšanje kvaliteta usluga zdravstvene zaštite.

Potreba za razvojem rehabilitacione i palijativne nege, kao i dugoročnih usluga zdravstvene nege

Palijativna, dugoročna i rehabilitaciona zdravstvena nega kao deo sistema zdravstvene nege, nije dovoljno razvijena u regionu. Dugoročnu negu najvećim delom obezbeđuje porodica i postoji mali broj resursa koji stoji na raspolaganju za neformalne negovatelje.

Potreba za poboljšanjem finansiranja javnih sistema zdravstvene zaštite

Javni sistemi zdravstvene zaštite u regionu nisu finansirani u dovoljnoj meri, što je u prvom redu posledica budžetskih prepreka. U nekim je zemljama, međutim, nedovoljno finansiranje povezano sa niskim prioritetom koji vlade dodeljuju zdravstvenom sektoru. Tako da je politička volja glavni faktor za poboljšanje funkcionisanja javnih sistema zdravstvene zaštite.

Studija pokazuje da finansiranje ne samo da bi trebalo da postoji u većem obimu, već bi takođe trebalo bolje da bude orijentisano ka kapitalnim investicijama u opremu i tehnologiju. Kapitalne investicije u obezbeđivanju sekundarne i tercijarne nege variraju od zemlje do zemlje, ali su one uopšteno niže ako se uporede sa investicijama koje se preduzimaju u sektoru primarne nege. Kao opšte pravilo može se konstatovati da je visokotehnološka oprema dostupna samo u većim centrima, dok svakodnevna niskotehnološka medicinska oprema nedostaje ili je zastarela u mnogim oblastima, naročito u manjim medicinstim ustanovama. Informaciona tenologija se nalazi u razvoju, ali je rascepkana i nekoordinisana u većini zemalja koje su bile predmet istraživanja.

Potreba za delotvornom kadrovskom politikom

U skoro svim izučavanim zemljama dostupnost svih vrsta medicinskih profesionalnih stručnjaka je prilično ispod evropskog proseka. Kadrovsko planiranje je postalo prioritet tek nedavno, posebno u kontekstu masovne emigracije medicinskih stručnjaka. Mnogi lekari i medicinske sestre su napustili svoj posao, a često i zemlju, u potrazi za boljom platom, boljim uslovima rada i/ili društvenim priznanjem. Mobilnost profesionalnih zdravstvenih radnika je od značaja, pogotovo što su regioni koji su se u ekonomskom pogledu nalazili u drugom planu, najviše pogođeni odlascima.

Problem nedostatka stručnjaka ipak nije povezan samo sa apsolutnim brojem lekara, već i sa njihovim profilom. Imajući u vidu da je porodična medicina jedna od najtraženijih specijalnosti u nekim zemljama Evropske unije, vrlo je verovatno da će se početne nejednakosti po pitanju primarne nege i dalje produbljivati, ukoliko se nastavi ili poveća emigracija porodičnih lekara. To će takođe negativno uticati na pojedine specijalnosti i veštine na bolničkom nivou.

Takođe je izveštavano o nedostatku nekih specijalnosti i veština u proučavanim zemljama – Hrvatskoj, Makedoniji, Kosovu, Moldaviji i one nisu obavezno povezane sa mobilnošću zdravstvenih stručnjaka.

Potreba bavljenjem neformalnim plaćanjima u javnom zdravstvenom sektoru

Studija je pokazala da neformalna plaćanja i dalje predstavljaju prepreku za pristup modernim medicinskim tretmanima pogotovo kada se radi o hroničnim bolestima. Shodno tome bavljenje neformalnim plaćanjima bi trebalo da postane prioritet. Podaci o plaćanjima iz džepa govore o tome da su ona raširena kako u sferi ambulantne, tako i u sferi bolničke nege, a u nekim zemljama predstavljaju veliki izvor finansiranja. Neformalna plaćanja su povezana sa kulturnim i istorijskim faktorima, ali u prvom redu predstavljaju odgovor na slabe kapacitete javnog sistema zdravstvene nege za obezbeđivanje adekvatnog pristupa osnovnim uslugama.

4.5 Основни заключения: Най-важните области на реформите в общественото здравеопазване в държавите от ЮИЕ

Изследването *Функциониране на системата на общественото здравеопазване* анализира функционирането на системите на общественото здравеопазване в Югоизточна Европа, като насочва вниманието си върху потребностите на пациентите във връзка с пет здравни проблема: инфаркт на миокарда, удар, рак, травми и диабет /тип 2/.

Целта на настоящото емпирично сравнително изследване бе да се осигури качествена представа за *очакваното* функциониране на системата на общественото здравеопазване сравнено с действителното такова, за да се посочат най-важните области, които изискват намеса както на национално, така и на европейско равнище. Изследването е разработено с оглед предоставяне на информация по теми и въпроси, които трудно се улавят посредством количествени методи на изследване. Т.е. изследването разчита на качествени изследователски способи и събира гледните точки както на посветени наблюдатели (1 006 интервюта), така и на отделни свидетели (432 интервюта).

Докладът предлага анализ на базата на общоприета аналитична рамка за всички осем държави и използва многобройни източници: базата данни на СЗО „European HFA", европейски статистически данни от различни бази данни на Евростат, Световната банка – световните показатели за развитие; национални статистически данни; национална информация, съдържаща се в проучвания за отделните страни.

4.5.1 Основни констатации

Социо-демографски аспекти

Изследването обхваща осем европейски държави, три от които – членки на ЕС, а останалите пет – кандидати за членство в началните стадии на процеса на присъединяване.

Макар че по-голямата част от събитията са специфични за отделната държава поради различната стартова позиция преди прехода, както и различните подходи и усилия /както политически, така и икономически/, положени за социалните политики, изследваните държави имат някои общи черти и сфери за намеса.

Фигура 1. Социо-демографски тенденции в осем държави от ЮИЕ

	BG	HR	RKS	MK	MD	ME	RO	SRB
Население към 1.01.2013 (в хил.души)	7,285	4,262	1,794	2,062	3,559	623	20,057	7,182
Деца <15 години - тенденция	▼	▼	▲	▼	▼	▼	▼	▼
Дял на децата <15 г. от цялото население	13%	15%	28%	17%	16%	19%	15%	14%
Прираст на населението*	▼	▼	▲	▲	▼	▲	▼	▼
Коефициент на плодовитост (след 1990)	▼	▼	▼	▼	▼	▼	▼	▼
Смъртност (след 2000)	▲	▲	=	▲	▼	▲	▲	▲
Преждевременна смъртност	▲	▲	▲	▲	▲	=	▲	▲
Детска смъртност (след 2000)	▼	▼	▼	▼	▼	▼	▼	▼
Продължителност на живота (след 1990)	▲	▲	=	▲	▲	▼	▲	▲
БВП на глава от населението (след 2000)	▲	▲	▲	▲	▲	▲	▲	▲
БВП на гл.от нас. в сравнение. с ЕС	47%	61%		35%	10%	43%	49%	35%
Индекс на човешкото развитие	High	Very high	High	High	Medium	High	High	High

Легенда: Клетките в червено сочат отрицателна тенденция. В зелено – положителна тенденция. В сиво – без промяна. Стрелките нагоре сочат увеличение, надолу – намаление. Забележка: *Нарастването на населението в Косово бе положително до 2011, когато бе отбелязано значително намаление от 2 208 хил. на 1 799 хиляди души.

Във всички осем държави, включени в настоящото изследване, общият стандарт на живот, измерен като БВП на глава от населението, бележи непрекъснато нарастване от 1990 г. насам, но все пак остава значително под нивото на 28те членки на ЕС. Според по-широката дефиниция на благосъстоянието (която отчита средните достижения по три основни измерения на човешкото развитие – дълъг и здрав живот, знания и достоен стандарт на живот) повечето от изследваните държави се числят към групата на държавите с високо човешко развитие. Единствено в Хърватия то се оценява като "много високо", а Молдова – „средно".

След 1990, всички държави от ЮИЕ преживяват огромни социални промени, свързани с прехода към демокрация и пазарна икономика и/или към война. Промените в обществено-икономическите условия засягат здравето на населението както пряко, така и посредством психологически фактори (Marmot and Wilkinson, 1999). Подобно на повечето от републиките от бившия Съветски съюз, всички обхванати в изследването държави преминаха през криза на смъртността в началото на 90-те години на миналия век. От 2000 година насам относителният дял на децата под 15-годишна възраст е намалял във всички държави, с изключение на Косово. През 2012 г. децата под 15 годишна възраст съставляват между 13% от общото население в България и 19% от общото население в Черна гора.

Процентът на прираст на населението бележи отрицателни стойности в България, Хърватия, Молдова, Румъния и Сърбия, докато в Косово, Македония и Черна гора той е положителен. Отрицателният естествен прираст на населението основно е резултат от продължителното намаляване на коефициента на плодовитост, наред с увеличаване на смъртността. Във всички осем държави коефициентът на плодовитост спада от 1980 г. насам; най-голям е спадът в Молдова, а в Черна гора коефициентът на плодовитост остава стабилен от 2000 година насам. Всички държави са изправени пред висок коефициент на смъртност и нарастващ коефициент на преждевременна смъртност /с изключение на Черна гора/.

В региона здравето на населението като цяло се е подобрило от 70-те години на миналия век, тъй като продължителността на живота се е увеличила в шест от осемте изследвани държави. През последните двадесет години в почти всички изследвани страни продължителността на живота при новородените е увеличена със стойности между по-малко от една година в Молдова и почти четири години в Румъния. Въпреки това обаче разликата между ЕС и тези държави остава значителна.

Подобно на други европейски държави, жените живеят по-дълго от мъжете. През 2011 г. разликата е съществена – осем години в Молдова, седем в България и Румъния, в сравнение с четири години в Косово и Македония. В повечето държави мъжете не само имат по-малка продължителност на живота, но и по-кратък период от живота, през който се радват на добро здраве, в сравнение с жените. Въпреки това във всички подбрани държави средният брой години в добро здраве е значително по-малък, отколкото средните стойности в ЕС-15, които са над 70 години.

От 70-те години на миналия век намалява детската смъртност. Въпреки това обаче във всички проучвани държави коефициентът на детска смъртност бележи стойности, по-високи от средните за ЕС. През 2011 г. само Черна гора и Хърватия /с нива от съответно 4,4 и 4,7 на 1000/ отбелязват коефициент на смъртност, сравним със средния от ЕС-28 (3,9 на 1000). За другите шест държави коефициентите на детска смъртност са значително по-високи, особено в Косово (13,1 на 1000) и Молдова (11 на 1000).

Основни причини за настъпване на смърт

В изследваните държави от ЮИЕ, подобно на целия европейски регион, заразните заболявания се срещат рядко, което е в резултат на постоянното усъвършенстване на системите за наблюдение и доброто имунизационно покритие. От тях единствено в Република Молдова заразни болести от типа на HIV и туберкулоза (ТВ) все още представляват сериозни причини за заболеваемост и смъртност, което се дължи на недостатъчния капацитет на системата да установява и реагира на огнищата на зараза.

За разлика от тях, незаразните болести (NCD) – сърдечно-съдови заболявания (напр. сърдечни инфаркти и мозъчни удари), рак, хронични

респираторни заболявания и диабет – имат най-голям дял за смъртността в глобален план: близо 80% от смъртните случаи. В Европа през 2009 г. болестите на кръвоносната система са причинители на близо 50% от всички случаи на смърт с по-високи стойности сред мъжете, отколкото сред жените, следвани от раковите заболявания (неоплазма), с 20% от смъртните случаи, и външни причинители на травми и отравяния, на които се дължат 8% от всички смъртни случаи. (СЗО, 2013а)

Изследваните държави от ЮИЕ /за Косово няма данни/ следват европейската матрица. Заболяванията на кръвоносната система и неоплазмите представляват първите два основни фактора на смъртност във всичките осем държави. Третият основен фактор е различен в различните държави – от външно причинени травми и отравяния в България и Хърватия, до заболяванията на дихателните пътища в България, Черна гора и Сърбия, съответно заболявания на храносмилателната система в Молдова и Румъния.Във всички осем държави се увеличава делът на незаразните болести.

Високият дял на незаразните болести е пряко свързан с широкото разпространение на рискови фактори. Тютюнопушенето, заседналият живот, нездравословното хранене и злоупотребата с алкохол увеличават риска и причиняват най-често срещаните незаразни заболявания. „Що се касае до основните групи заболявания, причиняващи висока смъртност, заболеваемост и инвалидност (...), два основни фактора на риска водят до различни заболявания и остават важен приоритет за разрешаване: тютюнопушенето и вредната употреба на алкохол. От европейска гледна точка тяхното разпространение е все още голямо сред всички популации въпреки познанията и наличните технологии за справяне и с двете". (СЗО, 2013а, стр. 40-41)

Неравенство в здравеопазването

По отношение неравенството в здравеопазването и справедливия достъп до здравни услуги факторите като доход, образованост и статус на заетост имат голямо въздействие върху здравния статус, смъртността и рисковите фактори в страните от ЕС (Mladovsky et al., 2009). В осемте изследвани държави основната неравнопоставеност в системата на здравеопазване е свързана с бедността, финансовите бариери, етноса /роми/, географските бариери и миграцията.

Финансиране на системата на здравеопазване

Общите разходи за здравеопазване варират значително – от най-малките 3% от БВП в Косово и 5,8% в Румъния[182] до 10,4% в Сърбия и 11,4% в Република Молдова (сравнено със средна стойност за ЕС-28 от 9,6% от БВП по данни за 2011 г.). Така Молдова изглежда, че харчи най-много. Въпреки това обаче, поради нивото на БВП в абсолютни стойности, общите разходи за здравеопазване на глава от населението в Молдова са най-ниски /няма данни за Косово/, почти два пъти по-ниски, отколкото в Македония и Румъния, близо три пъти по-ниски, отколкото в България, Черна гора и Сърбия и около четири пъти по-ниски в сравнение с Хърватия (която харчи най-много за здравеопазване), което съставлява едва 12% от средната стойност за ЕС-28. Тези значителни различия по отношение разходите за здравеопазване се превръщат в значителни различия по отношение обхвата на услугите за населението, което води до големи различия в здравния резултат.

Фискалният контекст[183] представлява основен двигател на относително малките разходи за здравеопазване, тъй като повечето изследвани страни имат нива на държавни разходи, които са под 40% от БВП в сравнение със средното за ЕС-28 – 47,9% от БВП (изключение правят Черна гора и Сърбия, данни за Косово няма). Вторият фактор за относително ниските разходи за здравеопазване в региона е приоритетът, с който правителствата разглеждат сектора

182 Румъния съкрати разходите за здравеопазване на само 4% от БВП през 2012, с което регистрира едни от най-ниските разходи за здравеопазване в Европа.

183 Фискалният контекст се отнася за настоящите и очаквани възможности на правителството да реализира разходи. По-богатите държави съумяват да бъдат по-ефективни за мобилизиране на приходите от данъци, с което имат по-високи нива на държавни разходи като дял от БВП, като по-ограниченото фискално пространство се свързва с малки държавни разходи, включително за здравеопазване.

здравеопазване. Държавните разходи за здравеопазване съставляват едва 8% от общите държавни разходи в Косово и по-малко от 15% в Румъния, в сравнение с 19-21% в България, Хърватия, Македония и Черна гора (средни стойности за ЕС-28), и почти 23% в Сърбия и даже 29% в Молдова.

В повечето изследвани държави по-голямата част от разходите за здравеопазване (като част от БВП) се акумулират от държавни средства. Въпреки това обаче плащанията от джоба на пациента за здравно обслужване надвишават 40% от общите разходи за здравеопазване в Молдова, България и Косово.

В целия регион огромно предизвикателство продължават да бъдат постигането на универсално покритие за маргинализираните бедни слоеве на населението, ромите, вътрешно разселените лица или лицата, завърнали се по домовете си чрез реадмисия от държавите от ЕС. В някои държави като България, Македония, Румъния и Сърбия затрудненията за издаване на лични документи и регистрацията в здравно-осигурителни схеми системно дискриминират така и така сериозно уязвимото ромско население. (виж Zoon, 2001; Figueras and McKee, 2012) Дългосрочните грижи и домашният патронаж се финансират от европейски фондове (като напр. в България) или от дарения (в Румъния) и продължават да бъдат предизвикателство, което все още не е намерило своето решение в изследваните държави. (Genet et al., ed., 2012)

За гарантиране на финансова устойчивост под натиска на фискални ограничения, повечето държави прибягват до пренасочване на тежестта от колективното финансиране към отделния индивид, било то като стимулират частното доброволно здравно осигуряване (макар че частният пазар продължава да бъде ограничен) и/или посредством увеличено самоучастие и удръжки за здравни осигуровки и бонуси за неползвалите здравните си застраховки.

Предоставяне на здравни услуги

По отношение управлението и организацията, във всички изследвани държави с изключение на Косово, системите на здравеопазване са организирани съобразно принципите за универсален достъп до основни здравни услуги, равенство и солидарност при финансиране на здравеопазването. Системите на здравеопазване включват един микс от държавни и частни заведения, както и държавни агенции и власти, имащи отношение към предоставянето, финансирането, регулирането и администрирането на здравните услуги. Регулаторните функции са централизирани в министерствата на здравеопазването, където също се събират и анализират данни и се генерира съответната информация, насочена към разработването на политики на базата на доказателства. Почти всички избрани държави прокламират принцип на „Здраве чрез всички политики" по пътя на много- и интердисциплинарното сътрудничество, като Министерството на здравеопазването гарантира координирането на дейностите за осигуряване на обществено здраве в рамките на своя сектор и извън него.

Системата за здравеопазване е организирана на три нива: първично, вторично и третично.[184] Както държавните, така и частните доставчици на здравно обслужване могат да сключват договори пряко с националните здравноосигурителни каси за предоставяне на медицинско обслужване по линията на задължителното здравно осигуряване.

Рационализирането на болничната материална база и въвеждането на нови структури на управление са включени в дневния ред на реформите в България, Хърватия, Косово, Молдова и Румъния. Повечето от избраните страни наследиха многобройни заведения и здравен персонал от комунистическата епоха. Инфраструктурата бе значително редуцирана, но в

184 Системата за първична грижа е мрежа от семейни лекари. Държавните медицински заведения на вторично ниво предлагат специализирани грижи на обществеността и се числят към местните държавни власти. Медицинските заведения на третично ниво включват изследователски и университетски институти, които предлагат също специализирани и високо специализирани медицински грижи за цялото население. Голям брой паралелни медицински услуги се предлагат от държавни медицински институции, собственост на други клонове на държавното управление, които се финансират от държавния бюджет чрез съответните министерства, но също имат възможност да сключват договори с националните здравноосигурителни каси.

някои държави броят на леглата продължава да бъде ненужно висок. В целия регион болничното обслужване е съсредоточено в определени райони, особено в по-големите градове и столиците. Наред с големите разлики от район до район, проблемът се корени в неадекватната структура на болничния капацитет, който не е съобразен с нуждите на населението в конкретни населени райони.

В повечето от изследваните държави аптечната мрежа не е изцяло приватизирана. В градовете има изобилие от аптеки, докато в селските райони все още има проблем с дефицит, макар и ситуацията постепенно да се подобрява.

Euro Health Consumer Index 2013 сочи, че всички държави от ЮИЕ следва да подобрят функционирането на своите системи на здравеопазване във всички разглеждани области: пациентски права и информация, достъпност (време за чакане за лечение), резултати, обхват и покритие на предоставяните услуги, превенция, както и разпространение на лекарствени средства.

Възприемано функциониране на системите на държавно здравеопазване в държавите от ЮИЕ

Доминиращото мнение за функционирането на системите за здравеопазване в региона на ЮИЕ е всъщност въпрос на противоречия между професионалистите в здравната област. Първо, доминиращото мнение се различава значително в различните държави. В Хърватия и Черна гора повечето специалисти в здравната област са склонни да смятат, че националните системи за здравеопазване работят добре в смисъл на достъпност, наличие и качество на услугите, и че се ползват с доверието на населението. За разлика от тях в Косово, Молдова и Румъния специалистите в здравната област са разделени почти поравно между положителните и отрицателни оценки.

Второ, в целия регион професионалистите в здравната област от селските райони оценяват функционирането на системата като много по слабо, отколкото в градските райони.Това мнение е резултат на различията между града и селото, които са много отчетливи в статистиката и показателите за здравния статус и предлагането на здравни услуги.

Трето, функционирането на системите на здравеопазване в региона на ЮИЕ е значително по-нерезултатно по отношение на определени групи заболявания, като например рак.

Четвърто, оценката зависи и от профила на оценяващия. Така пациентските организации са склонни да бъдат много критично настроени, НПО са по-скоро неутрални (или почти поравно разделени между положително и отрицателно отношение), докато специализираните лекари и представители на ръководствата (както на регионално, така и на национално равнище на обществено здравеопазване) са най-положително настроени по отношение функционирането на системата. Тези различия между пациентските организации и представителите на системата са особено изразени в случаите на нелечимите заболявания (например рак). Пациентските организации насочват вниманието върху „безнадеждните случаи"; бедните; ромите или други уязвими групи, които се нуждаят от подкрепа за достъпа си до подходяща здравна грижа. За разлика от тях представителите на системата са склонни да насочват вниманието върху истории на успеха, върху представителите на здравни професии, които се стараят да предлагат най-съвременни услуги в условията на сериозни ограничения от всякакво естество или върху усилията за гарантиране на минимални условия на фона на значително орязване на средствата и бюджетен дефицит.

Справяне с петте избрани здравни проблема в региона на ЮИЕ

Болестите на кръвоносната система (включително инфаркт на миокарда и удар) и неоплазмите (рак) са основните причинители на смърт в изследваните държави от ЮИЕ. Възрастово стандартизирания коефициент на смъртност от инфаркт на миокарда бележи спад през изминалите години, но все пак остава по-висок, отколкото средните европейски стойности в Хърватия, Румъния и особено в Молдова. Смъртността от сърдечно-съдови заболявания бележи спад през последните години, но остава по-висока от средната за Европа във всички осем изследвани страни.

