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### **3 Health reform in Bulgaria**

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#### **Introduction**

The poor and deteriorating health status of Bulgaria's population at the beginning of the 1990s, together with the democratic changes in the country, resulted in the recognition of the need for fundamental changes to the health system. The Bulgarian health system suffered from a number of structural weaknesses, including an orientation towards supply rather than demand, an inefficient utilisation of human, material and technical resources, health inequalities and poor quality of medical care and even before the democratic changes in 1989 it became apparent that the health system was unable to meet the needs of the population (*Rabotnichesko delo* daily, Issue 307 from 2.11.1989 and Issue 312 from 8.11.1989). In particular, the health system failed to respond to the epidemiological transition of the population, with very high cardiovascular mortality and largely stagnating life expectancy throughout the 1970s and 1980s.

After 1989, the health system became incompatible with the new political and economic environment. Thus, the reform of the Bulgarian health system at the beginning of the 1990s had two main objectives (Popov ed., 1997, 1998). The first was to improve population health. The second was to establish a health system that would correspond to the population's health needs and be based on democratic principles (including the decentralisation and deconcentration of management, a greater influence of professionals, civil participation to ensure accountability and responsiveness to patient's needs, and protection of patients' rights), as well as the introduction of market principles (reducing state regulation of the health system, increasing the autonomy of

health care providers, and introducing a split between purchasers and providers of health services).

More than twenty years later, many of these fundamental issues are still unresolved. Although there were some improvements in population health, the main health indicators are still far below EU averages. The main principles, which the new health system should have been built on, have not been fully achieved and both, patients and health professionals, are dissatisfied with the current state of the system.

This chapter explores the recent health reform in Bulgaria and the reasons it has failed to achieve its main objectives. It builds on analysis carried out in 2005-2007 under a project financed by the Open Society Institute – Sofia, which investigated the changes in the Bulgarian health system in 1989-2005 through an in-depth study of documents and publications, an analysis of health indicators, and a nationally representative sociological survey carried out in 2006 using standardized interviews with 458 medical specialists, 168 health management representatives, and 1,213 citizens (Dimova et al., 2007). For the purpose of this chapter, this analysis was complemented through an exploration of changes in health system and policies after 2005.

## **The health reform process**

The health reform process over the last twenty years has passed through a number of definite stages which differed from each other in terms of significance, intensity, and effects. Three stages can be distinguished, mainly based on whether significant changes took place or whether only partial alterations to the system were implemented.

### ***The first stage: 1989–1996***

In 1989 and the first years thereafter, the political situation in Bulgaria was characterized by instability. Different political parties held power for relatively short periods of time, with opposing or at least incompatible views about the nature and content of the health reform. Under these circumstances it was impossible to achieve the necessary conceptual coherence of priorities for a health reform. Consequently, efforts were directed towards the implementation of essential but partial changes. Three of these changes were of particular importance since they altered the health care landscape and significantly affected the development of health reform in the following years.

The first, and probably most significant, change was to end the state monopoly on health care provision, financing, and management through the legal restoration and regulation of the private sector (development of private medical practice and privatization of the pharmaceutical sector) and the restoration of professional organisations of physicians and dentists.

The second important change concerned decentralisation and the creation of a peripheral health care administration. Regional Health Centres (RHCs) were established in each of the country's 28 regions as local structures of the Ministry of Health. Their task was to coordinate and control health activities and initiatives at the regional and district level. Municipalities were granted certain responsibilities for health management at the district level through the establishment of municipal health administrations. Changes in governing bodies of health care organizations and the implementation of principles of self-governance supported the decentralisation of the health system.

The third significant change in the early years of the reform was the introduction of new economic relations and the market-based restructuring of the health system. The idea of health insurance emerged as a major way of changing health financing, and the health reform as a whole

was identified with it. However, during this early stage of reform the financial organisation of the health system did not actually change.

### ***The second stage: 1997-2001***

This stage witnessed the most significant changes in Bulgaria's health system, which included the introduction of a health insurance system. The reform process entailed the adoption of a package of laws (on health insurance, health organizations, and professional organisations of physicians and dentists), as well as new legislation on pharmaceuticals. These laws aimed to provide a new regulatory basis for the democratic and market development of medical, dental and pharmaceutical care in Bulgaria.. Partial changes were carried out also in the area of public health, with the adoption of laws on healthy and safe working conditions, food, and the control of narcotic substances and precursors, as well as the adoption of new regulations on prevention and health promotion activities and the organisation of hygiene and epidemiological services.

This new legislation resulted in significant qualitative changes in the health system. In 1998, a health insurance system was introduced by establishing the National Health Insurance Fund (NHIF) and legalizing voluntary health insurance. The collection of social health insurance contributions started in 1999. The implementation of the new health insurance system was step-wise: beginning in 2000, the NHIF started to fund outpatient medical and dental care, and since 