В периода 1990-2010 заболеваемостта от рак се увеличи значително във всички избрани държави, за което има налични данни (данни на СЗО). Има големи различия в процента на ракови заболявания в различните държави от ЮИЕ, както при мъжете, така и при жените. Заболеваемостта от рак е по-висока от средната за ЕС-27 в Хърватия при мъжете (462 на 100 000 души население) и в Сърбия (данните включват и Косово) при жените (330 на 100 000 души население). Другите шест държави отчитат по-ниска заболеваемост от рак както при мъжете, така и при жените, като най-ниски стойности са регистрирани в Молдова (323 при мъжете и 229 при жените на 100 000 души население). Въпреки това обаче, смъртността от рак е същата или по-висока от средната за ЕС-27 във всички изследвани държави.

Смъртните случаи, дължащи се на травми, бележат намаление през последните години, но остават по-високи от средните за ЕС-28 в Хърватия, Румъния и особено в Молдова. В държавите, за които има данни, самоубийствата, пътните инциденти и паданията са трите основни причини за фатални травми. Смъртността в резултат на диабет е същата или по-висока от средната в ЕС-28 за повечето изследвани държави, с изключение на Румъния и Молдова. Най-висока смъртност в резултат на диабет е отчетена в Македония, а най-ниска – в Румъния.

Налице са национални институционални решения и политики за справяне с всичките пет болести в почти всички държави. Съществуването на протоколи и указания за управление на болестта, национални програми или национални стратегии в отделните държави за дадената болест е отбелязано с x в таблицата по-долу.

В случая на болестите на кръвоносната система (инфаркт на миокарда и удар), протоколи за управление на болестта, национални програми или национални стратегии има установени в Косово, Македония, Черна гора, Румъния и Сърбия. В Република Молдова отсъстват последователни и финансово устойчиви политики за превенция, установяване, диагностициране и лечение на инфаркт на миокарда и от 2002 г. насам Молдова не е одобрявала или изпълнявала национални програми за контрол върху сърдечно-съдовите заболявания.

Национални регистри на раковите заболявания има в България, Хърватия, Македония, Молдова, Румъния, Сърбия, а в Черна гора се изработват в момента. Само в отделни части на тези държави тези регистри са интегрирани в по-широкообхватни онкологични програми. Всички държави обаче (с изключение на Косово) са приели стратегически документи и закони за контрол на тютюнопушенето, злоупотребата с алкохол и наркотици, както и за безопасност на храните (регулиращи максималното съдържание на захар, сол, наситени мазнини и други добавки в индустриално произвежданите храни, както и по-коректно етикетиране на съставките на храните), които са важни за превенция на карциноми и имат за крайна цел намаляване на заболеваемостта и смъртността като последствия на унищожителното влияние на рисковото поведение. Публичната информация, превенция и ранно установяване на заболяванията обаче все още не са достатъчно развити в региона.

Във всички държави отговорността за превенция на травми е доста разпокъсана върху най-различни сектори на политики – в зависимост от мястото и обстоятелствата, при които възникват, (в домашни условия, на работното място, на почивка и при спортни дейности, по пътищата и др.). В изследваните държави правителствата са приели стратегии за хроничните незаразни болести, които обхващат зоната на травмата, в резултат на важността на травмите за националните патологии. Освен това

	BG	HR	RKS	MK	MD	ME	RO	SRB
Инфаркт на миокарда			x	x		x	x	x
Удар			x	x		x	x	x
Рак	x	x		x	x		x	x
Травми	x	x	x	x	x	x	x	x
Диабет		x		x	x		x	x

всички държави са разработили национални стратегии и законодателство за безопасно движение по пътищата и/или превенция на злоупотребата с наркотици, включващи тютюн и алкохол, които ограничават влиянието на рисковите фактори върху увеличаването на заболеваемостта и разпространението на травмите. Въпреки това обаче, в много държави правоприлагането е доста слабо.

Национални регистри или национални програми за хората, страдащи от диабет, има в Хърватия, Македония, Молдова, Румъния и Сърбия. В Черна гора предстои да бъде създадена Национална комисия за диабета, която ще изпълнява мерките, начертани в Националната стратегия за здравеопазване на хората, живеещи с диабет.

Основни бариери пред достъпа до съвременно лечение в общественото здравеопазване

Четири бяха аспектите на системите на здравеопазване, които бяха споменати като основни бариери пред достъпа до съвременно лечение при всички избрани здравни проблеми във всички държави:

Слаба запознатост и ниско ниво на информираност, и отсъствие на поведение, ориентирано към ранна профилактика.

Националните изследвания отчитат доста високо ниво на рискови фактори за инфаркт на миокарда, удар, рак или диабет. Поради ниското ниво на достъпна информация, много пациенти не разпознават симптомите си навреме. Така голям брой пациенти не биват диагностицирани докато не настъпи фатална животозастрашаваща ситуация (инфаркт на миокарда, удар) или болестта не се развие с усложнения (рак, диабет), когато възможността да се получи подходящо медицинско лечение не дава положителен резултат.

В някои райони няма доктор или медицинско обслужване

Селските райони и отдалечени краища (като островите в Хърватия или планинските села в Косово и Румъния) във всички държави се отчитат като ощетени по отношение достъпа до базисно медицинско обслужване. В тези райони може да няма и аптеки, или те да са не достатъчно добре заредени с по-съвременни лекарствени средства. Въпреки това обаче лошият достъп до аптеки много по-рядко бе споменаван като бариера пред достъпа.

Лошо качество и ефективност на медицинското обслужване, особено що се касае до (a) дълго време за чакане и (b) лошо оборудване в обществените клиники/болници

Докато отделните свидетели са склонни да насочват вниманието към неприемливо дълго време за чакане за различните здравни услуги, особено за преглед при специалист, посветените наблюдатели са склонни да поставят ударението върху недостатъчното и/или морално остаряло работно оборудване.

Специализираните услуги са налице само в отделни райони, а спешната медицинска помощ не е достатъчно развита в пет от осемте държави

Недостатъчният достъп до специализирани услуги бе посочван като бариера във връзка с три заболявания: инфаркт на миокарда, удар и рак.

Тези бариери сочат необходимост от по-добро финансиране на системата на здравеопазване: от повече медицински персонал, от разширяване на съществуващата мрежа от държавни здравни заведения, от по-добро оборудване и също от по-добро географско покритие на специализираните медицински услуги.

Таблица 1. Бариери пред достъпа до съвременно лечение в общественото здравеопазване по заболяване и респонденти

Респонденти: ОС – отделни свидетели и ПН – посветени наблюдатели

Таблицата дава броя на страните, в които даден аспект е споменат като бариера пред достъпа при конкретно заболяване.

	Инфаркт на миокарда		Удар		Рак		Травми		Диабет	
Бариери пред достъпа	ОС	ПН	ОС	ПН	ОС	ПН	ОС	ПН	ОС	ПН
Късен първи контакт с доктор		3		4	6	5			3	1
Слаба запознатост и ниво на информираност на населението. Отсъства поведение, ориентирано към ранна профилактика.		7		7	4	8		3	8	8
В някои райони няма доктор или медицинско обслужване	2	6	2	6	3	6	1	6	2	6
Само в отделни райони има специализирано обслужване	1	4	4	6	6	7				
Специализирано обслужване има предимно в частни болници/клиники или в чужбина					1	1				
Няма/недостатъчно рехабилитационни звена в някои райони	1	4	1	6			1	4		
В някои райони няма аптеки	1	2	1	1		5		1		
В някои райони няма или не е достатъчно развита спешната медицинска помощ	1	5	2	5			1	2		
Не достатъчно развити или прекалено скъпи транспортни услуги		2	2	2	3	3		4		1
Разстоянията между дома и болницата/ клиниката са прекалено дълги и/или прекалено скъпи					4	3	4	2	2	
Времето за чакане при специалист е много дълго	4	4	4	2	4	5	1	2	6	3
Времето за чакане за лечение или получаване на лекарствени средства е много дълго	2	1	1	1	2	4		1	2	1
Времето за чакане за рехабилитация е много дълго	1	2	2	2			2	2		
Недостатъчна компетентност на сестрите или на останалия медицински персонал						2				
Липса на заинтересованост или непрофесионализъм на доктора или на медицинския персонал		1	2			1	2	2	4	2
Дискриминационно или неподходящо поведение на медицинския персонал										1
Липса на доверие към докторите, сестрите или медицинския персонал		1	2	1	2	4	1		1	2
Липса на хуманност от страна на персонала	2		3	2	6		3			
Липса на пари да се плати на доктора	1	1	1	1	2					
Липса на пари да се плати за необходимите изследвания			4	2	2	2				1
Липса на пари за плащане от джоба на пациента	1	4	4	3	2	2	1	2		
Лошо качество и ефективност на медицинското обслужване	5	4	4	5	2	2	4	6	3	5
Висока цена на лекарствата	6	2	2	1		3	2	2	3	1
Лошо оборудване на държавните клиники/ болници		4	3	3	4	6	3	4	2	4
Липса на достъп и приемственост на лечението	2		4	1	1	2	3			
Липсват или не са достатъчни специалистите по определени под-специалности		1		2		2				2
Малък капацитет на клиниките/болниците						2				
Друго, моля посочете подробности										1

Данни: ФФЕ (2012-2013) Функциониране на държавната система на здравеопазване. Забележки: Липса на хуманност от страна на персонала: не се отнасят добре с пациента, неуважително, не дават разяснения за заболяването и лечението. Лоша ефективност на обслужването: необосновано дълго време за чакане, лабораторните изследвания не се отчитат навреме и правилно, лошо работно оборудване, нечиста и разхвърляна болница/клиника. Липса на достъп и приемственост на обслужването: неподходящ брой столове в чакалнята, наличие на услугите по всяко време, бройката на персонала за всички необходими манипулации при всяко посещение. Други: обществено-икономически фактор като слаба здравна култура и оскъдни условия на живот. Съкращения на държавите: BG - България, HR - Хърватия, RKS - Косово, MK - Македония, MD - Молдова, ME – Черна гора, RO - Румъния, SRB - Сърбия.

4.5.2 Шест основни области на реформи в политиките

На база резултатите от изследването могат да бъдат очертани шест основни области на реформи в политиките с оглед подобряване функционирането на системата на общественото здравеопазване.

Нужда от по-добро дефиниране и оценка на цената на пакетите от услуги

Според националното си законодателство всичките осем държави предлагат цялостни пакети от здравни услуги. Основният проблем е, че никоя от изследваните системи на здравеопазване няма капацитета да гарантира универсалното предоставяне на тези услуги. Следователно, необходимо е да има по-реалистични пакети от услуги. „(…)дефинирането на по реалистичен пакет от услуги ще бъде ключова стратегия за гарантиране на финансова устойчивост. Ангажиментът за финансиране както универсалното покритие и един наистина всеобхватен пакет от услуги е нереалистично и неустойчиво в много държави в региона. Въпреки политическите и технически трудности и опасения по отношение равнопоставеността, държавите може би трябва да обмислят една експлицитна дефиниция на по-ограничен обхват на безплатните услуги, като държавните средства се насочат към най-рентабилните интервенции и най-бедните сегменти от обществото и защитата на общественото здраве.' (Figueras et al., 2004, p.15)

Нужда от изграждане на профилактични услуги

В повечето държави има профилактични програми или еднократни профилактични акции, но резултатите от тях не отговарят на нуждите на населението, поради което предстои много работа по профилактиката. Участието на семейните лекари и специалисти в предлагането на профилактични услуги започва в повечето случаи на етап назначаване на лечение, без да се отчита образователното ниво на пациента.

Системата на общинската сестра се счита за най-мощния балансьор в системата на здравеопазване, но до голяма степен тя не се използва в повечето държави. Въпреки усилията за развитие на първичната гриж, достъпът до адекватно и холистично обществено здравеопазване продължава да бъде предизвикателство за определени сегменти от населението (групи с ниски доходи, живеещи в селски региони и малки градове, роми и пр.).

Развитието на профилактичните услуги е още по-наложително предвид високото ниво на предотвратима смъртност в региона. Матриците на предотвратима смъртност налагат укрепване на политиките и тяхното прилагане (особено по отношение на жените) особено на политиките по отношение на тютюна и алкохола. Така може да се осъществи значителен напредък за намаляване смъртността в тези държави, като вниманието се насочи към здравните услуги. Под насочване на вниманието имаме предвид не само по-добро финансиране на системата на здравеопазване, но и модернизиране и повишаване качеството на здравните услуги.

Нужда от развиване на рехабилитацията, палиативните и дългосрочни услуги

Палиативните, дългосрочните и рехабилитационните грижи не са достатъчно развити като част от системите на здравеопазване в региона. Повечето дългосрочни грижи се полагат в семейството и ресурсите за неформални болногледачи са ограничени.

Нужда да се подобри финансирането на системите на общественото здравеопазване

Системите на общественото здравеопазване в региона са недостатъчно финансирани, преди всичко в резултат на фискални ограничения. Въпреки това в някои държави поне недостатъчното финансиране е свързано с ниския приоритет, който правителствата отреждат на здравния сектор. Така политическата воля е съществено важен фактор за по-доброто функциониране на системите на общественото здравеопазване.

Изследването сочи, че финансирането трябва да бъде не само по-мащабно, но и по-добре насочено към капиталовложения в оборудване и технологии. Капиталовложенията във вторичната и третична грижа се различават в различните държави, но като цяло са по-малки в сравнение с инвестициите, които са направени в първичната грижа. Като общо правило високотехнологичното оборудване е налице само в по-големите центрове, докато в много райони липсва нискотехнологично медицинско оборудване за ежедневна употреба, особено в по-малките здравни заведения. Информационните технологии се развиват, но са разпокъсани и некоординирани в повечето изследвани държави.

Нужда от ефективна политика за човешките ресурси в здравеопазването

В почти всички изследвани държави броят налични медицински кадри от всякакъв вид е далеч под средния за Европа. Планирането на човешките ресурси се превърна в приоритет едва през последните години, особено предвид масовата емиграция на медици-професионалисти. Много лекари и сестри напускат медицината – и често страната си – в търсене на по-добро заплащане, по-добри условия на труд и/или обществено признание. Мобилността на здравните професионалисти предизвиква опасения, особено поради факта, че икономически най-уязвимите райони са най-засегнати от този отлив.

Въпреки това проблемът с недостига на здравни кадри не е свързан единствено с абсолютния брой на докторите, а и с тяхната профилираност. В уязвимите селски региони заминаването дори на няколко само специализирали доктори може да предизвика значителен ефект върху предоставянето на здравни услуги. Предвид факта, че семейните лекари са най-търсената специалност в някои държави от ЕС, най-вероятно неравнопоставеността в достъпа до първична помощ ще се задълбочава още повече, ако продължи и/или се увеличи емиграцията на семейни лекари. Също така някои специалности и умения на ниво болнична помощ могат да бъдат засегнати неблагоприятно.

Недостиг в някои специалности и умения се отчита и в изследваните страни Хърватия, Македония, Косово и Молдова, като той не е непременно свързан с мобилността на професионалистите в здравната област.

Нужда от справяне с неформалните плащания в системата на обществено здравеопазване

Изследването сочи, че неформалните плащания все още представляват бариера пред достъпа до съвременно лечение особено що се касае до хроничните заболявания. Ето защо справянето с неформалните плащания трябва да се превърне в приоритет. Данни за плащанията от джоба на пациента сочат, че те са широко разпространено явление както в доболничната, така и в болничната грижа, а в някои държави те представляват съществен източник на финансиране. Неформалните плащания са свързани с културни и исторически фактори, но преди всичко те представляват реакция на слабия капацитет на системата на общественото здравеопазване да осигури адекватен достъп до базови услуги.

4.6 Главни заклучоци: Клучни области за реформи во јавната здравствена заштита во земјите од ЈИЕ

Студијата насловена *Перформанси на јавниот систем на здравствена заштита* ги анализира перформансите на системите на јавното здравство во југоисточна Европа, фокусирајќи се на потребите на пациентите поврзани со пет здравствени проблеми: Инфаркт на миокардот, мозочен удар, рак, повреди и дијабетес (тип 2).

Целта на оваа емпириска компаративна студија е да се понуди квалитативен преглед на *очекуваните* наспроти *реалните* перформанси на јавните системи на здравствена заштита со намера да се посочат главните области каде се потребни интервенции на национално и на европско ниво. Проучувањето е осмислено на начин со кој ќе се обезбедат информации за теми и прашања кои тешко се утврдуваат преку методите на квантитативно проучување. Оттаму, студијата се потпира на техники на квалитативна анализа и во себе ги обединува ставовите на искусни набљудувачи (1.006 интервјуа) и на поединечни сведоци (432 интервјуа).

Извештајот нуди анализа која се заснова врз заедничката рамка за анализа на сите осум земји и обединува многу видови на извори: европската база на податоци на СЗО (WHO European HFA Database) – Здравје за сите, европски статистички податоци преземени од различни податочни бази на Евростат, Светска Банка – Светски развојни индикатори; национални статистички податоци и национални податоци обезбедени за студиите по земји.

4.6.1 Клучни согледувања

Социо-демографски аспекти

Оваа студија опфаќа осум европски земји од кои три се земји-членки на ЕУ, а пет се земји-кандидати во рана фаза од процесот на приклучување во ЕУ.

Сепак, иако степенот на напредок на секоја земја е различен поради различните појдовни точки пред транзицијата и различните пристапи и напорот вложен во социјалните политики (политички и економски), земјите кои беа предмет на студијата споделуваат одредени заеднички особености и области за интервенција.

Во сите осум земји вклучени во ова студија е забележан постојан раст на животниот стан-

Приказ 1. Социо-демографските трендови во осум земји на ЈИЕ

	БГ	ХР	РКС	МК	МД	ЦГ	РО	СРБ
Население на 01/01 2013. (на 1.000 лица)	7,285	4,262	1,794	2,062	3,559	623	20,057	7,182
Тренд кај децата под 15 години	▼	▼	▲	▼	▼	▼	▼	▼
Деца под 15 години од вкупното насел.	13%	15%	28%	17%	16%	19%	15%	14%
Раст на населението*	▼	▼	▲	▲	▼	▲	▼	▼
Стапка на плодност (на 1990 г.)	▼	▼	▼	▼	▼	▼	▼	▼
Вкупна стапка на смртност (по 2000 г.)	▲	▲	=	▲	▼	▲	▲	▲
Стапка на прематурен морталитет	▲	▲	▲	▲	▲	=	▲	▲
Морталитет кај новородени (по 2000 г.)	▼	▼	▼	▼	▼	▼	▼	▼
Очекуван животен век (по 1990)	▲	▲	=	▲	▲	▼	▲	▲
БДП по глава на жител (по 2000)	▲	▲	▲	▲	▲	▲	▲	▲
БДП по глава на жител споредено со ЕУ	47%	61%		35%	10%	43%	49%	35%
Индекс на човековиот развој	висок	мн. висок	висок	висок	среден	висок	висок	висок

Легенда: Црвените полиња означуваат негативни, а зелените позитивни трендови. Сивите полиња означуваат стабилност. Стрелките поставени нагоре индицираат пораст, а оние надолу пад. Забелешка: *Населението на Косово имало позитивен раст до 2011, кога почнува да бележи пад на бројот на населението од 2.208 на 1.799 илјади лица.

дард од 1990 год., мерен како БДП по глава на жител, но сепак останува значително под нивото на ЕУ-28. Според поширокатa дефиниција на добростостојба (која ги вклучува просечните постигнувања во три основни димензии на човековиот развој: долг и здрав живот, знаење, и пристоен животен стандард повеќето од проучуваните земји спаѓаат во групата на земји со висок степен на човековиот развој. Само Хрватска е рангирана со 'многу висок' а Молдавија со 'среден'.

По 1990 год., сите земји во ЈИЕ доживеале драматични социјални промени поврзани со транзицијата кон демократија и пазарна економија и/или кон војна. Промените во социоекономските услови директно и преку психосоцијални фактори влијаеле врз здравјето на населението (Marmot и Wilkinson, 1999). Како и во повеќето земји на поранешниот Советски Сојуз, сите земји вклучени во студијата искусиле криза на морталитет во раните 1990-ти години. Од 2000 год. уделот на детската популација помлада од 15 год,. има опаѓачки тренд во сите земји со исклучок на Косово. Во 2012 год., на децата помлади од 15 год. отпаѓало помеѓу 13% од вкупното население во Бугарија, до 19% од вкупното население на Црна Гора.

Стапката на раст на населението бележи негативни вредности во Бугарија, Хрватска, Молдавија, Романија и Србија, додека во Косово, Македонија и Црна Гора таа е позитивна. Негативниот тренд на природниот раст на населението е резултат пред сè на долгорочното опаѓање на стапката на фертилитет заедно со растот на смртноста. Во сите осум земји стапката на фертилитет е во опаѓање од 1980 год.; најизразена е во Молдавија, додека во Црна Гора истата е стабилна од 2000 год. Сите земји се соочени со високи стапки на смртност и зголемен прематурен морталитет (со исклучок на Црна Гора).

Во регионот, општото здравје на населението е подобрено од 1970-те години, бидејќи животниот век бележи зголемување во шест од осумте земји кои се предмет на студијата. Во изминатите дваесет години скоро во сите опфатени земји, очекуваниот животен век на раѓање е зголемен со вредности кои вариираат за помалку од една година во Молдавија, и за скоро четири години во Романија. Сепак, разликата во вредности помеѓу овие и земјите на ЕУ останува значителна.

Како и во останатите европски земји, жените во просек живеат подолго од мажите. Во 2011 година расчекорот бил дури осум години во Молдавија, седум години во Бугарија и Романија, споредено со четири години во Косово и Македонија. Во повеќето земји, мажите освен што имаат пократок животен век имаат и пократок очекуван број на години поминати во добро здравје во однос на жените. Сепак, во сите избрани земји просечниот број години поминати во добро здравје е далеку под просекот на ЕУ-15 кој изнесува над 70 години.

Стапката на смртност кај доенчињата е во опаѓање од 1970-те години. Сепак, во сите земји опфатени со студијата стапката на смртност кај доенчињата бележи вредности повисоки од просекот на ЕУ. Во 2011 година, само во Црна Гора и Хрватска (со стапки од 4,4 и 4,7 на 1.000) биле забележани стапки споредливи со просекот на ЕУ-28 (3,9 на 1.000). Кај останатите шест земји стапките на смртност кај доенчињата се многу повисоки, посебно во Косово (13,1 на 1.000) и во Молдавија (11 на 1.000).

Главни причини за смртност

Во земјите на ЈИЕ опфатени со студијата, како и во целиот европски регион, преносливите болести се помалку распространети како резултат на постојаното подобрување на надзорните системи и добрата покриеност со имунизација. Помеѓу анализираните земји, само во Република Молдавија преносливите болести како ХИВ и туберкулозата (ТБ) се уште се главна причина за морбидитет и морталитет поради недоволниот капацитет на системот за детекција и одговор на евентуални епидемии.

Спротивно на ова, на незаразните болести (НЗБ) како што се кардиоваскуларните болсти (пр. срцев удар и мозочен удар), ракот, хроничните респираторни болести и дијабетесот, глобално отпаѓа најголемиот удел во морталитетот: околу 80% од сите смртни случаи. Во Европа во 2009 год., болестите на циркулаторниот систем биле причинител на скоро 50% од сите смртни случаи, со поголема стапка кај ма-

жите отколку кај жените, а дури потоа следел ракот (неоплазми) со 20% од смртните случаи, па надворешните причинители за повреди и труења на кои отпаѓа 8% од вкупниот морталитет. (СЗО, 2013а)

Проучуваните земји на ЈИЕ (нема податоци за Косово) го следат овој европски образец. Циркулаторните болести и неоплазмите се најголемите причинители за смрт во сите осум земји. Третата најголема причина за смртност варира помеѓу земјите, во Бугарија и Хрватска тоа се надворешните случаи на повреди и труење, или болести на респираторниот систем во Бугарија, Црна Гора и Србија, сè до болести на дигестивниот систем во Молдавија и Романија. Во сите осум земји товарот на непреносливите болести како фактор на ризик постојано се зголемува.

Високиот товар на НЗБ е директно поврзан со високата преваленца на ризик-факторите. Тутунот, физичката неактивност, нездравата исхрана и штетната употреба на алкохол го зголемува ризикот од предизвикување на поголемиот број НЗПБ. 'Кај повеќето групи на болести кои предизвикуваат висока смртност, морбидитет и инвалидитет (...), двата главни ризик фактори кои остануваат приоритет кој треба да се решава се: пушењето тутун и штетната употреба на алкохол. Од европска перспектива нивните нивоа на превалентност остануваат високи кај сите популациони групи, наспроти сето знаење и технологии кои се на располагање во насока на справување со овие фактори.' (СЗО, 2013а, стр. 40-41)

Нееднаквости во здравјето

Во однос на нееднаквостите во здравјето и недоволниот пристап до здравствени услуги, факторите како што се приходи, образование и работниот статус високо влијаат врз здравствениот статус, морталитетот и ризик факторите во земјите на ЕУ (пр. Mladovsky и др., 2009 г.). Во осумте земји кои се предмет на проучување, главните нееднаквости во поглед на здравјето се поврзани со сиромаштијата, финансиските проблеми, етничката припадност (Роми), географските пречки/пристап (посебно во руралните области но и во некои региони) и миграцијата.

Финансирање на здравствениот систем

Вкупните расходи за здравството значително варираат помеѓу ниски 3% од БДП во Косово и 5.8% во Романија[185] до 10,4% во Србија или 11,4% во Република Молдавија (во однос на просекот на ЕУ-28 од 9,6% од БДП, податок за 2011). Оттаму, се чини дека Молдавија најмногу троши. Сепак, поради нивото на БДП, во апсолутни износи, вкупните здравствени расходи по глава на жител во Молдавија се најниски (нема податок за Косово), скоро два пати пониски отколку во Македонија и Романија, три пати пониски од Бугарија, Црна Гора и Србија или четири пати пониски од Хрватска (која троши најмногу) што преставува само 12% од просекот на ЕУ-28. Оваа значителна разноликост кај здравствените расходи се рефлектира со разлики во однос на придобивките за населението, што води кон разлики во здравствените исходи.

Фискалниот контекст[186] е главниот двигател на релативно ниските здравствени расходи, бидејќи во најмногу проучуваните земји вкупните владини расходи се пониски од 40% од БДП споредено со просекот на ЕУ-28 од 47,9% од БДП (исклучоци се Црна Гора и Србија; нема податок за Косово). Вториот фактор на релативно ниските здравствени расходи во регионот е приоритетот владите да се усогласат околу здравствениот сектор. Владините расходи во секторот здравство изнесуваат само 8% од вкупните владини расходи во Косово и помалку од 15% во Романија, споредено со 19-21% во Бугарија, Хрватска, Македонија и Црна Гора (просекот на ЕУ-28), и со околу 23% во Србија а дури 29% во Молдавија.

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185 Фискалниот контекст се однесува на тековниот и очекуваниот капацитет за трошење на владата. Побогатите земји обично поефективно ги мобилизираат даночните приходи со цел повисоки нивоа на јавни расходи како удел од БДП, додека поограниченият фискален простор се поврзува со пониски владини расходи, вклучително и за здравството.

186 Фискалниот контекст се однесува на тековниот и очекуваниот капацитет за трошење на владата. Побогатите земји обично поефективно ги мобилизираат даночните приходи со цел повисоки нивоа на јавни расходи како удел од БДП, додека поограниченият фискален простор се поврзува со пониски владини расходи, вклучително и за здравството.

Во повеќето земји опфатени со студијата, најголемиот дел од здравствените расходи (како сооднос од БДП) се прибираат јавно. Сепак приватните исплати на корисниците за јавни услуги надминуваат 40% од вкупните расходи во Молдавија, Бугарија и Косово.

Во целиот регион најголем предизвик сепак останува реализирањето универзална покриеност на маргинализираните сиромашни жители, на Ромите, внатрешно раселените лица или лицата повратници преку процесот на реадмисија од земјите на ЕУ. Во некои земји како што се Бугарија, Македонија, Романија и Србија, поради потешкотии со административно регулирање на документи за лична идентификација и со тоа регистрирање во постојните шеми за осигурување, систематски се дискриминира онаа, веќе најмаргинализираната, ромска популација. (пр. Zoon, 2001; Figueras и McKee, 2012) Долготрајната нега и домашната нега се финансира од фондовите на ЕУ (како во Бугарија) или од донации (како во Романија) и останува како предивик на кој сеуште не се одговара на конзистентен начин во земјите опфатени со студијата. (Genet и др., рев., 2012)

Со цел финансиска одржливост под притисок на фискалните штедења, повеќето земји се обидуваат да го префрлат товарот од колективно кон поединечно финансирање, преку охрабрување на приватното, доброволно осигурување (иако приватниот пазар останува ограничен) и/или преку зголемена партиципација или одбитоци и намалена стапка за осигурување.

Реализација на здравствената заштита

Во поглед на управувањето и организирањето, во сите земји опфатени со студијата со исклучок на Косово, здравствените системи се организирани согласно принципот на универзален пристап до основните здравствени услуги, рамноправност и солидарност во однос на финансирањето на здравствената заштита. Здравствените системи вклучуваат мешавина на јавни и приватни медицински установи, како и јавни агенции и фондови кои се вклучени во обезбедувањето, финансирањето, регулирањето и спроведувањето на здравствените услуги. Регулаторните функции се централизирани преку министерствата за здравство кои се исто така задолжени за прибирање и анализа на податоците и обработка на релевантни информации кои помагаат да се развијат политики засновани на докази. Скоро сите избрани земји го промовираат принципот на Здравје во сите политики преку меѓусекторска соработка, со што министерството за здравство е задолжено за координирање на јавните здравствени активности во рамките на секторот и надвор од него.

Системот на обезбедување здраствена заштита е организиран на три нивоа: примарно, секундарно и терцијарно.[187] И приватните и јавните даватели на здравствена заштита може да имаат непосредно склучени договори со националните органи за здравствено осигурување за пружање медицински услуги, согласно задолжителното здравствено осигурување.

Разционализација на болничните капацитети и воведувањето нови управувачки структури во болниците е на реформската агенда на Бугарија, Хрватска, Косово, Молдавија и Романија. Повеќето одбрани земји имаат наследено многу капацитети и здравствен персонал од ерата на комунизмот. Инфраструктурниот потенцијал е значително намален, но во некои земји се уште има вишок на болнички кревети. Во целиот регион, болничките услуги се сконцентрирани во одредени области, посебно во поголемите и главните градови. Освен големите разлики по региони, проблемот потекнува од несоодветната структура на болнички капацитети која не е сообразна со потребите на населението во одделни територии.

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[187] Примарниот систем на заштита е мрежата на матични здравствени установи. Јавните медицински установи на секундарно ниво пружаат специјалистичка нега на заедницата и се дел од локалните јавни власти. Медицинските установи на терцијарно ниво вклучуваат научно-наставни установи кои исто така пружаат специјалистичка и високо специјализирана медицинска заштита за целото население. Дополнително на ова постојат други паралелни здравствени услуги кои ги нудат медицински установи кои припаѓаат на другите нивоа на управување, финансирани од државниот буџет преку ресорните министерства но и врз база на склучени договори со националните органи за здравствено осигурување.

Во повеќето земји кои се предмет на проучување, фармацевтската добавувачка мрежа е скоро целосно приватизирана. Има преголема понуда на лекови во урбаните места, додека во руралните места нивниот недостиг сеуште претставува проблем иако состојбата постепено се подобрува.

Според европскиот Индекс на здравственот систем (Euro Health Consumer Index) за 2013 год. потребно е сите земји од ЈИЕ да ги подобрат перформансите на своите здравствени системи во сите засегнати области: права на пациентите и информации, достапност (време на чекање за третман), исходи, опфат и степен на обезбедени услуги, превенција, како и користење на лекарства.

Перформанси на системите на јавно здравство во земјите на ЈИЕ

Доминантниот став во однос на перформансите на здравствените системи во регионот на ЈИЕ е повеќе прашање на контроверзии помеѓу здравствените професии. Најпрво, доминантиот став широко варира од една земја до друга. Во Хрватска и Црна Гора повеќето здравствени работници обично сметаат дека националните здравствени системи добро функционираат од гледна точка на достапност, расположливост и квалитет на услугите и населението им верува. Спротивно на тоа, во Косово, Молдавија и Романија здравствените работници се скоро еднакво поделени во однос на позитивните и негативните оценки.

Понатаму, во целиот регион здравствените работници од руралните места обично имаат пониски оценки за перформансите на системот во споредба со урбаните места. Ова мислење се одразува на расчекорот помеѓу градските и селските средини, кој е највидлив во статистиката и индикаторите за здравствениот статус и давањето здравствена нега.

Трето, функционирањето на здравствените системи во регионот на ЈИЕ е значително пониско во однос на одредени групи заболувања, како што е ракот, на пример.

Четврто, проценката зависи од профилот на евалуаторот. Оттаму, организациите на пациенти обично се многу критични, НВО-та се доста неутрални (или скоро еднакво поделени помеѓу позитивно и негативно мислење), додека докторите специјалисти и претставниците на раководните структури (од регионалните и националните органи на јавното здравство) се најпозитивни кога се оценува функционирањето на системот. Овој расчекор помеѓу организациите на пациенти и претставниците на системот е изразито акцентиран кога има случаи на терминални заболувања (како што е ракот). Организациите на пациенти најмногу се фокусираат на 'очајните случаи': сиромашните, Ромите, или другите ранливи категории на кои им треба помош и поддршка да пристапат кон соодветните здравствени услуги. Наспроти тоа, претставниците на системот сакаат да се фокусираат на успешните приказни, на здравствените професии кои макотрпно се вложуваат за обезбедување на квалитетни услуги наспроти ограничувањата од секаков тип или на нивните напори да се создадат најосновни услови во состојба на значителни резови и буџетски недостатоци.

Решавање на петте наведени здравствени проблеми во регионот на ЈИЕ

Циркулаторните заболувања (вклучително миокарден инфаркт и мозочни удари) и неоплазмите (ракот) се главни причинители за смртност во опфатените земји на ЈИЕ. Стапката на смртност стандардизирана според возраст во однос на инфарктот на микардот бележи опаѓање во последните години, но сепак останува повисока во однос на европскиот просек во Хрватска, Романија а посебно во Молдавија. Смртноста од цереброваскулрните заболувања бележи пад во последните години, сепак останува повисока отколку европскиот просек во сите осум засегнати земји.

Во периодот од 1990 до 2010 год., случаите на рак значително пораснале во сите одбрани земји за кои има достапни податоци (податоци на СЗО). Постојат големи варијации во стапката на рак во земјите на ЈИЕ, и кај мажите и кај жените. Случаите на рак се повисоки отколку во просекот на ЕУ-27 во Хрватска кај мажите (462 на 100.000 жители) и во Србија (податоците се однесуваат и за Косово) кај жените (330 на 100.000 жители). Другите шест земји бележат

помалку случаи на рак кај мажите и кај жените, со најниски стапки регистрирани во Молдавија (323 за мажи и 229 за жени на 100.000 жители). Сепак, смртноста од рак е еднаква или повисока во споредба со ЕУ-27 просекот во сите опфатени земји.

Стапките на смртност поради повреди бележи пад во изминативе години, но останува повисока од просекот на ЕУ-28 во Хрватска, Романија а посебно во Молдавија. Во земјите за кои има расположливи податоци, трите главни причини за фатални повреди се самоубиства, сообраќајни несреќи и падови. Смртноста предизвикана од дијабетес е еднаква или повисока отколку просекот на ЕУ-28 во повеќето опфатени земји, со исклучок на Романија и Молдавија. Највисоката стапка на смртност предизвикана од дијабетес е нотирана во Македонија, а најниската во Романија.

Домашни институционални мерки и политики за решавање на сите пет заболувања се воспоставени скоро во сите земји. Постоењето на протоколи и водичи за справување со болестите, национални програми или стратегии одделно по земја и заболување се дадени во табелата подолу со одбележан 'x' знак.

Што се однесува до циркулаторните заболувања (инфаркт на миокард и мозочни удари), воставени се протоколи и водичи за управување со болеста, национални програми и/или национални стратегии во Косово, Македонија, Црна Гора, Романија и Србија. Во Република Молдавија сеуште не постојат кохерентни и финансиски одржливи политики за превенција, детектирање, дијагноза и третман на миокардниот инфаркт и од 2002 год. Молдавија нема усвоено или имплементирано национални програми за контрола на кардиоваскуларните заболувања.

Во Бугарија, Хрватска, Македонија, Молдавија, Романија и Србија постојат национални Регистри за рак а во Црна Гора истиот е во изработка. Само во дел од овие земји овие регистри се интегрирани во поширoки онколошки програми. Сепак, сите земји, (со исклучок на Косово) имаат усвоено стратешки документи и законски акти за контрола на злоупотребата на тутун, алкохол и дрога како и за безбедност на храната (за регулирање на максималните количини на шеќер, сол, заситени масти и различни адитиви во индустриски произведената храна, како и за попрецизно етикетирање на составот на храната), што е важно за спречување на карциноми и чија единствена цел е намалување на морбидитетот и морталитетот како резултат на разорното влијание на ризичното однесување. Јавните информации, превенцијата и раната детекција сепак се недоволно развиени во регионот.

Во сите земји одговорноста за спречување на повредите е распределена на различни сектори, во зависност од опкружувањето во кое се јавуваат и од околностите (дома, на работа, при разонода и спортски активности, на патиштата итн.). Во проучуваните земји, владите усвоиле стратегии за хронични незаразни болести, кои ја покриваат областа на повредите поради важноста која повредите ја имаат за националните патологии. Дополнително, сите земји имаат разработено национални стратегии и легислатива за безбедност на патиштата и/или за превенција на злоупотребата на дрога, вклучително алкохол и тутун, што влијае на ризик-факторите за поголем број случаи и превалентност на повредите. Сепак, во многу земји она што заостанува е спроведување на законите.

Национални регистри или програми за лица со дијабетес постојат во Македонија, Хрватска, Молдавија, Романија и Србија. Во Црна

	БГ	ХР	РКС	МК	МД	ЦГ	РО	СРБ
Миокарден инфаркт			x	x		x	x	x
Мозочен удар			x	x		x	x	x
Рак	x	x		x	x		x	x
Повреди	x	x	x	x	x	x	x	x
Дијабетес		x		x	x		x	x

Гора сега ќе се формира Национална комисија за дијабетес задолжена за имплементација на мерките дефинирани со Националната стратегија за здравствена заштита на лицата со дијабетес.

Главни пречки за достапност до најсовремени третмани во јавното здравство

Постојат четири аспекти од системот на здравствена заштита наведени како главни пречки за достапност до најсовремени третмани, за сите одбрани здравствени проблеми, во сите земји:

(1) Недоволно знаење и информации и недоволем степен на превентивно однесување кога станува збор за здравјето.

Домашните студии известуваат за прилично често присуство на ризик фактори за миокарден инфаркт, мозочен удар, рак или дијабетес. Поради ниските нивоа на расположливи информации, многу пациенти не ги препознаваат нивните симпроми навремено. Оттаму, многу пациенти остануваат недијагностицирани до случување на одредена ситуација која им го загрозува животот (миокарден инфаркт, мозочен удар) или до фаза кога болеста напреднала со компликции (рак, дијабетес), кога можноста за пружање соодветен медицински третман не дава позитивни резултати.

(2) Немањето доктори или медицински услуги во некои области

Руралните и оддалечените области (како што се островите во Хрватска или планинските села во Косово и Романија) во сите земји беа посочени како слаба точка во поглед на достапноста на основни медицински услуги. Во овие области исто така недостасуваат лекови или понапредни лекарства. Сепак, слабата достапност до лекарства многу помалку се посочува како пречка за достапност.

(3) Неквалитетни или неефикасни медицински служби, посебно поврзани со (а) долгото време на чекање и (б) недоволно опремените клиники/болници

Иако поединечните сведоци имаат тенденција да се фокусираат на несоодветното време за чекање за различни услуги од здравствената заштита, посебно за преглед кај специјалист, искусните набљудувачи обично ја наведуваат недоволната и/или застарена работна опрема.

(4) Специјалистички услуги се достапни само во одредени области, додека ургентни медицински услуги не се доволно развиени во пет од осумте земји

Недоволниот пристап до специјалистички услуги беше споменат како пречка во однос на три здравствени услови: инфаркт на миокардот, мозочни удари, и рак.

Овие пречки ја посочуваат потребата за подобро финансирање на здравствениот систем: за повеќе медицински персонал, за проширување на постојната мрежа на јавни установи, за подобра опрема и за подобра географска покриеност на специјализираните медицински услуги.

Табела 1. Пречки за достапност до најсовремени третмани во јавното здравство според здравствен проблем и испитаник

Испитаници: ПС – поединечни сведоци и ИН – искусни набљудувачи

На табелата е претставен бројот на земји во кои даденият аспект беше споменат како пречка за достапност во однос на конкретен здравствен проблем.

	Миокарден инфаркт		Удар		Рак		Повре-ди		Дијабе-тес	
Пречки на достапност	ПС	ИН	ПС	ИН	ПС	ИН	ПС	ИН	ПС	ИН
Задоцнет прв контакт со доктор		3		4	6	5			3	1
Недоволно знаење и ниво на информации кај населението. Навики поврзани со превентивното здравје се невообичаени		7		7	4	8		3	8	8
Доктор или медицински услуги не се достапни во некои области	2	6	2	6	3	6	1	6	2	6
Специјалистички услуги се достапни само во одредени области	1	4	4	6	6	7				
Специјалистички услуги се достапни главно во приватни болници/клиники или во странство					1	1				
Единици/услуги за рехабилитација не се достапни/доволни во одредени области	1	4	1	6			1	4		
Аптеките не се достапни во одредени области	1	2	1	1		5		1		
Ургентните услуги не се достапни во одредени области или не се доволно развиени	1	5	2	5			1	2		
Услугите за превоз се недоразвиени или прескапи		2	2	2	3	3		4		1
Оддалеченоста од дома до болница/клиника е преголема и/или прескапа					4	3	4	2	2	
Времето на чекање за прием кај специјалист е предолго	4	4	4	2	4	5	1	2	6	3
Времето на чекање за третман или лекарства е предолго	2	1	1	1	2	4		1	2	1
Времето на чекање за рехабилитација е предолго	1	2	2	2			2	2		
Недоволна компетентнист на средниот медицински персонал						2				
Недоволен интерес или непрофесионалност на докторот или медицинскиот перонал		1	2			1	2	2	4	2
Дискриминирачко или несоодветно однесување на медицинскиот персонал										1
Недоверба кон докторите и останатиот медицински персонал		1	2	1	2	4	1		1	2
Недоволна хуманост на персоналот	2		3	2	6		3			
Немање средства за плаќање на докторите	1	1	1	1	2					
Немање средства за потребните тестови			4	2	2	2				1
Немање средства за приватни исплати на корисниците	1	4	4	3	2	2	1	2		
Низок квалитет и ефективност на медицинските услуги	5	4	4	5	2	2	4	6	3	5
Скапи лекарства	6	2	2	1		3	2	2	3	1
Недоволна опременост на јавните клиники/болници		4	3	3	4	6	3	4	2	4
Недоволна достапност и континуитет на негата	2		4	1	1	2	3			
Недостиг на специјалисти во одредени супспецијалности		1		2		2				2
Низок капацитет на клиниките/болниците						2				
Друго, ве молиме наведете										1

Податоци: FES (2012-2013) *Перформанси на јавниот систем на здравствена заштита*. Забелешки: Недоволна хуманост на персоналот: лош третман, без респект, без давање објаснувања за болеста и третманот. Ниска ефективност на услугите: несоодветно време на чекање, времетраење и непрецизни лабораториски тестови, лоша работна опрема, нечисти и неуредни болници/клиники. Недоволна допстапност и континуитет на негата: несоодветен број столчиња во чекалните, достапност на саканите услуги во секое време, број на персонал за реализација на потребните задачи при секоја посета. Друго: социо-економски фактори како ниска здравствена култура и незадоволителни услови за живот. Кратенки за земјите: БГ - Бугарија, ХР - Хрватска, РКС - Косово, МК - Македонија, МД - Молдавија, ЦГ – Црна Гора, РО – Романија, СРБ - Србија.

4.6.2 Шест главни области за реформи во политиките

Надградувајќи ги резултатите од истражувањето може да се посочат шест главни области за реформи во политиките со цел подобрување на перформансите на јавниот систем на здравствена заштита.

Потребата подобро да се дефинираат и евалуираат трошоците на пакетите за осигурениците

Во сите осум земји, согласно националното законодавство, се нудат сеопфатни пакети на здравствени услуги. Главниот проблем е тоа што ниеден од проучуваните здравствени системи нема капацитет со кој би се осигурало универзално обезбедување на тие услуги. Оттаму, постои потреба од пореални пакети на услугите. '(…) *дефинирањето на пореални пакети за корисниците* ќе биде клучната стратегија за осигурување на финансиска одржливост. Заложбата за финансирање на универзална покриеност и на целосно сеопфатни пакети за осигурениците е нереална и неодржлива во многу од земјите од регионот. И покрај политичките и техничките потешкотии и заложби околу еднаквоста, земјите можеби ќе треба да се определат поексплицитно да ги дефинираат поограничените права со цел да се осигура дека јавните приходи ќе бидат насочени кон најисплатливите интервенции и најсиромашните сегменти од општеството и кон заштита на јавното здравство.' (Figueras и др., 2004, стр.15)

Потребата за зајакнати превентивни услуги

Во повеќето земји постојат превентивни програми или поедини превентивни активности но резултатите не успеале да ги задоволат потребите на населението, оттаму потребата за дополнителни превентивни активности. Учеството на матичните лекари и специјалистите во превентивата во повеќето случаи почнува дури во фазата на пропишување третман, без интерес за знаењата на пациентот.

Системот на нега во заедницата преку патронажни медицински тимови, кои се сметаат за многу корисни во здравството, сеуште не се користи во повеќето земји. И покрај напорите за развивање на примарната нега, достапноста до соодветна и целосна здравствена заштита во заедницата останува како предизвик за одредени сегменти на популацијата (групи со пониски примања, жители на рурални области и мали градови, Ромите, итн.).

Развојот на превентивните услуги во регионот е уште попотребен со оглед на високото ниво на морталитет кој може да се избегне, чии обрасци бараат засилени политики и нивна имплементација (посебно кај жените) особено кога станува збор за разработување на политики поврзани со тутунот и алкохолот. Оттаму, може да се постигне значителен напредок кај намалувањето на смртноста во овие земји преку насочување на здравствените услуги. Под насочување подразбираме не само подобро финансирање на здравствениот систем туку и модернизирање и јакнење на квалитетот на здравствените услуги.

Потребата од услуги во палијативна, рехабилитациска и долготрајна нега

Палијативната, рехабилитациската и долготрајната нега не се доволно развиени како делови од системот на здравствена заштита во регионот. Најголемиот дел од долготрајната нега се дава во семејството и достапни се одредени средства за давателите на неформална нега.

Потребата за подобрено финансирање на јавниот систем на здравствена заштита

Јавните системи на здравствена заштита се недоволно финансирани, најмногу како резултат на фискалните штедења. Сепак, барем во одредени земји ова недоволно финансирање е резултат на недоволниот приоритет кој владите го даваат на здравствениот сектор. Оттаму, политичката волја е главен фактор за подобрување на перформансите на системите на здравствена заштита.

Студијата покажува дека финансирањето треба да се зајакне но и подобро да се насочи кон капитални инвестиции во опрема и технологија. Капиталните инвестиции во пружањето секундарна и терцијарна нега се разликуваат од земја до земја, но генерално се пониски споредено со инвестициите во примарната нега. Како генерално правило, високо-технолошката опрема е достапна само во поголемите центри, додека секојдневно потребната медицинска опрема од пониска технологија или недостига или е застарена во многу области, посебно во помалите медицински установи. Информацискатa технологија се развива но е раслоена и некоординирана во повеќето опфатени земји.

Потребата за ефикасна кадрова политика во здравството

Во скоро сите проучувани земји расположливоста на сите видови на медицински работници е далеку под европскиот просек. Планирањето на човечки ресурси стана приоритет во изминатите години, посебно кога станува збор за масовна миграција и напуштање на медицинските професии. Многу доктори и медицнски сестри ја напуштиле медицината, а често и земјата, во потрага по подобра плата, работни услови и/или социјално признавање. Мобилноста на здравствените работници загрижува, посебно бидејќи ваквиот одлив е најприсутен во регионите кои економски стојат најлошо.

Сепак, проблемот на недостиг не е поврзан само со апсолутниот број на доктори туку и со нивниот профил. Во посиромашните рурални области заминувањето само на малку доктори специјалисти може да предизвика значителен ефект врз давањето и квалитетот на услугите. Со оглед на тоа што семејната медицина е една од најбараните специјалности во некои земји на ЕУ, најверојатно е дека нееднаквостите во поглед на достапноста до примарна нега ќе пораснат дополнително доколку продолжи и/или се зголеми исселувањето на матичните доктори. Дополнително, ова може да се одрази и на определени специјалности и професии на болничко ниво.

Недостигот на одредени специјалности и професии се нотира и во проучуваните земји – Хрватска, Македонија, Косово, Молдавија и е се нужно поврзан со високата мобилност на здравствените работници.

Потребата да се решат неформалните плаќања во јавниот систем на здравствена заштита

Студијата покажува дека неформалните плаќања сеуште претставуваат пречка на достапноста кон најсовремен третман посебно кога станува збор за хроничните заболувања. Оттаму овие неформални плаќања мора да бидат приоритет. Податоците за овие исплати укажуваат дека се широко распространети и во амбулантната и во болничката нега и во некои земји претставуваат голем извор на финансирање. Неформалните плаќања се поврзани со културни и историски фактори, но пред сè тие се одговор на слабиот капацитет на јавниот систем на здравствена заштита да обезбеди соодветна достапност кон јавните услуги.

4.7 CONCLUZII PRINCIPALE: DOMENIILE MAJORE ALE REFORMEI SISTEMELOR DE SĂNĂTATE PUBLICĂ DIN ȚĂRILE EUROPEI DE SUD-EST

Studiul *Performanța sistemului de sănătate publică* analizează performanța sistemelor de sănătate publică din țările Europei de Sud-est, punând accentul pe nevoile pacienților în raport cu cinci probleme de sănătate: infarctul miocardic, atacul cerebral, cancerul, accidentele și diabetul (de tip 2).

Obiectivul acestui studiu empiric comparativ este acela de a oferi indicii privind performanța *preconizată* în raport cu cea reală a sistemelor de sănătate publică, în vederea identificării principalelor domenii care necesită intervenții atât la nivel național, cât și la nivel european. Studiul vizează obținerea de informații privind aspectele și problemele care sunt dificil de abordat prin metode de cercetare cantitativă. Astfel, studiul se bazează pe metode de cercetare calitativă, reunind atât perspectiva unor observatori competenți (1.006 interviuri), cât și pe cea a unor martori individuali (432 interviuri).

Raportul furnizează o analiză bazată pe un cadru analitic comun pentru opt țări și cuprinde mai multe tipuri de surse: baza de date OMS Sănătatea pentru Toți, date statistice europene extrase din diferite baze de date ale Eurostat, indicatori de dezvoltare mondială ai Băncii Mondiale; date statistice naționale; informații cu caracter național, furnizate de studii naționale.

4.7.1 Rezultate-cheie

Aspecte socio-demografice

Studiul acoperă opt țări europene, dintre care trei sunt membre ale UE, iar cinci sunt țări candidate aflate într-o fază incipientă a procesului de aderare.

Deși majoritatea evoluțiilor au specific național din cauza punctelor de pornire diferite în stadiul de pretranziție, precum și a abordărilor și a eforturilor diferite (atât din punct de vedere politic, cât și economic) depuse pentru politicile sociale, țările studiate prezintă câteva trăsături și domenii de intervenție comune.

Figura 38. Tendințe socio-demografice în opt state ESE

	BG	HR	RKS	MK	MD	ME	RO	SRB
Populația la 1 ian. 2013 (mii persoane)	7,285	4,262	1,794	2,062	3,559	623	20,057	7,182
Tendință copii <15 ani	▼	▼	▲	▼	▼	▼	▼	▼
Copii <15 ani în totalul populației	13%	15%	28%	17%	16%	19%	15%	14%
Creșterea populației*	▼	▼	▲	▲	▼	▲	▼	▼
Rata fertilității (după 2000)	▼	▼	▼	▼	▼	▼	▼	▼
Rata mortalității premature	▲	▲	=	▲	▼	▲	▲	▲
Mortalitatea infantilă (după 2000)	▲	▲	▲	▲	▲	=	▲	▲
Speranța de viață (după 1990)	▼	▼	▼	▼	▼	▼	▼	▼
PIB pe cap de locuitor (după 2000)	▲	▲	=	▲	▲	▼	▲	▲
PIB pe cap de locuitor în comparație cu EU	▲	▲	▲	▲	▲	▲	▲	▲
Creșterea	47%	61%		35%	10%	43%	49%	35%
Indicele dezvoltării umane	mare	f. mare	mare	mare	medie	mare	mare	mare

Legendă: Celulele de culoare roșie indică tendințele negative. Celulele de culoare verde indică tendințele pozitive. Celulele de culoare gri indică stabilitate. Săgețile în sus indică creștere, în timp ce săgețile în jos indică scădere. Notă: *Creșterea populației provinciei Kosovo a fost pozitivă până în 2011, când populația a înregistrat o reducere semnificativă de la 2.208 la 1.799 de mii de persoane.

În toate cele opt țări incluse în studiul de față, standardul de viață general, măsurat ca PIB pe cap de locuitor, a crescut în mod constant din 1990, însă a rămas destul de redus în comparație cu nivelul UE-28. Conform unei definiții extinse a bunăstării (care măsoară atingerea a trei dimensiuni fundamentale ale dezvoltării umane – o viață îndelungată și sănătoasă, nivelul de cunoaștere și un nivel de trai decent), majoritatea țărilor studiate fac parte dintr-un grup de țări cu un nivel ridicat de dezvoltare umană. Doar Croația a primit calificativul 'foarte ridicat', iar Moldova calificativul 'mediu'.

După 1990, toate țările ESE au suferit schimbări sociale profunde cauzate de tranziția la democrație, la economia de piață și/sau începerea războiului. Modificarea condițiilor socio-economice a afectat sănătatea populației atât în mod direct, cât și prin intermediul unor factori psihosociali (Marmot și Wilkinson, 1999). La fel ca în majoritatea statelor din fosta Uniune Sovietică, toate țările incluse în studiu au înregistrat o criză a mortalității la începutul anilor '90. Începând din anul 2000, ponderea copiilor cu vârste mai mici de 15 ani s-a redus în toate țările studiate, cu excepția provinciei Kosovo. În 2012, copiii cu vârste mai mici de 15 ani reprezentau între 13% din populația totală în Bulgaria și 19% din populația totală în Muntenegru.

Rata de creștere a populației a înregistrat valori negative în Bulgaria, Croația, Moldova, România și Serbia, în timp ce în Kosovo, Macedonia și Muntenegru a fost pozitivă. Sporul natural negativ al populației a fost determinat în principal de reducerea pe termen lung a fertilității concomitent cu creșterea mortalității. În toate cele opt țări, rata fertilității a scăzut începând cu 1980, cea mai mare scădere fiind înregistrată în Moldova, în timp ce în Muntenegru rata fertilității a rămas stabilă începând cu anul 2000. Toate țările se confruntă cu rate ridicate ale mortalității și cu o creștere a ratelor mortalității premature (cu excepția Muntenegrului).

În ansamblu, sănătatea populației în regiune s-a ameliorat începând cu anii '70, în timp ce speranța de viață a crescut în șase dintre cele opt țări studiate. În ultimii douăzeci de ani, în aproape toate țările studiate, speranța de viață la naștere a crescut cu valori situate între mai puțin de un an, în Moldova, și aproape patru ani, în România. Cu toate acestea, decalajul dintre UE și aceste țări rămâne semnificativ.

La fel ca în alte țări europene, femeile trăiesc în medie mai mult decât bărbații. În 2011, decalajul era mai mare de opt ani în Moldova, de șapte ani în Bulgaria și România, comparativ cu patru ani în Kosovo și Macedonia. În majoritatea țărilor, bărbații au nu numai o speranță de viață mai redusă, ci și o durată de viață prevăzută în stare bună de sănătate mai redusă decât cea a femeilor. Totuși, în toate țările selectate, perioada medie de viață caracterizată printr-o bună sănătate este mult mai redusă decât media UE-15 de peste 70 de ani.

Ratele mortalității infantile sunt în continuă scădere începând din 1970. Totuși, în toate țările studiate, ratele mortalității infantile au înregistrat valori mai ridicate decât media UE. În 2011, doar în Muntenegru și Croația (cu rate de 4,4, respectiv de 4,7 la mie) s-au înregistrat rate ale mortalității infantile comparabile cu media UE-28 (3,9 la mie). În celelalte șase țări, ratele mortalității infantile au fost mult mai mari, în special în Kosovo (13,1 la mie) și în Moldova (11 la mie).

Principalele cauze de deces

În țările ESE studiate, precum și în întreaga regiune Europeană, bolile transmisibile au o pondere scăzută datorită îmbunătățirii constante a sistemelor de monitorizare și acoperirii bune în ceea ce privește imunizarea. Dintre țările studiate, doar în Republica Moldova bolile transmisibile precum HIV și tuberculoza (TBC) reprezintă încă principalele cauze de morbiditate și de mortalitate ca urmare a capacității insuficiente a sistemului de a depista și combate epidemiile.

În schimb, bolile netransmisibile – bolile cardiovasculare (cum ar fi atacurile de cord și atacurile cerebrale), cancerele, bolile respiratorii cronice și diabetul – au cea mai mare pondere în mortalitatea globală: aproximativ 80% din decese. La nivel european, în 2009, bolile sistemului circulator se făceau vinovate de aproape 50% din totalul deceselor, cu rate mai ridicate în rândul bărbaților decât în rândul femeilor,

urmate ca frecvență de cancer (neoplasm), cu 20% din decese, cauzele externe precum accidentele și intoxicațiile reprezentând 8% din totalul deceselor. (OMS, 2013a)

Țările ESE studiate (nu există date despre Kosovo) urmează modelul European. Bolile sistemului circulator și neoplasmul reprezintă principalele două cauze majore de deces în toate cele opt țări. A treia cauză majoră de deces variază de la accidente și intoxicații, în Bulgaria și Croația, la boli ale sistemului respirator, în Bulgaria, Muntenegru și Serbia, respectiv boli ale sistemului digestiv, în Moldova și România. În toate cele opt țări, povara bolilor netransmisibile este în creștere.

Povara ridicată a bolilor netransmisibile este legată direct de prevalența mare a factorilor de risc. Fumatul, inactivitatea fizică, alimentația nesănătoasă și abuzul de alcool sporesc riscul sau cauzează majoritatea bolilor netransmisibile. „Pentru grupurile majore de boli care cauzează mortalitate, morbiditate și dizabilitate ridicată (...), există doi factori de risc principali care multiplică consecințele bolilor, combaterea acestora rămânând, prin urmare, o prioritate: fumatul și consumul abuziv de alcool. Dintr-o perspectivă europeană, prevalența și nivelurile acestora se mențin ridicate la nivelul întregii populații, în ciuda nivelului de cunoaștere și tehnologic disponibil pentru combaterea lor." (OMS, 2013a, p. 40-41)

Inegalitățile din sănătate

În ceea ce privește inegalitățile din sănătate și accesul echitabil la servicii de sănătate, factorii precum veniturile, educația și statutul profesional au o influență ridicată asupra stării de sănătate, mortalității și factorilor de risc în țările UE (de ex., Mladovsky et al., 2009). În cele opt țări studiate, inegalitățile majore în materie de sănătate sunt legate de sărăcie, bariere financiare, apartenența etnică (romii), barierele geografice (în special zonele rurale, însă și unele regiuni) și migrare.

Finanțarea sistemului de sănătate

Cheltuielile totale cu sănătatea variază în mod semnificativ de la 3% din PIB în Kosovo și 5,8% în Romania[188] la 10,4% în Serbia și 11,4% în Republica Moldova (în comparație cu media UE-28 de 9,6% din PIB în 2011). Astfel, Moldova pare să cheltuiască cel mai mult. Totuși, din cauza nivelului PIB-ului, în valoare absolută, cheltuielile totale cu sănătatea pe cap de locuitor în Moldova sunt cele mai scăzute (nu există date pentru Kosovo), aproape de două ori mai puțin decât în Macedonia și România, aproape de trei ori mai puțin decât în Bulgaria, Muntenegru și Serbia, și de aproximativ de patru ori mai puțin decât în Croația (țara cu cele mai mari cheltuieli), reprezentând doar 12% din media UE-28. Această variație substanțială în cheltuielile cu sănătatea se traduce într-o variație ridicată a acoperirii beneficiilor populației și, prin urmare, într-o variație mare a rezultatelor în materie de sănătate.

Contextul fiscal[189] reprezintă principalul factor determinant al cheltuielilor relativ scăzute cu sănătatea, majoritatea țărilor studiate înregistrând niveluri totale ale cheltuielilor guvernamentele mai mici de 40% în comparație cu media UE-28 de 47,9% din PIB (excepție fac Muntenegru și Serbia; nu există date pentru Kosovo). Al doilea factor determinant pentru cheltuielile relativ scăzute cu sănătatea în regiune este prioritatea pe care guvernele o acordă sectorului de sănătate. Cheltuielile guvernamentale cu sănătatea reprezintă doar 8% din totalul cheltuielilor guvernamentale în Kosovo și mai puțin de 15% în România în comparație cu 19-21% în Bulgaria, Croația, Macedonia și Muntenegru (media UE-28), și aproape 23% în Serbia și 29% în Moldova.

În cea mai mare parte a țărilor studiate, majoritatea cheltuielilor cu sănătatea (ca parte din PIB) este generată public. Cu toate acestea, plățile directe pentru serviciile de sănătate de-

[188] România și-a redus cheltuielile cu sănătatea la doar 4% din PIB în 2012, înregistrând astfel unul dintre cele mai scăzute niveluri ale cheltuielilor cu sănătatea din Europa.

[189] Contextul fiscal se referă la capacitatea curentă și prognozată a unui guvern de a face cheltuieli. Țările mai bogate tind să fie mai eficiente în mobilizarea veniturilor din taxe și impozite și înregistrează astfel niveluri mai ridicate ale cheltuielilor publice ca parte din PIB, în timp ce un spațiu fiscal mai limitat este asociat cu cheltuieli guvernamentale reduse, inclusiv în sănătate.

pășesc 40% din totalul cheltuielilor în Moldova, Bulgaria și Kosovo.

În întreaga regiune, obținerea unei acoperiri universale pentru populațiile sărace marginalizate, romii, persoanele strămutate intern sau persoanele revenite în procesul de readmitere din state membre ale UE a rămas o provocare majoră. În unele țări ca Bulgaria, Macedonia, România și Serbia, dificultățile de obținere a documentelor de identitate și de înregistrare în sistemul de asigurări au discriminat în mod sistematic populația romă deja puternic defavorizată. (de ex., Zoon, 2001; Figueras și McKee, 2012) Îngrijirea pe termen lung și îngrijirea la domiciliu sunt finanțate din fonduri europene (ca în Bulgaria) sau din donații (ca în România) și rămân o provocare insuficient abordată în țările studiate. (Genet et al., ed., 2012)

Pentru asigurarea sustenabilității financiare sub presiunea constrângerilor de natură fiscală, majoritatea țărilor au încercat să transfere povara dinspre finanțarea colectivă către individ prin promovarea asigurării private voluntare (deși piața privată rămâne limitată) și/sau prin coplăți și sume deductibile crescute și prin sistemul bonus-malus.

Furnizarea de asistență medicală

În ceea ce privește guvernanța și organizarea, în toate țările studiate, cu excepția provinciei Kosovo, sistemele de sănătate sunt organizate corespunzător principiilor accesului universal la serviciile medicale de bază, al echității și al solidarității în finanțarea sistemului de sănătate. Sistemele de sănătate includ o combinație de unități medicale publice și private, precum și agenții și autorități publice implicate în furnizarea, finanțarea, reglementarea și administrarea serviciilor medicale. Funcțiile de reglementare sunt centralizate în ministerele sănătății, care, de asemenea, colectează și analizează date și generează informații relevante, pentru a contribui la dezvoltarea politicilor bazate pe elemente concrete. Aproape toate țările selectate promovează principiul „Sănătatea în toate politicile" prin colaborarea multi- și inter-sectorială, Ministerul Sănătății asigurând coordonarea activităților de sănătate publică în interiorul și în afara sectorului.

Sistemul de sănătate este organizat pe trei niveluri: primar, secundar și terțiar.[190] Atât furnizorii publici de servicii medicale, cât și cei privați pot fi contractați în mod direct de către casele de asigurări de sănătate pentru furnizarea de servicii medicale pe baza unei asigurări medicale obligatorii.

Măsurile de raționalizare a rețelei de spitale și de implementare a unor noi structuri de management în spitale s-au aflat pe agenda de reformă în Bulgaria, Croația, Moldova și România. Majoritatea țărilor selectate au moștenit numeroase unități și cadre medicale din perioada comunistă. Infrastructura a fost redusă în mod semnificativ, însă, în unele țări, încă există un surplus de paturi. În întreaga regiune, serviciile spitalelor sunt concentrate în unele zone, în special în orașele mai mari și în capitale. Pe lângă disparitățile regionale mari, problema este generată de structura necorespunzătoare a capacităților spitalelor, care nu este adaptată la nevoile populației, în special din anumite teritorii.

În majoritatea țărilor studiate, rețeaua farmaceutică de aprovizionare a fost privatizată aproape în întregime. În zonele urbane există o supraofertă de farmacii, în timp ce în zonele rurale deficitele reprezintă încă o problemă, deși situația s-a ameliorat treptat.

Indicele de consum european pentru serviciile de sănătate pentru 2013 arată faptul că toate țările ESE necesită îmbunătățirea performanței propriilor sisteme de sănătate în toate domeniile abordate: drepturile și informarea pacienților, accesibilitatea (timpii de așteptare pentru a beneficia de tratament), rezultatele,

[190] Sistemul de asistență medicală primară reprezintă rețeaua de unități de medicină de familie. Unitățile medicale publice de nivel secundar furnizează asistență specializată comunității și sunt subordonate autorităților publice locale. Unitățile medicale de nivel terțiar includ instituțiile de cercetare și de învățământ care furnizează, de asemenea, servicii medicale specializate și înalt specializate întregii populații. Un număr mare de servicii medicale paralele sunt oferite, de asemenea, prin instituțiile medicale publice aparținând altor sectoare guvernamentale, care sunt finanțate de la bugetul de stat prin ministerele de resort, dar care pot, de asemenea, încheia contracte cu casele de asigurare națională de sănătate.

gama de servicii furnizate și accesul la acestea, prevenirea, precum și aprovizionarea cu medicamente.

Percepția asupra performanței sistemelor de sănătate publică din ESE

Opinia majoritară privind performanța sistemelor de sănătate publică în regiunea ESE este mai degrabă un subiect controversat în rândul cadrelor medicale. În primul rând, opinia preponderentă variază mult de la o țară la alta. În Croația și în Muntenegru, majoritatea personalului medical consideră că sistemele de sănătate publică funcționează bine din punct de vedere al accesibilității, al disponibilității și al calității serviciilor și că se bucură de încrederea populației. În schimb, în Kosovo, Moldova și România, aprecierile personalului medical asupra sistemului public de sănătate sunt în egală măsură distribuite între opinii pozitive și negative.

În al doilea rând, la nivelul întregii regiuni, personalul medical din zonele rurale tinde să aprecieze performanța sistemului ca fiind mult mai slabă prin comparație cu profesioniștii din zonele urbane. Această opinie reflectă decalajul dintre mediul urban și cel rural, care este foarte vizibil în statisticile și indicatorii privind starea de sănătate și furnizarea de asistență medicală.

În al treilea rând, performanța sistemelor de sănătate publică din regiunea ESE este semnificativ mai redusă în privința anumitor grupuri de boli, cum ar fi cancerul.

În al patrulea rând, evaluarea depinde și de profilul evaluatorului. Astfel, organizațiile de pacienți tind să fie foarte critice, ONG-urile sunt mai degrabă neutre (sau împărțite în proporții aproape egale între atitudini pozitive și negative), în timp ce medicii specialiști și reprezentanții managementului medical (din zonele regionale și naționale de sănătate publică) au în cea mai mare parte aprecieri pozitive la adresa performanțelor sistemului. Decalajul dintre organizațiile de pacienți și reprezentanții sistemului este deosebit de accentuat în cazul bolilor în fază terminală (cum ar fi cancerul). Organizațiile de pacienți se concentrează în principal pe „cazuri disperate", persoane sărace, romi sau alte persoane vulnerabile care au nevoie de ajutor și sprijin pentru a avea acces la servicii medicale corespunzătoare. Spre deosebire de acestea, reprezentanții sistemului au tendința de a pune accentul pe poveștile de succes, pe personalul medical care depune eforturi pentru a oferi servicii excelente în condiții de constrângeri severe de toate tipurile sau pe eforturilor de a furniza condiții minime în contextul reducerilor și deficitelor bugetare semnificative.

Abordarea celor cinci probleme de sănătate selectate din regiunea ESE

Bolile circulatorii (inclusiv infarctul miocardic și atacurile cerebrale) și neoplasmele (cancer) constituie principalele cauze de deces în țările ESE studiate. Ratele mortalității standardizate pe vârste cauzate de infarctul miocardic au înregistrat o scădere în ultimii ani, însă au rămas mai ridicate decât media europeană în Croația, în România și în special în Moldova. Mortalitatea cauzată de bolile cebro-vasculare a înregistrat o scădere în ultimii ani, însă a rămas mai ridicată decât media europeană în toate cele opt țări studiate.

Între 1990 și 2010, incidența cancerului a crescut în mod semnificativ în toate țările selectate pentru care sunt disponibile date (date OMS). Variația incidenței cancerului în țările ESE este mare atât la bărbați, cât și la femei. Incidența cancerului este mai mare decât media UE-27 în Croația pentru bărbați (462 la 100.000 de locuitori) și în Serbia (datele includ și Kosovo) pentru femei (330 la 100.000 de locuitori). Celelalte șase țări au înregistrat o incidență a cancerului mai mică atât la bărbați, cât și la femei, cea mai redusă incidență înregistrându-se în Moldova (332 la bărbați și 229 la femei la 100.000 de locuitori). Totuși, în toate țările studiate, mortalitatea cauzată de cancer este egală sau mai mare ca media UE-27.

Ratele mortalității cauzate de accidente au înregistrat o scădere în ultimii ani, însă au rămas mai ridicate în Croația, România și în special Moldova decât în EU-28. În țările pentru care sunt disponibile date, sinuciderile, accidentele

rutiere și căderile sunt principalele trei cauze ale accidentelor soldate cu decese. În majoritatea țărilor studiate, cu excepția României și a Moldovei, mortalitatea cauzată de diabet este egală sau mai ridicată decât media UE-28. Cea mai ridicată rată a mortalității cauzate de diabet a fost înregistrată în Macedonia, iar cea mai redusă în România.

Sisteme și politici instituționale naționale de combatere a tuturor celor cinci boli sunt implementate în aproape toate țările. În tabelul de mai jos este indicată cu un „x" existența protocoalelor și ghidurilor de gestionare a bolii, a programelor sau a strategiilor naționale în funcție de țară și problemă de sănătate.

În cazul bolilor circulatorii (infarctul miocardic și atacul cerebral), în Kosovo, Macedonia, Muntenegru, România și Serbia sunt implementate deja protocoale și ghiduri de gestionare a bolilor, programe și/sau strategii naționale. Republica Moldova duce lipsă de politici coerente și sustenabile din punct de vedere financiar privind prevenirea, depistarea, diagnosticarea și tratarea infarctului miocardic și, din 2002, Moldova nu a aprobat sau implementat programe naționale de control al bolilor cardiovasculare.

În Bulgaria, Croația, Macedonia, România și Serbia sunt disponibile deja registre naționale pentru cancer, iar în Muntenegru sunt în curs de implementare. Aceste registre sunt integrate în programe oncologice mai ample doar în unele țări. Totuși, toate țările (cu excepția Kosovo) au adoptat documente strategice și legi privind controlul abuzului de tutun, alcool și droguri, precum și siguranța alimentară (reglementarea cantităților maxime de zahăr, sare, grăsimi saturate și diverși aditivi din alimentele produse industrial, precum și etichetarea mai clară a compoziției alimentelor), care sunt importante pentru prevenirea carcinoamelor și au ca principal scop reducerea morbidității și a mortalității cauzate de impactul devastator al comportamentelor riscante. Informarea publicului, prevenirea și detectarea timpurie sunt dezvoltate încă insuficient în regiune.

În toate țările, responsabilitatea pentru prevenirea accidentelor este relativ dispersată într-o varietate de sectoare de politici – în funcție de mediul și circumstanțele în care acestea se produc (acasă, la locul de muncă, în timpul liber și în timpul activităților sportive, pe drumuri etc.). În țările studiate, guvernele au adoptat strategii pentru bolile netransmisibile cronice, care acoperă domeniul accidentelor, datorită importanței pe care accidentele o au pentru patologiile naționale. În plus, toate țările au dezvoltat strategii naționale și legislații pentru siguranța rutieră și/sau prevenirea abuzului de droguri, inclusiv abuz de alcool și tutun, care abordează influența factorilor de risc asupra creșterii incidenței și prevalenței accidentelor. Totuși, aplicarea legilor este mai degrabă slabă.

În Croația, Macedonia, Moldova, România și Serbia există registre sau programe naționale pentru persoanele afectate de diabet. În Muntenegru urmează să se instituie o comisie națională pentru diabet, care va pune în aplicare măsurile definite de strategia națională pentru îngrijirea persoanelor cu diabet.

Principalele obstacole din sistemul de sănătate în calea unui tratament medical de vârf

Există patru aspecte ale sistemelor de sănătate care au fost menționate ca obstacole în accesul la tratament de vârf, pentru toate problemele de sănătate selectate, în toate țările:

	BG	HR	RKS	MK	MD	ME	RO	SRB
Infarct miocardic			x	x		x	x	x
Atac cerebral			x	x		x	x	x
Cancer	x	x		x	x		x	x
Accidente	x	x	x	x	x	x	x	x
Diabet		x		x	x		x	x

(1) Nivelul slab de cunoaștere și de informare și absența comportamentului de prevenire a bolilor.

Studiile naționale indică o incidență destul de ridicată a factorilor de risc pentru infarctul miocardic, atacul cerebral, cancer și diabet. Ca urmare a nivelului redus de informații disponibile, mulți pacienți nu-și recunosc simptomele la timp. Astfel, un număr mare de pacienți rămân nediagnosticați până când survine un pericol iminent pentru viață (infarct miocardic, atac cerebral) sau boala avansează cu complicații (cancer, diabet), când posibilitatea de a beneficia de un tratament medical corespunzător nu oferă rezultate pozitive.

(2) În anumite zone nu există medici sau servicii medicale

Zonele rurale și zonele izolate (de exemplu, insulele din Croația sau satele montane din Kosovo și din România) au fost semnalate în toate țările ca fiind defavorizate în ceea ce privește accesul la servicii medicale de bază. În aceste zone este posibilă, de asemenea, absența farmaciilor sau aprovizionarea insuficientă a acestora cu medicamente pentru tratamente avansate. Totuși, accesul redus la farmacii a fost menționat într-o mai mică măsură ca fiind un obstacol în calea accesului.

(3) Calitatea și eficiența redusă a serviciilor medicale, în special în ceea ce privește timpii de așteptare mari și (b) dotările necorespunzătoare din clinicile/spitalele publice.

În timp ce martorii individuali tind să se concentreze pe timpii de așteptare necorespunzători pentru diferite tipuri de servicii de asistență medicală, în special pentru a fi examinați de către un specialist, observatorii competenți tind să evidențieze dotările insuficiente și/sau depășite.

(4) Serviciile specializate sunt disponibile doar în unele zone, în timp ce serviciile de urgență nu sunt suficient dezvoltate în cinci dintre cele opt țări.

Accesul insuficient la servicii specializate a fost menționat ca obstacol în raport cu trei afecțiuni medicale: infarctul miocardic, atacurile cerebrale și cancerul.

Aceste obstacole indică necesitatea unei mai bune finanțări a sistemului de sănătate: pentru un număr mai mare de cadre medicale, pentru extinderea rețelei de unități publice existente, pentru dotări mai bune și, de asemenea, pentru o mai bună acoperire geografică a serviciilor medicale specializate.

Tabel 23. Obstacolele din sistemul de sănătate publică în calea unui tratament de vârf în funcție de afecțiunea medicală și respondent

Respondenți: MI – martori individuali și OC – observatori competenți

Tabelul prezintă numărul de țări în care aspectul abordat a fost menționat ca reprezentând un obstacol în calea accesului în raport cu o anumită afecțiune medicală.

	Infarct miocardic		Atac cer-ebral		Cancer		Acci-dente		Diabet	
Obstacole în calea accesului	**MI**	**OC**	**MI**	**OC**	**MI**	**OC**	**MI**	**OC**	**MI**	**OC**
Amânarea primei vizite la medic		3		4	6	5			3	1
Nivelul redus de cunoaștere și de informare a populației. Comportamentul de prevenire a bolilor nu este un fapt uzual		7		7	4	8		3	8	8
În unele zone nu există medici sau servicii medicale	2	6	2	6	3	6	1	6	2	6
Serviciile specializate sunt disponibile doar în unele zone	1	4	4	6	6	7				
Serviciile specializate sunt disponibile în principal în spitale/clinici private sau în străinătate					1	1				
Unitățile/serviciile de reabilitare nu sunt disponibile/ suficiente în unele zone	1	4	1	6			1	4		
În unele zone nu există farmacii	1	2	1	1		5		1		
Serviciile de urgență nu sunt disponibile în unele zone sau sunt slab dezvoltate	1	5	2	5			1	2		
Serviciile de transport sunt slab dezvoltate sau prea costisitoare		2	2	2	3	3		4		1
Distanța dintre domiciliu și un spital /o clinică este prea mare și/sau prea costisitoare.					4	3	4	2	2	
Timpul de așteptare pentru examinarea de către un specialist este prea mare	4	4	4	2	4	5	1	2	6	3
Timpul de așteptare pentru obținerea tratamentului sau a medicației este prea mare.	2	1	1	1	2	4		1	2	1
Timpul de așteptare pentru servicii de reabilitare este prea mare.	1	2	2	2			2	2		
Competență insuficientă a asistenților sau a altor cadre medicale						2				
Lipsa de interes și neprofesionalismul medicului sau al personalului medical		1	2			1	2	2	4	2
Comportament discriminatoriu sau necorespunzător al cadrelor medicale										1
Lipsă de încredere în medici, asistenți sau personalul medical		1	2	1	2	4	1		1	2
Lipsa de umanitate a personalului	2		3	2	6		3			
Lipsa banilor pentru plata medicului	1	1	1	1	2					
Lipsa banilor pentru analizele necesare			4	2	2	2				1
Lipsa banilor pentru plăți directe	1	4	4	3	2	2	1	2		
Calitatea și eficiența redusă a serviciilor medicale	5	4	4	5	2	2	4	6	3	5
Costuri ridicate ale medicamentelor	6	2	2	1		3	2	2	3	1
Dotările inadecvate ale clinicilor/spitalelor publice		4	3	3	4	6	3	4	2	4
Lipsa accesibilității și continuității îngrijirii	2		4	1	1	2	3			
Specialiștii în anumite specialități lipsesc sau sunt insuficienți		1		2		2				2
Capacitate redusă a clinicilor/spitalelor						2				
Altele. Vă rugăm să detaliați										1

Date: FES (2012-2013) Performanța sistemului public de sănătate Note: Lipsa de umanitate a personalului: nu tratează în mod corespunzător, sunt lipsiți de respect, nu oferă explicații cu privire la boală și tratament. Eficiența redusă a serviciilor: timp de așteptare necorespunzător, analize de laborator nelivrate prompt și corect, dotări necorespunzătare, lipsa curățeniei în spital/clinică. Lipsa accesibilității și continuității îngrijirii: număr necorespunzător de scaune în sala de așteptare, disponibilitatea serviciile necesare la orice oră, numărul cadrelor care efectuează toate activitățile necesare la fiecare vizită. Altele: factori socio-economici, cum ar fi cultura sănătății și condiții de viață precare. Acronime țări: BG - Bulgaria, HR - Croația, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Muntenegro, RO - România, SRB - Serbia.

4.7.2 Șase domenii majore de reforme la nivelul politicilor

Pe baza rezultatelor cercetării se pot identifica șase domenii principale de reforme la nivelul politicilor pentru a îmbunătăți performanța sistemului de sănătate publică.

Necesitatea unei mai bune definiri și evaluări de cost ale pachetelor de beneficii

Toate cele opt țări oferă prin legislația națională pachete complexe de servicii de asistență medicală. Problema majoră este aceea că niciunul dintre sistemele de sănătate studiate nu are capacitatea de a asigura furnizarea universală a acestor servicii. Prin urmare, sunt necesare pachete de servicii mai realiste: „(…) definirea unui pachet de beneficii mai realist va reprezenta o strategie-cheie în asigurarea sustenabilității financiare. Angajamentul de instituire atât a unei acoperiri universale, cât și a unui pachet de beneficii cu adevărat complet este nerealist și nesustenabil în multe țări din regiune. În ciuda dificultăților de natură politică și tehnică și a îngrijorărilor privind echitatea, ar putea fi necesar ca țările să ia în considerare definirea într-o manieră explicită a unor drepturi mai limitate, pentru a se asigura că veniturile publice sunt orientate către cele mai eficiente intervenții din punct de vedere al costurilor și către segmentele cele mai sărace ale populației și că protejează sănătatea publică." (Figueras et al., 2004, p.15)

Necesitatea dezvoltării serviciilor de prevenire

În majoritatea țărilor au existat programe sau măsuri de prevenire singulare, însă rezultatele acestora nu au reușit să satisfacă nevoile populației, astfel că sunt necesare în continuare eforturi în acest sens. Participarea medicilor de familie și a medicilor specialiști la furnizarea de prevenire începe în majoritatea cazurilor în faza de administrare a tratamentului, fără a se lua în considerare educarea pacientului.

Sistemul de îngrijire comunitară, considerat a fi cel mai puternic „egalizator" în sistemul de sănătate, este încă în mare parte neutilizat în majoritatea țărilor. În ciuda eforturilor de a dezvolta servicii de îngrijire de bază, accesul la servicii holistice de îngrijire comunitară adecvată rămâne o provocare pentru anumite segmente de populație (grupuri cu venituri reduse, locuitorii zonelor rurale și ai orașelor mici, romi etc.).

Dezvoltarea serviciilor de prevenire este încă și mai necesară, ținând seama de nivelul ridicat al mortalității care poate fi evitată în regiune. Modelele de mortalitate care poate fi prevenită fac necesară consolidarea politicilor și a implementării lor (mai ales pentru femei), în special dezvoltarea continuă atât a politicilor în domeniul tutunului, cât și în cel al alcoolului. Prin urmare, s-ar putea obține progrese însemnate în ceea ce privește reducerea în continuare a mortalității în aceste țări prin vizarea serviciilor de sănătate. Ne referim nu numai la mai buna finanțare a sistemului de sănătate, ci și la modernizarea și creșterea calității serviciilor de asistență.

Necesitatea dezvoltării unor servicii de reabilitare, paliative și de îngrijire pe termen lung

Îngrijirea paliativă și pe termen lung și reabilitarea nu sunt dezvoltate suficient în cadrul sistemelor de sănătate din regiune. Cea mai mare parte a îngrijirii pe termen lung se acordă în cadrul familial, unde există puține resurse pentru îngrijitorii informali.

Necesitatea îmbunătățirii finanțării sistemelor de sănătate publică

Sistemele de sănătate publică din regiune sunt subfinanțate, în primul rând ca urmare a constrângerilor de natură fiscală. Totuși, cel puțin în unele țări, subfinanțarea este determinată de prioritatea redusă pe care guvernele o acordă sectorului de sănătate. Astfel, voința politică este un factor important de îmbunătățire a performanței sistemelor de sănătate publică.

Studiul indică nu numai faptul că nivelul finanțării ar trebui să fie mai ridicat, ci și că finanțarea ar trebui să fie mai bine orientată către investițiile de capital în echipament și tehnologie. Investiția de capital în asistența medicală secundară și terțiară a variat de la țară la țară, însă, în general, a fost mai redusă în comparație cu investiția în asistența medicală primară. Ca regulă generală, echipamentul de înaltă tehnologie este disponibil doar în centrele mari, în timp ce echipamentul medical de nivel tehnologic mai redus utilizat în intervențiile de rutină lipsește sau este învechit în unele zone, în special în unitățile medicale mai mici. Deși tehnologia informației este în continuă dezvoltare, ea rămâne fragmentată și necoordonată în majoritatea țărilor studiate.

Necesitatea unei politici eficiente în domeniul resurselor umane din sănătate

În aproape toate țările studiate, disponibilitatea tuturor tipurilor de cadre medicale se situează sub media europeană. Planificarea resurselor umane a devenit o prioritate în ultimii ani, în special având în vedere migrația masivă a cadrelor medicale. Mulți doctori și asistenți au părăsit sectorul medical și deseori țara în căutarea unei remunerații mai mari, a unor condiții de lucru mai bune și/sau pentru recunoaștere socială. Mobilitatea cadrelor medicale este îngrijorătoare, în special din cauza faptului că regiunile defavorizate din punct de vedere economic au fost cele mai afectate de aceste migrații.

Totuși, problema insuficienței nu se referă numai la numărul absolut al medicilor, ci și la profilul lor. În zonele rurale sărace, chiar și plecarea câtorva medici specialiști poate avea un impact semnificativ asupra furnizării serviciilor. Având în vedere faptul că medicina de familie este una dintre cele mai solicitate specialități în unele state membre ale UE, este foarte posibil ca inegalitățile privind accesul la servicii de îngrijire de bază să se amplifice în continuare dacă fenomenul de emigrare a medicilor de familie continuă și/sau ia amploare. De asemenea, unele specialități și competențe la nivel spitalicesc ar putea fi afectate în mod negativ.

Insuficiența unor specialități și competențe este semnalată și în țările studiate – Croația, Macedonia, Kosovo, Moldova, și nu este legată neapărat de mobilitatea profesională a cadrelor medicale.

Necesitatea abordării plăților informale în sistemul de sănătate publică

Studiul arată că plățile informale reprezintă un obstacol în calea unui tratament de vârf, în special în ceea ce privește bolile cronice. Prin urmare, abordarea plăților informale trebuie să fie o prioritate. Datele privind plățile directe sugerează că acestea sunt larg răspândite atât în cazul serviciilor medicale ambulatorii, cât și al celor spitalicești, și constituie o sursă majoră de finanțare în unele țări. Plățile informale au legătură cu factori culturali și istorici, însă reprezintă în primul rând un răspuns la slaba capacitate a sistemului de sănătate publică de a furniza un acces adecvat la serviciile de bază.

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ANNEX

Table A. 1. Main characteristics of total sample - Individual witnesses (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**175**	**175**	**213**	**175**	**175**	**175**	**175**	**175**	**1,438**
TOTAL	**Individual witnesses**	**50**	**50**	**82**	**50**	**50**	**50**	**50**	**50**	**432**
Type of individual	Patients	39	36	30	32	37	42	38	39	293
witnesses	Family members	11	14	52	18	13	8	12	11	139
Ethnicity	Majority ethnicity	50	50	71	37	41	50	50	48	397
	Minority ethnicity	0	0	11	13	9	0	0	2	35
Gender	Male	23	21	36	23	20	21	24	27	195
	Female	27	29	46	27	30	29	26	23	237
Age	Minimum age	11	20	19	9	18	25	29	22	9
(years)	Maximum age	78	88	86	81	85	81	78	98	98
	Average age	51	54	49	54	59	56	53	63	55
Employment	Managers	4	9	12	1	7	6	7	7	53
Status*	Clerical staff	16	2	11	6	1	8	9	6	59
	Non-manual workers	12	11	7	5	2	4	5	2	48
	Manual workers	4	7	9	11	4	3	13	5	56
	Pensioners	9	18	16	17	26	18	10	22	136
	Pupils/students	3	0	8	3	2	2	0	2	20
	Housewives	2	2	18	7	8	9	6	6	58
Level of	No formal schooling	0	1	.	3	0	0	0	1	5
Education*	Elementary	5	11	.	10	18	6	5	12	67
	Secondary	20	25	.	27	10	30	15	21	148
	Tertiary	25	13	.	10	22	13	30	16	129
Level of	Low	11	18	.	10	4	16	7	12	78
Incomes*	Middle-low	13	10	.	13	32	4	14	6	92
(self-assessed)	Middle	22	15	.	19	13	19	14	17	119
	Middle-high	4	7	.	6	1	11	9	13	51
	High	0	0	.	2	0	0	6	2	10

Data: FES (2012-2013) *Performance of the Public Health Care System*. Note: * Characteristic with missing cases. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 2. Main characteristics of total sample - Knowledgeable observers (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**175**	**175**	**213**	**175**	**175**	**175**	**175**	**175**	**1,438**
TOTAL	**Knowledgeable observers**	**125**	**125**	**131**	**125**	**125**	**125**	**125**	**125**	**1,006**
	Family physicians	38	40	14	45	49	29	28	35	278
Type of	Medical specialists	58	61	60	37	32	58	26	65	397
Knowledgeable observers	Regional or national directions of public health	14	7	7	7	21	5	8	4	73
	Hospitals	4	7	6	11	10	2	43	7	90
	Emergency centres	4	9	3	3	11	8	14	9	61
	NGOs	2	0	4	2	2	4	4	2	20
	Patients' organizations	2	1	37	3	0	0	2	3	48
	Others	3	0	0	17	0	19	0	0	39
Gender	Male	62	33	70	51	43	66	48	61	434
	Female	63	92	61	74	82	59	77	64	572
Age	Minimum age	32	26	20	24	24	24	26	27	20
(years)	Maximum age	65	78	65	67	64	73	62	65	78
	Average age	49	44	42	47	37	43	39	48	44

Data: FES (2012-2013) *Performance of the Public Health Care System*. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 3. Main characteristics of the sample on myocardial infarction - Individual witnesses (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**35**	**35**	**23**	**35**	**35**	**35**	**35**	**35**	**268**
TOTAL	**Individual witnesses**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**80**
Type of individual	Patients	9	6	5	7	7	8	8	10	60
witnesses	Family members	1	4	5	3	3	2	2	0	20
Ethnicity	Majority ethnicity	10	10	9	8	8	10	10	10	75
	Minority ethnicity	0	0	1	2	2	0	0	0	5
Gender	Male	7	4	6	7	5	7	4	5	45
	Female	3	6	4	3	5	3	6	5	35
Age	Minimum age	49	20	19	30	52	38	46	46	19
(years)	Maximum age	66	88	64	74	78	75	64	80	88
	Average age	56	50	41	54	66	59	53	65	54
Employment	Managers	2	2	1	1	1	1	1	2	11
Status*	Clerical staff	4	1	2	2	0	1	2	0	12
	Non-manual workers	3	3	1	0	1	0	0	1	9
	Manual workers	0	2	3	1	0	1	5	1	13
	Pensioners	1	2	-	5	7	6	2	4	27
	Pupils/students	0	0	1	1	0	0	0	0	2
	Housewives	0	0	1	0	1	1	0	2	5
Level of	No formal schooling	0	0	-	0	0	0	0	0	0
Education*	Elementary	0	3	-	1	3	1	0	2	10
	Secondary	2	6	-	7	2	6	1	4	28
	Tertiary	8	1	-	2	5	3	9	4	32
Level of	Low	1	3	-	1	1	1	0	2	9
Incomes*	Middle-low	2	2	-	0	8	1	6	0	19
(self-assessed)	Middle	5	3	-	6	1	5	3	4	27
	Middle-high	2	2	-	2	0	3	1	4	14
	High	0	0	-	1	0	0	0	0	1

Data: FES (2012-2013) *Performance of the Public Health Care System*. Note: * Characteristic with missing cases. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 4. Main characteristics of the sample on myocardial infarction - Knowledgeable observers (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**35**	**35**	**23**	**13**	**35**	**35**	**35**	**35**	**268**
TOTAL	**Knowledgeable observers**	**25**	**25**	**13**	**25**	**25**	**25**	**25**	**25**	**188**
	Family physicians	9	7	0	7	9	4	5	5	46
Type of	Medical specialists	13	15	8	8	7	12	5	18	86
knowledgeable observers	Regional or national directions of public health	3	0	2	4	4	1	2	1	17
	Hospitals	0	0	0	2	2	2	8	0	14
	Emergency centers	0	3	0	1	3	3	3	1	14
	NGOs	0	0	0	1	0	2	2	0	5
	Patients' organizations	0	0	3	0	0	0	0	0	3
	Others	0	0	0	2	0	1	0	0	3
Gender	Male	17	5	9	9	10	11	9	15	85
	Female	8	20	4	16	15	14	16	10	103
Age	Minimum age	38	35	34	24	25	26	29	33	24
(years)	Maximum age	61	53	61	67	57	59	54	65	67
	Average age	48	44	47	47	36	40	36	53	44

Data: FES (2012-2013) *Performance of the Public Health Care System*. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 5. Main characteristics of the sample on stroke - Individual witnesses (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**35**	**35**	**51**	**35**	**35**	**35**	**35**	**35**	**296**
TOTAL	**Individual witnesses**	**10**	**10**	**30**	**10**	**10**	**10**	**10**	**10**	**100**
Type of individual	Patients	4	5	11	3	8	9	6	5	51
witnesses	Family members	6	5	19	7	2	1	4	5	49
Ethnicity	Majority ethnicity	10	10	25	7	9	10	10	10	91
	Minority ethnicity	0	0	5	3	1	0	0	0	9
Gender	Male	4	6	15	5	8	3	5	5	51
	Female	6	4	15	5	2	7	5	5	49
Age	Minimum age	32	34	22	45	30	42	29	45	22
(years)	Maximum age	76	80	86	81	71	78	78	98	98
	Average age	60	59	56	65	61	62	59	72	62
Employment	Managers	0	4	4	0	1	1	2	0	12
Status*	Clerical staff	3	-	3	1	0	2	3	0	12
	Non-manual workers	3	1	1	1	1	1	0	0	8
	Manual workers	0	0	2	3	2	1	2	2	12
	Pensioners	4	3	10	2	6	2	1	8	36
	Pupils/students	0	-	4	0	0	0	0	0	4
	Housewives	0	1	6	3	0	3	2	0	15
Level of	No formal schooling	0	0	-	1	0	0	0	0	1
Education*	Elementary	2	2	-	4	4	2	0	1	15
	Secondary	7	2	-	4	3	5	2	5	28
	Tertiary	1	6	-	1	3	3	8	4	26
Level of	Low	3	3	-	4	0	5	2	1	18
Incomes*	Middle-low	4	2	-	2	6	0	0	2	16
(self-assessed)	Middle	3	1	-	3	4	4	3	3	21
	Middle-high	0	4	-	0	0	1	3	4	12
	High	0	0	-	1	0	0	2	0	3

Data: FES (2012-2013) *Performance of the Public Health Care System*. Note: * Characteristic with missing cases. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 6. Main characteristics of the sample on stroke - Knowledgeable observers (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**35**	**35**	**51**	**35**	**35**	**35**	**35**	**35**	**296**
TOTAL	**Knowledgeable observers**	**25**	**25**	**21**	**25**	**25**	**25**	**25**	**25**	**196**
	Family physicians	7	10	3	12	8	6	5	5	56
Type of	Medical specialists	13	10	11	7	5	8	5	18	77
knowledgeable observers	Regional or national directions of public health	3	0	1	0	5	1	1	1	12
	Hospitals	0	3	1	2	2	0	9	0	17
	Emergency centres	2	2	1	0	5	5	5	1	21
	NGOs	0	0	1	0	0	1	0	0	2
	Patients' organizations	0	0	3	0	0	0	0	0	3
	Others	0	0	0	4	0	4	0	0	8
Gender	Male	11	6	13	12	10	13	9	8	82
	Female	14	19	8	13	15	12	16	17	114
Age	Minimum age	35	30	20	25	24	25	26	35	20
(years)	Maximum age	65	60	61	66	64	61	52	65	66
	Average age	50.9	47	37	42.2	39	42	40	50.7	44

Data: FES (2012-2013) *Performance of the Public Health Care System*. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 7. Main characteristics of the sample on cancer - Individual witnesses (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**35**	**35**	**59**	**35**	**35**	**35**	**35**	**35**	**304**
TOTAL	**Individual witnesses**	**10**	**10**	**22**	**10**	**10**	**10**	**10**	**10**	**92**
Type of individual	Patients	8	7	8	7	7	9	8	9	63
witnesses	Family members	2	3	14	3	3	1	2	1	29
Ethnicity	Majority ethnicity	10	10	17	8	7	10	10	8	80
	Minority ethnicity	0	0	5	2	3	0	0	2	12
Gender	Male	4	4	6	4	2	3	3	6	32
	Female	6	6	16	6	8	7	7	4	60
Age	Minimum age	36	32	30	35	51	37	35	35	30
(years)	Maximum age	78	83	78	74	85	68	62	79	85
	Average age	54	57	46	55	63	53	52	60	54
Employment	Managers	2	1	6	0	2	0	1	2	14
Status	Clerical staff	2	1	5	0	0	2	2	2	14
	Non-manual workers	3	1	0	2	0	2	2	0	10
	Manual workers	0	2	2	3	0	0	2	1	10
	Pensioners	3	4	2	4	4	4	1	3	25
	Pupils/students	0	0	1	0	0	0	0	1	2
	Housewives	0	1	6	1	4	2	2	1	17
Level of	No formal schooling	0	1	.	1	0	0	0	0	2
Education*	Elementary	1	5	.	1	5	1	2	4	19
	Secondary	3	2	.	7	0	8	4	3	27
	Tertiary	6	2	.	1	5	1	4	3	22
Level of	Low	3	6	.	2	1	2	2	4	20
Incomes*	Middle-low	1	0	.	3	5	2	2	0	13
(self-assessed)	Middle	4	4	.	5	4	1	2	3	23
	Middle-high	2	0	.	0	0	5	3	3	13
	High	0	0	.	0	0	0	1	0	1

Data: FES (2012-2013) *Performance of the Public Health Care System*. Note: * Characteristic with missing cases. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 8. Main characteristics of the sample on cancer - Knowledgeable observers (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**35**	**35**	**59**	**35**	**35**	**35**	**35**	**35**	**304**
TOTAL	**Knowledgeable observers**	**25**	**25**	**37**	**25**	**25**	**25**	**25**	**25**	**212**
	Family physicians	6	5	2	11	11	5	5	7	52
Type of	Medical specialists	9	13	7	5	9	12	5	8	68
knowledgeable observers	Regional or national directions of public health	3	7	4	0	2	1	1	2	20
	Hospitals	3	0	5	3	2	0	8	3	24
	Emergency centres	0	0	2	0	0	0	2	4	8
	NGOs	2	0	2	0	1	1	2	.	8
	Patients' organizations	2	0	15	1	0	0	2	1	21
	Others	0	0	0	5	0	6	0	0	11
Gender	Male	9	11	19	9	11	11	7	14	91
	Female	16	14	18	16	14	14	18	11	121
Age	Minimum age	32	28	24	25	25	28	26	27	24
(years)	Maximum age	62	67	65	62	55	73	57	64	73
	Average age	48	40	42	44	36	45	40	51	43

Data: FES (2012-2013) *Performance of the Public Health Care System*. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 9. Main characteristics of the sample on injuries - Individual witnesses (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**35**	**35**	**42**	**35**	**35**	**35**	**35**	**35**	**287**
TOTAL	**Individual witnesses**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**80**
Type of individual	Patients	8	8	4	8	5	7	6	7	53
witnesses	Family members	2	2	6	2	5	3	4	3	27
Ethnicity	Majority ethnicity	10	10	10	6	10	10	10	10	76
	Minority ethnicity	0	0	0	4	0	0	0	0	4
Gender	Male	4	3	6	5	4	2	4	6	34
	Female	6	7	4	5	6	8	6	4	46
Age	Minimum age	11	36	26	9	18	25	29	22	9
(years)	Maximum age	65	64	86	78	80	75	55	68	86
	Average age	38	46	49	43	44	48	42	49	45
Employment	Managers	0	2	0	0	2	4	2	2	12
Status	Clerical staff	2	0	0	2	1	2	2	3	12
	Non-manual workers	1	3	4	1	0	0	2	1	12
	Manual workers	2	2	2	2	2	0	2	1	13
	Pensioners	1	3	2	1	3	2	0	1	13
	Pupils/students	3	0	0	2	2	1	0	1	9
	Housewives	1	0	2	2	0	1	2	1	9
Level of	No formal schooling	0	0	-	1	0	-	0	1	2
Education*	Elementary	2	1	-	2	2	1	0	2	10
	Secondary	5	6	-	3	4	4	3	5	30
	Tertiary	3	3	-	4	4	4	7	2	27
Level of	Low	3	2	-	2	2	1	2	2	14
Incomes*	Middle-low	4	5	-	3	5	1	1	3	22
(self-assessed)	Middle	3	3	-	3	3	6	4	3	25
	Middle-high	0	0	-	2	0	2	2	1	7
	High	0	0	-	0	0	0	1	1	2

Data: FES (2012-2013) *Performance of the Public Health Care System*. Note: * Characteristic with missing cases. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 10. Main characteristics of the sample on injuries - Knowledgeable observers (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**35**	**35**	**42**	**35**	**35**	**35**	**35**	**35**	**287**
TOTAL	**Knowledgeable observers**	**25**	**25**	**32**	**25**	**25**	**25**	**25**	**25**	**207**
	Family physicians	6	10	7	7	11	7	7	5	60
Type of	Medical specialists	12	10	15	9	3	13	6	13	81
knowledgeable observers	Regional or national directions of public health	2		0	0	6	1	3		12
	Hospitals	1	1	0	3	2	0	6	3	16
	Emergency centres	2	4	0	2	3	0	3	2	16
	NGOs	0	0	0	0	0	0	0	1	1
	Patients' organizations	0	0	10	2	0	0	0	1	13
	Others	2	0	0	2	0	4	0	0	8
Gender	Male	15	5	20	16	7	11	13	14	101
	Female	10	20	12	9	18	14	12	11	106
Age	Minimum age	38	31	29	27	24	27	29	28	24
(years)	Maximum age	64	53	63	64	64	64	62	64	64
	Average age	50	42	40	42	38	42	42	44	43

Data: FES (2012-2013) *Performance of the Public Health Care System*. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 11. Main characteristics of the sample on diabetes (type 2) - Individual witnesses (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**35**	**35**	**38**	**35**	**35**	**35**	**35**	**35**	**283**
TOTAL	**Individual witnesses**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**80**
Type of individual	Patients	10	10	2	7	10	9	10	8	66
witnesses	Family members	0	0	8	3	0	1	0	2	14
Ethnicity	Majority ethnicity	10	10	10	8	7	10	10	10	75
	Minority ethnicity	0	0	0	2	3	0	0	0	5
Gender	Male	4	4	3	2	1	6	8	5	33
	Female	6	6	7	8	9	4	2	5	47
Age	Minimum age	33	40	27	32	52	32	34	60	27
(years)	Maximum age	59	79	68	78	72	81	73	77	81
	Average age	46	59	53	62	62	59	58	69	57
Employment	Managers	0	0	1	0	1	0	1	1	4
Status	Clerical staff	5	0	1	1	0	1	0	1	9
	Non-manual workers	2	3	1	1	0	1	1	0	9
	Manual workers	2	1	0	2	0	1	2	0	8
	Pensioners	0	6	2	5	6	4	6	6	35
	Pupils/students	0	0	2	0	0	1	0	0	3
	Housewives	1	0	3	1	3	2	0	2	12
Level of	No formal schooling	0	0	-	0	0	0	0	0	0
Education*	Elementary	0	0	-	2	4	1	3	3	13
	Secondary	3	9	-	6	1	7	5	4	35
	Tertiary	7	1	-	2	5	2	2	3	22
Level of	Low	1	4	-	1	0	7	1	3	17
Incomes*	Middle-low	2	1	-	5	8	0	5	1	22
(self-assessed)	Middle	7	4	-	2	1	3	1	4	22
	Middle-high	0	1	-	2	1	0	2	1	7
	High	0	0	-	0	0	0	1	1	2

Data: FES (2012-2013) *Performance of the Public Health Care System*. Note: * Characteristic with missing cases. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

Table A. 12. Main characteristics of the sample on diabetes (type 2) - Knowledgeable observers (number of interviews)

		BG	HR	RKS	MK	MD	ME	RO	SRB	TOTAL
TOTAL	**All interviewees**	**35**	**35**	**38**	**35**	**35**	**35**	**35**	**35**	**283**
TOTAL	**Knowledgeable observers**	**25**	**25**	**28**	**25**	**25**	**25**	**25**	**25**	**203**
	Family physicians	10	8	2	8	10	4	6	13	61
Type of	Medical specialists	11	13	19	8	8	12	5	8	84
knowledgeable observers	Regional or national directions of public health	3	0	0	3	4	1	1	0	12
	Hospitals	0	3	0	1	2	2	12	1	21
	Emergency centers	0	0	0	0	0	3	1	1	5
	NGOs	0	0	1	1	1	2	0	1	6
	Patients' organizations	0	1	6	0	0	0	0	1	8
	Others	1	0	0	4	0	1	0	0	6
Gender	Male	10	6	9	5	5	20	10	10	75
	Female	15	19	19	20	20	5	15	15	128
Age	Minimum age	33	26	24	27	25	24	28	29	33
(years)	Maximum age	62	78	62	62	55	58	54	65	62
	Average age	50	47		43	38	45	38	41	50

Data: FES (2012-2013) *Performance of the Public Health Care System*. Country acronyms: BG - Bulgaria, HR - Croatia, RKS - Kosovo, MK - Macedonia, MD - Moldova, ME - Montenegro, RO - Romania, SRB - Serbia.

RESEARCH INSTRUMENTS

(A) Individual witnesses

Social-demographic data

Type of respondent	Data about respondent
Patient Family member	**Region/ county:** **Residency:** **1. large urban** **2. small urban** **3. rural** **Ethnicity:** *(According to the country)* **Age: (in years)** |__|__| **Gender:** 1. male 2. female **Occupation:** *(According to the country, but please make sure that it can be recorded into the following categories for comparison between countries)* **1. manager, specialist** **2. clerical staff** **3. non-manual worker** **4. manual worker** **5. pensioner** **6. student** **7. housewife or other inactive** **Education:** *(According to the country but keep in mind ISCED levels for comparisons)* **Income:** **1. low** **2. middle-low** **3. middle** **4. middle-high** **5. high** *Provide the interviewer with estimates of income for each category in your country for helping the respondent to select the category most appropriate for his/her situation.*

Interview no.: |__|__|	**Module: |_1A_|**	**Disease: MYOCARDIAL INFARCTION**

Therapeutic scheme

Symptoms identification
1. Consult a doctor (general practitioner, emergency doctor, specialist) and getting the diagnostic
2. Treatment (medication and non-medication) and rehabilitation

History of the health problem

Step 1. Symptoms identification

PREVENTION
Did you receive any information or were you performed any preventive action (that relates to current condition) before getting ill? *If YES, tell us more about this preventive information or testing.*

SYMPTOMS
When the myocardial infarction occurred, did you know to recognize the symptoms?
Most frequent symptoms: chest pain, pressure, fullness and/or squeezing sensation of the chest, jaw pain, toothache, headache, shortness of breath, nausea, vomiting, sweating, heart-burn and/ or indigestion, arm pain (more commonly the left arm, but may be either arm), upper back pain, general malaise (vague feeling of illness);

No symptoms (approximately one quarter of all heart attacks are silent, without chest pain or new symptoms. Silent heart attacks are especially common among patients with diabetes)

History of the health problem

Step 2. Consult a doctor and getting the diagnostic

TIME
When did the myocardial infarction occur?

PERSONS INVOLVED
When it happened, were you in the position to call the emergency centre or someone else did it?
Please ask a history of the events.
Who called the emergency centre?
How long took the ambulance to arrive? (in minutes)
Was the patient tested in the ambulance?
How long is the distance (in km) from the patients' home to the nearest clinic/hospital?

DIAGNOSTIC
How long did it take for you to be diagnosed?

SATISFACTION
Do you consider that the diagnostic was given in a professional and timely manner or it was erroneous and/or delayed so that it affected further your health condition?

History of the health problem

Step 3. Treatment and rehabilitation

TIME
After how many hours since the first symptoms appeared, did you start the stabilization treatment?

TYPE OF TREATMENT
Your treatment included surgical intervention? If yes, how much did you pay (official or informal)?
The amount you had to pay for the entire treatment did cover (*Circle your answers)*

- Doctor/ specialists
- Nurses or other medical staff
- Laboratory tests
- Clinic/hospital medication
- Proper care (food, cleaning, etc.)
- Others (transportation, accommodation, etc.)

What would happen if a patient cannot pay the demanded amount for the entire treatment?

COSTS OF TREATMENT AND REHABILITATION
(*Clinic/hospital refer also to the rehabilitation facilities*)
The health-care services received at the clinic/ hospital were free of costs?
Did you have to pay the medical staff to receive proper care?
Did you have to pay for the laboratory tests taken at the clinic/hospital?
Did you have to pay for the clinic/ hospital medication?

REHABILITATION
What medical professionals specialized in post-myocardial infarction rehabilitation did help you?
Please ask a history of doctors (e.g. physician, rehabilitation therapist or nurses, physical therapist, occupational and recreational therapist, etc.) and places.

Did you follow a program of rehabilitation? (in a clinic/ hospital or at home)

The distance from your home to the clinic/ hospital was acceptable?

STATE OF ART
Was the treatment provided in the public health-care system at the level of state of art? If no, please provide details.
Have you been prescribed a type of treatment or rehabilitation that you have not followed? If yes, what treatment and why?

MEDICATION
Do you have to take regular medication?
If yes, can you obtain the prescribed medication easily at your local pharmacy?
If no, please explain how did you manage to obtain the prescribed medication?
Your medication was free of costs?
If no, approximately how much do you have to spend per month for the necessary medication?

FACTORS HAMPERING ACCESS

Taking into consideration your experience during the entire process (from diagnostic to the recovery period) which are the main factors that prevent state of art (high quality) treatment in case of myocardial infarction?

(Please check the following list of potential factors)

- *Distance from home to a hospital/clinic is too large and/or too costly?*
- *Emergency services are not available or are limited? Rehabilitation services are not available?*
- *Distance from home to pharmacy is too large?*
- *The waiting time for being received by the doctor or clinic/hospital or rehabilitation unit is very long?*
- *The waiting time for getting the medication is very long?*
- *Lack of interest or unprofessionalism of the doctor or medical staff? Discriminatory or inappropriate behaviour of medical staff?*
- *Lack of trust in doctors, nurses or medical staff?*
- *Low quality (low effectiveness) of medical services? Poor equipment of clinic/hospital? Poor equipment of the emergency services?*
- *High costs of medical services to pay the doctor, the nurses or other medical staff or to pay the needed tests?*
- *High costs of medication?*
- *Lack of humanness of the staff (not treated well, disrespectful, not provided with explanations about disease and treatment)?*
- *Low effectiveness of services (inappropriate waiting tine, laboratory tests not reported promptly and correctly, poor working equipment, unclean and untidy hospitall/ clinic)?*
- *Lack of accessibility and continuity of care (inappropriate number of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit)?*
- *Others, please give details*

Therapeutic scheme

1. Symptoms identification
2. Consult a doctor (general practitioner, emergency doctor, specialist) and getting the diagnostic
3. Treatment (medication and non-medication) and rehabilitation

History of the health problem

Step 1. Symptoms identification

PREVENTION
Did you receive any information or were you performed any preventive action (that relates to current condition) before getting ill? *If YES, tell us more about these preventive information or testing.*

SYMPTOMS
When the stroke occurred, did you know to recognize the symptoms?
Most frequent symptoms: Sudden numbness or weakness of the face, arm, or leg; Sudden confusion, trouble speaking or understanding speech; Sudden trouble seeing in one or both eyes; Sudden trouble walking, dizziness, loss of balance or coordination; Sudden severe headache with no known cause.

History of the health problem

Step 2. Consult a doctor and getting the diagnostic

TIME
When did the stroke occur?

PERSONS INVOLVED
When it happened, were you in the position to call the emergency centre or someone else did it?

Please ask a history of the events.

Who called the emergency centre?

How long took the ambulance to arrive? (in minutes)

Was the patient tested in the ambulance?

How long is the distance (in km) from the patients' home to the nearest clinic/hospital? Is there a neurovascular department in the nearest clinic/ hospital?

DIAGNOSTIC
How long did it take for you to be diagnosed?
What kind of stroke? Ischemic stroke (clot) or Hemorrhagic stroke (bleeding)?

SATISFACTION
Do you consider that the diagnostic was given in a professional and timely manner or it was erroneous and/or delayed so that it affected further your health condition?

History of the health problem

Step 3. Treatment and rehabilitation

TIME
After how many hours since the first symptoms appeared, did you start the stabilization treatment?

TYPE OF TREATMENT
Your treatment included surgical intervention?
If yes, how much did you pay (official or informal)?
The amount you had to pay for the entire treatment did cover (*Circle your answers)*

- Doctor/ specialists
- Nurses or other medical staff
- Laboratory tests
- Clinic/hospital medication
- Proper care (food, cleaning, etc.)
- Others (transportation, accommodation, etc.)

What would happen if a patient cannot pay the demanded amount for the entire treatment?

COSTS OF TREATMENT AND REHABILITATION
(*Clinic/hospital refer also to the rehabilitation facilities*)
The health-care services received at the clinic/ hospital were free of costs?
Did you have to pay the medical staff to receive proper care?
Did you have to pay for the laboratory tests taken at the clinic/hospital?
Did you have to pay for the clinic/ hospital medication?

DISABILITIES
Did the stroke result in any disabilities?
If yes, mention the types of disabilities. E.g. Paralysis or problems controlling movement (motor control)

Sensory disturbances including pain

Problems using or understanding language (aphasia)

Problems with thinking and memory

Emotional disturbances

REHABILITATION
What medical professionals specialized in post-stroke rehabilitation did help you?
Please ask a history of doctors (e.g. physician, rehabilitation therapist or nurses, physical therapist, occupational and recreational therapist, speech-language pathologist, vocational therapist) and places.

What type of rehabilitation program did you follow?
(see the definitions bellow)

- *Inpatient rehabilitation units*
- *Outpatient rehabilitation units*
- *Nursing facilities*
- *Home-based rehabilitation*

The distance from your home to the clinic/ hospital was acceptable?

Definitions - What type of rehabilitation program did you follow?

■ *Inpatient rehabilitation units*
Inpatient facilities may be freestanding or part of larger hospital complexes. Patients stay in the facility, usually for 2 to 3 weeks, and engage in a coordinated, intensive program of rehabilitation. Such programs often involve at least 3 hours of active therapy a day, 5 or 6 days a week. Inpatient facilities offer a comprehensive range of medical services, including full-time physician supervision and access to the full range of therapists specializing in post-stroke rehabilitation

■ *Outpatient rehabilitation units*
Outpatient facilities are often part of a larger hospital complex and provide access to physicians and the full range of therapists specializing in stroke rehabilitation. Patients typically spend several hours, often 3 days each week, at the facility taking part in coordinated therapy sessions and return home at night. Comprehensive outpatient facilities frequently offer treatment programs as intense as those of inpatient facilities, but they also can offer less demanding regimens, depending on the patient's physical capacity.

■ *Nursing facilities*
Rehabilitative services available at nursing facilities are more variable than are those at inpatient and outpatient units. Skilled nursing facilities usually place a greater emphasis on rehabilitation, whereas traditional nursing homes emphasize residential care. In addition, fewer hours of therapy are offered compared to outpatient and inpatient rehabilitation units.

■ *Home-based rehabilitation*
Home rehabilitation allows for great flexibility so that patients can tailor their program of rehabilitation and follow individual schedules. Stroke survivors may participate in an intensive level of therapy several hours per week or follow a less demanding regimen. These arrangements are often best suited for people who require treatment by only one type of rehabilitation therapist. Patients dependent on Medicare (medical insurance) coverage for their rehabilitation must meet Medicare's "homebound" requirements to qualify for such services; at this time lack of transportation is not a valid reason for home therapy. The major disadvantage of home-based rehabilitation programs is the lack of specialized equipment. However, undergoing treatment at home gives people the advantage of practicing skills and developing compensatory strategies in the context of their own living environment. In the recent stroke rehabilitation trial, intensive balance and strength rehabilitation in the home was equivalent to treadmill training at a rehabilitation facility in improving walking.

STATE OF ART
Was the treatment provided in the public health-care system at the level of state of art? If no, please provide details.
Have you been prescribed a type of treatment or rehabilitation that you have not followed? If yes, what treatment and why?

MEDICATION

Do you have to take regular medication?
If yes, can you obtain the prescribed medication easily at your local pharmacy?
If no, please explain how did you manage to obtain the prescribed medication?
Your medication was free of costs?
If no, approximately how much do you have to spend per month for the necessary medication?

FACTORS HAMPERING ACCESS

Taking into consideration your experience during the entire process (from diagnostic to the recovery period) which are the main factors that prevent state of art (high quality) treatment in case of stroke?
(Please check the following list of potential factors.)

- Distance from home to a hospital/*clinic with a neurovascular department is too large and/ or too costly?*
- *Emergency services are not available or are limited? Rehabilitation services are not available?*
- *Distance from home to pharmacy is too large?*
- *The waiting time for being received by the doctor or clinic/hospital or rehabilitation unit is very long?*
- *The waiting time for getting the medication is very long?*
- *Lack of interest or unprofessionalism of the doctor or medical staff? Discriminatory or inappropriate behaviour of medical staff?*
- *Lack of trust in doctors, nurses or medical staff?*
- *Low quality (low effectiveness) of medical services? Poor equipment of clinic/hospital? Poor equipment of the emergency services?*
- *High costs of medical services to pay the doctor, the nurses or other medical staff or to pay the needed tests?*
- *High costs of medication?*
- *Lack of humanness of the staff (not treated well, disrespectful, not provided with explanations about disease and treatment)?*
- *Low effectiveness of services (inappropriate waiting tine, laboratory tests not reported promptly and correctly, poor working equipment, unclean and untidy hospital/ clinic)?*
- *Lack of accessibility and continuity of care (inappropriate number of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit)?*
- *Others,* please give details

Therapeutic scheme

1. Symptoms identification
2. Consult a doctor (general practitioner, specialist, oncologist) and getting the diagnostic
3. Treatment (medication and non-medication)
4. Monitoring period

History of the health problem

Step 1. Symptoms identification

TIME
When did you notice the first symptoms?
How did you notice the first symptoms?
1. During some routine or preventive consults
2. Felt ill one day and went to a doctor
3. Felt ill for a period of time and went to a doctor only when pain became unbearable

PREVENTION
Did you receive any information or were you performed any preventive action (that relates to current condition) before getting ill?
(i.e. for woman with breast cancer this would mean… were they instructed ever to carry out self-examination)

PERSONS INVOLVED
Who did you talk to about the symptoms first?
A family member? A general practitioner? A specialist? Another medical representative? Another person. Who?

History of the health problem

Step 2. Consult a doctor and getting the diagnostic

PERSONS INVOLVED
Who did you talk to about the disease?
Please ask a history of doctors and places.

Example: First, the patient visited his general practitioner who referred him to a specialist in the same locality. The specialist recommended few tests and met him again after two weeks, recommending medication. After treatment the patient did not feel better. So, he decided to go to a second specialist in the same locality who recommended additional tests and after two more weeks referred the patient to an oncologist from another city (xxx km away). The patient went to the oncologist who ran some tests and recommended medication. After four weeks the situation was not improving so the patient went to a much larger hospital from a large city for consulting another oncologist. The second opinion was a cancer diagnostic and the patient was registered in the National Registry and he was included in the National Programme of Oncology.

Please note if the patient was referred to the private sector and/or to treatment abroad.

TESTS
Did you have to pay (official or informal) for any of the required tests including blood test, ultrasound, radiography, mammography, tomography, nuclear magnetic resonance spectroscopy, others?
If yes, for which tests have you paid? (*Circle the paid tests*)

1. Blood tests
2. Ultrasound
3. Radiography
4. Mammography
5. Tomography
6. Nuclear magnetic resonance (NMR) spectroscopy
7. Other, namely

Overall, how much did you pay for all tests (official and informal)?

DIAGNOSTIC
When were you diagnosed with cancer?
What kind of cancer?
Did you ask for a second opinion?
Did you enter the National Programme of Oncology?

SATISFACTION
Do you consider that the diagnostic was given in a professional and timely manner or it was erroneous and/or delayed so that it affected further your health condition?

History of the health problem

Step 3. Treatment

TIME
When did you start the treatment?

ABOUT TREATMENT
Please describe the treatment you have taken.

Have you been prescribed a type of treatment that you have not followed? If yes, what treatment and why? The treatment was provided at home or in a clinic/ hospital or both? Were there in the public or private system?

How much time did you spend in a public clinic/hospital?

Was the treatment provided in the public health-care system at the level of state-of-art? If no, please provide details.

Did you spend time in private facilities or out of country? Were the same physicians working in both sectors who condition the patient to receive the treatment in a private facility?

COSTS OF TREATMENT

The health-care services received at the clinic/ hospital were free of costs?
Did you have to pay the medical staff to receive proper care?
Did you have to pay for the laboratory tests taken at the clinic/hospital?
Did you have to pay for the clinic/ hospital medication?

TYPE OF TREATMENT

What type of treatment did you have to follow?	For this treatment did you had to pay, officially or informally, any money? (circle your answer)		How much did you pay officially?	How much did you pay informally?
Surgical intervention	Yes	No	.....	.....
Chemotherapy	Yes	No	.....	.....
Radiotherapy	Yes	No	.....	.....
Laser therapy	Yes	No	.....	.....
Photodynamic therapy	Yes	No	.....	.....
Hormonal therapy	Yes	No	.....	.....

What would happen if a patient cannot pay the demanded amount for the entire treatment?
The amount you had to pay for the entire treatment did cover (*Circle your answers)*

- Doctor/ specialists
- Nurses or other medical staff
- Laboratory tests
- Clinic/hospital medication
- Proper care (food, cleaning, etc.)
- Others (transportation, accommodation, etc.)

History of the health problem

Step 4. Recovery period

PERSONS INVOLVED

For the monitoring period you went to:

1. public facility 2. private facility 3. both
1. only in the country 2. abroad 3. both

All the health-care services that you needed during the monitoring period were present at the nearest clinic/ hospital or you had to visit different doctors located in various places?

The distance from your home to the clinic/ hospital was acceptable?

MEDICATION

Do you have to take regular medication?

If yes, can you obtain the prescribed medication easily at your local pharmacy?

If no, please explain how did you manage to obtain the prescribed medication?

If yes, was the medication free of costs?

If no, approximately how much do you have to spend per month for the necessary medication?

Factors hampering the access

Taking into consideration your experience during the entire process (from diagnostic to the recovery period) which are the main factors that prevent state of art treatment in case of cancer? *(Please check the following list of potential factors.)*

- Did *not think/ know that they had to do something? Usually, he/she does not contact a doctor until the situation becomes urgent?*
- *Specific ethnic culture? Costumes/tradition related factors… family would not let woman to visit the doctor… or similar…*
- *Doctor or medical services are not available in the locality?*
- *Distance from home to a hospital/clinic is too large and/or too costly?*
- *Distance from home to pharmacy is too large?*
- *The waiting time for being received by the doctor is very long?*
- *The waiting time for getting the medication is very long?*
- *Lack of interest or unprofessionalism of the doctor or medical staff?*
- *Discriminatory or inappropriate behaviour of medical staff?*
- *Lack of money to pay the doctor?*
- *Lack of money to pay the needed tests?*
- *Lack of money for out-of-pocket payments?*
- *Lack of trust in doctors, nurses or medical staff?*
- *Lack of humanness of the staff (not treated well, disrespectful, not provided with explanations about disease and treatment)?*
- *Low effectiveness of services (inappropriate waiting time, laboratory tests not reported promptly and correctly, poor working equipment, unclean and untidy hospital/ clinic)?*
- *High costs of medication?*
- *Oncology services are not available in your city/ village?*
- *Low quality (low effectiveness) of medical services?*
- *Poor equipment of clinic/hospital?*
- *Lack of accessibility and continuity of care (inappropriate number of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit*
- *Others, please give* details

Therapeutic scheme

1. Accident/ Symptoms identification
2. Consult a doctor (general practitioner, emergency doctor, specialist) and getting the diagnostic
3. Treatment (medication and non-medication) and rehabilitation

History of the health problem

Step 1. Symptoms identification

PREVENTION
Did you receive any information or were you performed any preventive action (that relates to current condition) before getting the injuries (fractures)?
(Were you conscious about the possibility of getting injured during your current activities/ work/ free time?)

ACCIDENT/ SYMPTOMS
When the injuries (fractures) occurred, did you know to recognize the symptoms?
Most frequent symptoms: swelling, bruising, the bone sticking out or bending, a grating feeling or sound.

History of the health problem

Step 2. Consult a doctor and getting the diagnostic

TIME
When did the accident happen?

PERSONS INVOLVED
When it happened, were you in the position to call the emergency centre or someone else did it?

Please ask a history of the events.

Did he go by himself to the doctor? Who called the emergency centre? How long took the ambulance to arrive? Was the patient tested in the ambulance? Did he receive any first aid at the place of the accident or in the ambulance? How long is the distance (in km) from the patients' home to the nearest clinic/hospital?

DIAGNOSTIC
How long did it take for you to be diagnosed?
What type of fracture?

E.g.: Closed (simple) fractures (the skin is intact), Open (compound) (involve wounds that communicate with the fracture, or where fracture hematoma is exposed), Compression fractures (usually occurs in the vertebrae), Complete fracture (bone fragments separate completely), Incomplete fracture (bone fragments are still partially joined), Linear fracture (a fracture that is parallel to the bone's long axis), Transverse fracture (a fracture that is at a right angle to the

bone's long axis), Oblique fracture (a fracture that is diagonal to a bone's long axis), Spiral fracture (fracture where at least one part of the bone has been twisted), Comminute fracture (a fracture in which the bone has broken into a number of pieces), Impacted fracture (caused when bone fragments are driven into each other).

SATISFACTION
Do you consider that the diagnostic was given in a professional and timely manner or it was erroneous and/or delayed so that it affected further your health condition?

History of the health problem

Step 3. Treatment and rehabilitation

TIME
After how many hours since the first symptoms appeared, did you start the stabilization treatment?

TYPE OF TREATMENT
Your treatment included surgical intervention?
If yes, how much did you pay?
The amount you had to pay for the entire treatment (official or informal) did cover
(*Circle your answers)*
- Doctor/ specialists
- Nurses or other medical staff
- Laboratory tests
- Clinic/hospital medication
- Proper care (food, cleaning, etc.)
- Others (transportation, accommodation, etc.)

What would happen if a patient cannot pay the demanded amount for the entire treatment?

COSTS OF TREATMENT AND REHABILITATION
(*Clinic/hospital refer also to the rehabilitation facilities*)
The health-care services received at the clinic/ hospital were free of costs?
Did you have to pay the medical staff to receive proper care?
Did you have to pay for the laboratory tests taken at the clinic/hospital?
Did you have to pay for the clinic/ hospital medication?

DISABILITIES
Did the injuries (fracture) result in any disabilities?

REHABILITATION
What medical professionals specialized in post-fracture rehabilitation did help you?
Please ask a history of doctors (e.g. physician, rehabilitation therapist or nurses, physical therapist, occupational and recreational therapist, etc.) and places.
Did you follow any program of rehabilitation?
Please ask for details – what type of programme, where, how long, how much money?
The distance from your home to the clinic/ hospital was acceptable?

STATE OF ART

Was the treatment provided in the public health-care system at the level of state of art? If no, please provide details.

Have you been prescribed a type of treatment or rehabilitation that you have not followed? If yes, what treatment and why?

MEDICATION

Do you have to take regular medication?

If yes, can you obtain the prescribed medication easily at your local pharmacy?

If no, please explain how did you manage to obtain the prescribed medication?

Your medication was free of costs?

If no, approximately how much do you have to spend per month for the necessary medication during the recovery period?

FACTORS HAMPERING ACCESS

Taking into consideration your experience during the entire process (from diagnostic to the recovery period) which are the main factors that prevent state of art (high quality) treatment in case of injuries (fractures)?

(Please check the following list of potential factors.)

- *Distance* from home to a hospital/clinic is too large and/or too costly?
- Emergency services are not available or are limited? Rehabilitation services are not available?
- Distance from home to pharmacy is too large?
- The waiting time for being received by the doctor or clinic/hospital or rehabilitation unit is very long?
- The waiting time for getting the medication is very long?
- Lack of interest or unprofessionalism of the doctor or medical staff? Discriminatory or inappropriate behaviour of medical staff?
- Lack of trust in doctors, nurses or medical staff?
- Low quality (low effectiveness) of medical services? Poor equipment of clinic/hospital? Poor equipment of the emergency services?
- High costs of medical services to pay the doctor, the nurses or other medical staff or to pay the needed tests?
- High costs of medication?
- Lack of humanness of the staff (not treated well, disrespectful, not provided with explanations about disease and treatment)?
- Low effectiveness of services (inappropriate waiting tine, laboratory tests not reported promptly and correctly, poor working equipment, unclean and untidy hospital/ clinic)?
- Lack of accessibility and continuity of care (inappropriate number of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit)?
- Others, please give *details*

Therapeutic scheme

1. Symptoms identification
2. Consult a doctor (general practitioner, specialist, endocrinologist) and getting the diagnostic
3. Treatment (medication and non-medication)
4. Monitoring period

History of the health problem

Step 1. Symptoms identification

TIME
When did you notice the first symptoms?
How did you notice the first symptoms?

1. During some routine or preventive consults
2. Felt ill one day and went to a doctor
3. Felt ill for a period of time and went to a doctor

PREVENTION
Did you receive any information or were you performed any preventive action (that relates to current condition) before getting ill? If YES, tell us more about these preventive information or testing. *E.g.: Many cases of type 2 diabetes could be prevented or delayed through simple lifestyle changes that lower the risks of diabetes. These risks include excess weight, poor diet, inactivity, smoking and too much alcohol).*

PERSONS INVOLVED
Who did you talk to about the symptoms first?
A family member? A general practitioner? A specialist? Another medical representative? Another person. Who?

History of the health problem

Step 2. Consult a doctor and getting the diagnostic

PERSONS INVOLVED
Who did you talk to about the disease?
Please ask a history of doctors and places.
Example: First, the patient visited his general practitioner who referred him to a specialist in the same locality. The specialist recommended few tests and met him again after two weeks, recommending medication. The diagnostic was type 2 diabetes and the patient was registered in the National Registry and he was included in the National Programme of Diabetes. Please note if the patient was referred to the private sector and/or to treatment abroad.

TESTS
Did you have to pay (official or informal) for any of the required tests (blood tests, oral glucose tolerance test)?
Overall, how much did you pay (official or informal) for all tests? *(in your national currency)*

DIAGNOSTIC
When were you diagnosed with type II diabetes?
Did you ask for a second opinion?
Did you enter the National Programme of Diabetes?

SATISFACTION
Do you consider that the diagnostic was given in a professional and timely manner or it was erroneous and/or delayed so that it affected further your health condition?

History of the health problem

Step 3. Treatment

TIME
When did you start the treatment?

ABOUT TREATMENT
What type of treatment did you follow?
E.g.: Non-pharmacologic treatment (lifestyle optimization: diet, physical exercises, weight loss, quitting smoking, reducing alcohol consumption); Pharmacologic treatment (aspirin treatment, mono oral therapy, combined oral therapy, insulin therapy). Please ask the patient if he received any information about how to put in practice correctly the non-pharmacologic treatment or regarding the administration of the pharmacological treatment

PLEASE DESCRIBE THE TREATMENT YOU HAVE TAKEN
Have you been prescribed a type of treatment that you have not followed? If yes, what treatment and why?
The treatment was provided at home or in a clinic/ hospital or both? Were there in the public or private system?
How much time did you spend in a public clinic/ hospital?
Was the treatment provided in the public health-care system at the level of state-of-art? If no, please provide details.
Did you spend time in private facilities or out of country? Were the same physicians working in both sectors who condition the patient to receive the treatment in a private facility?

COSTS OF TREATMENT
The health-care services received at the clinic/ hospital were free of costs?
Did you have to pay the medical staff to receive proper care?
Did you have to pay for the laboratory tests taken at the clinic/hospital?
Did you have to pay for the clinic/ hospital medication?

TYPE OF TREATMENT

What type of treatment did you have to follow?	For this treatment did you had to pay, officially or informally, any money? (circle your answer)		How much did you pay officially?	How much did you pay informally?
Oral mono-therapy	Yes	No	.....	.....
Combined oral therapy	Yes	No	.....	.....
Insulin therapy	Yes	No	.....	.....
Other	Yes	No	.....	.....

The amount you had to pay for the entire treatment did cover (*Circle your answers)*
- Doctor/ specialists
- Nurses or other medical staff
- Laboratory tests
- Clinic/hospital medication
- Proper care (food, cleaning, etc.)
- Others (transportation, accommodation, etc.)

What would happen if a patient cannot pay the demanded amount for the entire treatment?

History of the health problem

Step 4. Recovery period

PERSONS INVOLVED

For the monitoring period you went to:

1. public facility 2. private facility 3. both
1. only in the country 2. abroad 3. both

All the health-care services that you needed during the monitoring period were present at the nearest clinic/ hospital or you had to visit different doctors located in various places?

The distance from your home to the clinic/ hospital was acceptable?

MEDICATION

Do you have to take regular medication?
If yes, can you obtain the prescribed medication easily at your local pharmacy?
If no, please explain how did you manage to obtain the prescribed medication?
If yes, is the medication free of costs?
If no, approximately how much do you have to spend per month for the necessary medication?
Which of the following tests are you doing periodically?
- Glucose control
- Blood pressure control
- Cardiovascular risk protection
- Eye screening
- Kidney damage
- Foot care
- Nerve damage

Please ask for the respondent: how often he/ she is tested, where (at home, in a public or private clinic/ hospital), the costs involved (payment for the laboratory tests, medical staff, transportation, accommodation).

FACTORS HAMPERING ACCESS

Taking into consideration your experience during the entire process (from diagnostic to the recovery period) which are the main factors that prevent state of art (high quality) treatment in case of type II diabetes?
(Please check the following list of potential factors.)

- *Did not think/* know *that they had to do something? Usually, he/she does not contact a doctor until the situation becomes urgent?*
- *Specific ethnic culture? Costumes/tradition related factors… family would not let woman to visit the doctor… or similar…*
- *Doctor or medical services are not available in the locality?*
- *Distance from home to a hospital/clinic is too large and/or too costly?*
- *Distance from home to pharmacy is too large?*
- *The waiting time for being received by the doctor is very long?*
- *The waiting time for getting the medication is very long?*
- *Lack of interest or unprofessionalism of the doctor or medical staff?*
- *Discriminatory or inappropriate behaviour of medical staff?*
- *Lack of money to pay the doctor?*
- *Lack of money to pay the needed tests?*
- *Lack of money for out-of-pocket payments?*
- *Lack of trust in doctors, nurses or medical staff?*
- *Lack of humanness of the staff (not treated well, disrespectful, not provided with explanations about disease and treatment)?*
- *Low effectiveness of services (inappropriate waiting time, laboratory tests not reported promptly and correctly, poor working equipment, unclean and untidy hospital/ clinic)?*
- *High costs of medication?*
- *Low quality (low effectiveness) of medical services?*
- *Poor equipment of clinic/hospital?*
- *Lack of accessibility and continuity of care (inappropriate number of chairs in the waiting room, availability of the needed services at any hour, the number of staff to perform all the tasks needed at each visit*
- *Others, please give* details

(B) Knowledgeable observers

General assessment of the public health-care services:					
On a scale from 1 to 5, how do you evaluate …?	**Very poor**	**Poor**	**Medium**	**Good**	**Very good**
The **availability** of health-care services in your country	1	2	3	4	5
The **quality** of health-care services in your country	1	2	3	4	5
Population's **confidence** in the public health-care system	1	2	3	4	5
Health-care services in your country are **accessible to any person** who needs them, regardless their economic situation	1	2	3	4	5

Type of respondent	Data about respondent
1. General practitioners 2. Specialist doctors 3. Representatives of regional or national directions of public health 4. Hospital representatives 5. Emergency centres representatives 6. Representatives of NGOs active in the field 7. Representatives of patient organizations 8. Others, namely	**Region/ county:** **Residency:** 1. large urban 2. small urban 3. rural **Age** (in years) |__|__| **Gender** 1. Male 2. Female

Interview no.: |__|__| **Module: |_1B_|** **Disease: MYOCARDIAL INFARCTION**

STATE OF ART

State-of-art treatment of myocardial infarction is available in your country?

Would you say that in the public health-care system, most clinics/ hospitals and doctors provide state-of-art care in case of myocardial infarct?

There is no European Guide for Diagnostic and Treatment. However, is there any national guide or other standard procedures?

RISK FACTORS

Which of the following risk factors are most often linked to the cases of myocardial infarction in your country?

Previous cardiovascular disease, older age, tobacco smoking, high blood levels of certain lipids (low-density lipoprotein cholesterol, triglycerides) and low levels of high density lipoprotein (HDL) cholesterol, diabetes, high blood pressure, lack of physical activity and obesity, chronic kidney disease, excessive alcohol consumption, the abuse of illicit drugs (such as cocaine and amphetamines), and chronic high stress levels

AT-RISK
In your country, which are the main groups with disproportionate risk of myocardial infarction?

1. Geographic
2. Age
3. Gender
4. Ethnicity
5. Socio-economic
6. Religious
7. Others, namely

LESS ACCESS
Is the state-of-the-art treatment (including diagnostics, monitoring etc.) accessible to everybody, which means free of major charges, in case of myocardial infarction?
Which are the main groups with limited access to quality health-care in the public system, in case of myocardial infarction?

1. Geographic
2. Age
3. Gender
4. Ethnicity
5. Socio-economic
6. Religious
7. Others, namely

COSTS OF TESTS
Overall a "standard" patient how much would approximately pay (official or informal) for all required tests?
(Please note the approximate values or intervals in your national currency)

COSTS OF TREATMENT
Overall a "standard" patient how much would approximately pay for the entire treatment (surgical intervention)?
(Please note the approximate values or intervals in your national currency)

Which types of services are covered by the payments made officially or informally by the "standard" patient?
(*Circle your answers)*

- Doctor/ specialists
- Nurses or other medical staff
- Laboratory tests
- Clinic/hospital medication
- Proper care (food, cleaning, etc.)
- Others (transportation, accommodation, etc.)

What would happen if a patient cannot pay the demanded amount for the entire treatment?

FACTORS HAMPERING ACCESS
Which are the main factors that limit access to quality health-care in the public system?

(Please check the following list of potential factors.)

- *Poor knowledge and level of information of population? Preventive health related behaviour is uncommon, while risk-behaviours are widespread?*
- *Doctor or medical services are not available in some localities or disadvantaged areas?*
- *Emergency services are not available or underdeveloped?*
- *Pharmacies are not available in some localities or disadvantaged areas?*
- *Rehabilitation units are not available or very limited?*
- *Transport services are underdeveloped or too costly?*
- *The waiting time for being received by a specialist or a rehabilitation unit is very long?*
- *Lack of interest or unprofessionalism of the doctors? Insufficient competence of nurses or other medical staff?*
- *Discriminatory or inappropriate behaviour of medical staff?*
- *Population does not trust in doctors, nurses or medical staff?*
- *Low quality of medical services in the public system? Poor equipment of the public clinics/ hospitals? Poor equipment of the emergency units?*
- *High costs of the public medical services to pay the doctor, the nurses or other medical staff or to pay the needed tests?*
- *The waiting time for getting the medication is very long? High costs of medication?*
- *The demanded out-of-pocket payments?*
- *Others, please give details*

Interview no.: |__|__| **Module: |_2B_|** **Disease: STROKE**

DISEASE
Which is the type of stroke with the highest prevalence in your country?

STATE OF ART
State-of-art treatment of stroke is available in your country? For all types of stroke?
If only for one type which is it?
Would you say that in the public health-care system, most clinics/ hospitals and doctors provide state-of-art care in case of stroke?

State of art treatment of stroke (including diagnostics, monitoring etc.) complies with the European Guide (ESO) of diagnostic and treatment?

RISK FACTORS
Which of the following risk factors are most often linked to the cases of stroke in your country?
Personal or family history of stroke? High blood pressure? High cholesterol? Diabetes? Cardiovascular disease, including heart failure, a heart defect, heart infection, or abnormal heart rhythm?
Use of birth control pills or hormone therapies that include estrogens? Cigarette smoking? Being overweight or obese? Physical inactivity? Heavy or binge drinking? Use of illicit drugs such as cocaine and methamphetamines?

AT-RISK
In your country, which are the main groups with disproportionate risk of stroke?

1. Geographic
2. Age
3. Gender
4. Ethnicity
5. Socio-economic
6. Religious
7. Others, namely

LESS ACCESS
Is the state-of-the-art treatment (including diagnostics, monitoring etc.) accessible to everybody, which means free of major charges, in case of stroke?
Which are the main groups with limited access to quality health-care in the public system, in case of stroke?

1. Geographic
2. Age
3. Gender
4. Ethnicity
5. Socio-economic
6. Religious
7. Others, namely

COSTS OF TESTS
Overall a "standard" patient how much would approximately pay (official and informal) for all required tests?
(Please note the approximate values or intervals in your national currency)

COSTS OF TREATMENT
Overall a "standard" patient how much would approximately pay (official or informal) for the entire treatment (surgical intervention)?
(Please note the approximate values or intervals in your national currency)
Which types of services are covered by the payments made officially or informally by the "standard" patient? (*Circle your answers)*

- Doctor/ specialists
- Nurses or other medical staff
- Laboratory tests
- Clinic/hospital medication
- Proper care (food, cleaning, etc.)
- Others (transportation, accommodation, etc.)

What would happen if a patient cannot pay the demanded amount for the entire treatment?

FACTORS HAMPERING ACCESS
Which are the main factors that limit access to quality health-care in the public system?

(Please check the following list of potential factors.)

- *Poor knowledge and level of information of population? Preventive health related behaviour is uncommon, while risk-behaviours are widespread?*
- *Doctor or medical services are not available in some localities or disadvantaged areas? Emergency services are not available or underdeveloped? Pharmacies are not available in some localities or disadvantaged areas? Rehabilitation units are not available or very limited?*
- *Transport services are underdeveloped or too costly?*
- *Neurovascular services are available only in some hospital/clinics? Distance to these hospitals/clinics is too large and/or too costly for a large part of the population?*
- *The waiting time for being received by a specialist or a rehabilitation unit is very long?*
- *Lack of interest or unprofessionalism of the doctors? Insufficient competence of nurses or other medical staff?*
- *Discriminatory or inappropriate behaviour of medical staff?*
- *Population does not trust in doctors, nurses or medical staff?*
- *Low quality of medical services in the public system? Poor equipment of the public clinics/ hospitals? Poor equipment of the emergency units?*
- *High costs of the public medical services to pay the doctor, the nurses or other medical staff or to pay the needed tests?*
- *The waiting time for getting the medication is very long? High costs of medication?*
- *The demanded out-of-pocket payments?*
- *Others, please give details*

Interview no.: |__|__|	**Module: |_3B_|**	**Disease: CANCER**

DISEASE
Which are the types of cancer with the highest prevalence in your country?
Is there a National Registry of people affected by cancer?
Is there a National Programme of Oncology? If yes, since when?

AT-RISK
In your country, which are the main groups with disproportionate risk of cancer?

1. Geographic
2. Age
3. Gender
4. Ethnicity
5. Socio-economic
6. Religious
7. Others, namely

STATE OF ART
State-of-art treatment of cancer is available in your country? *If yes, for all types of cancer?*
If only for some types, which are those? *Would you say that in the public health-care system, most clinics/ hospitals and doctors provide state-of-art care in case of cancer?*

State of art treatment of cancer (including diagnostics, monitoring etc.) complies with the European Guide (ESO) of diagnostic and treatment?

LESS ACCESS

Is the state-of-the-art treatment (including diagnostics, monitoring etc.) accessible to everybody, which means free of major charges, in case of cancer?

1. Yes, accessible to everybody
2. Yes, for the "standard" patients, but there are small groups with less chances to receive it
3. Yes, but only for some groups of population
4. No

Which are the main groups of population that systematically are less likely to receive the state-of-the-art treatment available with the public health system?

1. Geographic
2. Age
3. Gender
4. Ethnicity
5. Socio-economic
6. Religious
7. Others, namely

FACTORS HAMPERING ACCESS

Which are the main factors that limit access to quality health-care in the public system?
(Please check the following list of potential factors.)

- *Specific ethnic culture? Costumes/tradition related factors… family would not let woman to visit the doctor… or similar…*
- *Poor knowledge and level of information of population. Preventive health related behaviour is uncommon.*
- *Doctor or medical services are not available in some localities or disadvantaged areas?*
- *Pharmacies are not available in some localities or disadvantaged areas?*
- *Transport services are underdeveloped or too costly?*
- *Oncology services are available only in some hospital/clinics?*
- *Distance to these hospitals/clinics is too large and/or too costly for a large part of the population?*
- *Oncology services are available only in private hospital/clinics or out of the country?*
- *The waiting time for being received by a specialist is very long?*
- *Lack of interest or unprofessionalism of the doctors?*
- *Insufficient competence of nurses or other medical staff?*
- *Discriminatory or inappropriate behaviour of medical staff?*
- *Population does not trust doctors, nurses or medical staff?*
- *Low quality of medical services in the public system? Poor equipment of the public clinics/hospitals?*
- *High costs of the public medical services to pay the doctor, the nurses or other medical staff or to pay the needed tests?*
- *The waiting time for getting the medication is very long? High costs of medication?*
- *The demanded out-of-pocket payments?*
- *Others, give details*

COSTS OF TESTS
Overall a "standard" patient how much would approximately pay (official and informal) for all required tests (blood tests, ultrasound, radiography, mammography, tomography, nuclear magnetic resonance (NMR) spectroscopy)?
(Please note the approximate values or intervals in your national currency)

COSTS OF TREATMENT
Overall a "standard" patient how much would approximately pay (official and informal) for the entire treatment (surgical intervention, chemotherapy, radiotherapy, laser therapy, photodynamic therapy, hormonal therapy)?
(Please note the approximate values or intervals in your national currency)

Which types of services are covered by the payments made officially or informally by the "standard" patient?
(*Circle your answers)*
- Doctor/ specialists
- Nurses or other medical staff
- Laboratory tests
- Clinic/hospital medication
- Proper care (food, cleaning, etc.)
- Others (transportation, accommodation, etc.)

What would happen if a patient cannot pay the demanded amount for the entire treatment?

Interview no.: |__|__|	**Module: |_4B_|**	**Disease: INJURIES**

DISEASE
Which type of injuries (fractures) have the highest prevalence in your country?

STATE OF ART
State-of-art treatment of injuries (fractures) is available in your country? If yes, only for some types (2), which is it?
Would you say that in the public health-care system, most clinics/ hospitals and doctors provide state-of-art care in case of injuries (fractures)? There is no European Guide for Diagnostic and Treatment. However, is there any national guide or other standard procedures?

RISK FACTORS
Which are the main risk factors that are most often linked to the cases of injuries (fractures) in your country?

AT-RISK
In your country, which are the main groups with disproportionate risk of injuries (fractures)?
1. Geographic
2. Age
3. Gender
4. Ethnicity
5. Socio-economic
6. Religious
7. Others, namely

LESS ACCESS
Is the state-of-the-art treatment (including diagnostics, monitoring etc.) accessible to everybody, which means free of major charges, in case of injuries (fractures)?
Which are the main groups with limited access to quality health-care in the public system, in case of injuries (fractures)?

1. Geographic
2. Age
3. Gender
4. Ethnicity
5. Socio-economic
6. Religious
7. Others, namely

COSTS OF TESTS
Overall a "standard" patient how much would approximately pay (official and informal) for all required tests (initial and monitoring)?
(Please note the approximate values or intervals in your national currency)

COSTS OF TREATMENT
Overall a "standard" patient how much would approximately pay (official or informal) for the entire treatment (including surgical intervention)?
(Please note the approximate values or intervals in your national currency)

What would happen if a patient cannot pay the demanded amount for the entire treatment?

FACTORS HAMPERING ACCESS
Which are the main factors that limit access to quality health-care in the public system?
(Please check the following list of potential factors.)

- *Poor knowledge and level of information* of population?
- *Doctor or medical services are not available in some localities or disadvantaged areas?*
- *Emergency services are not available or underdeveloped?*
- *Pharmacies are not available in some localities or disadvantaged areas?*
- *Rehabilitation units are not available or very limited?*
- *Transport services are underdeveloped or too costly?*
- *The waiting time for being received by a specialist or a rehabilitation unit is very long?*
- *Lack of interest or unprofessionalism of the doctors? Insufficient competence of nurses or other medical staff?*
- *Discriminatory or inappropriate behaviour of medical staff?*
- *Population does not trust in doctors, nurses or medical staff?*
- *Low quality of medical services in the public system? Poor equipment of the public clinics/ hospitals? Poor equipment of the emergency units?*
- *High costs of the public medical services to pay the doctor, the nurses or other medical staff or to pay the needed tests?*
- *The waiting time for getting the medication is very long? High costs of medication?*
- *The demanded out-of-pocket payments?*
- *Others, please give details*

DISEASE
How prevalent is type 2 diabetes in your country?

RISK FACTORS
Which are the main risk factors that are most often linked to the cases of type 2 diabetes in your country?
Is there a National Registry of people affected by diabetes?
Is there a National Programme of Diabetes?

AT-RISK
In your country, which are the main groups with disproportionate risk of type II diabetes?
1. Geographic
2. Age
3. Gender
4. Ethnicity
5. Socio-economic
6. Religious
7. Others, namely

STATE OF ART
State-of-art treatment of type 2 diabetes is available in your country?
Would you say that in the public health-care system, most clinics/ hospitals and doctors provide state-of-art care in case of type II diabetes? There is no European Guide for Diagnostic and Treatment. However, is there any national guide or other standard procedures?

LESS ACCESS
Is the state-of-the-art treatment (including diagnostics, monitoring etc.) accessible to everybody, which means free of major charges, in case of type II diabetes?
Which are the main groups of population that systematically are less likely to receive the state-of-the-art treatment available with the public health system?
1. Geographic
2. Age
3. Gender
4. Ethnicity
5. Socio-economic
6. Religious
7. Others, namely

FACTORS HAMPERING ACCESS
Which are the main factors that limit access to quality health-care in the public system?
(Please check the following list of potential factors.)

- *Specific ethnic culture? Costumes/tradition related factors… family would not let woman to visit the doctor… or similar…*
- *Poor knowledge and level of information of population. Preventive health related behaviour is uncommon.*
- *Doctor or medical services are not available in some localities or disadvantaged areas? Pharmacies are not available in some localities or disadvantaged areas? Transport services are underdeveloped or too costly?*
- *The waiting time for being received by a specialist is very long?*

- *Lack of interest or unprofessionalism of the doctors? Insufficient competence of nurses or other medical staff? Discriminatory or inappropriate behaviour of medical staff?*
- *Population does not trust doctors, nurses or medical staff?*
- *Low quality of medical services in the public system? Poor equipment of the public clinics/ hospitals?*
- *High costs of the public medical services to pay the doctor, the nurses or other medical staff or to pay the needed tests?*
- *The waiting time for getting the medication is very long? High costs of medication?*
- *The demanded out-of-pocket payments?*
- *Others, give details*

COSTS OF TESTS

Overall a "standard" patient how much would approximately pay (official or informa) for all required tests

Please ask separately for the initial tests and for the monitoring test; note the approximate values or intervals in your national currency.

COSTS OF TREATMENT

Overall a "standard" patient how much would approximately pay (official or informa) for the entire treatment?

Please ask the costs of the treatment in one regular month; note the approximate values or intervals in your national currency.

Which types of services are covered by the payments made officially or informally by the "standard" patient?

(*Circle your answers)*

- Doctor/ specialists
- Nurses or other medical staff
- Laboratory tests
- Clinic/hospital medication
- Proper care (food, cleaning, etc.)
- Others (transportation, accommodation, etc.)

What would happen if a patient cannot pay the demanded amount for the entire treatment?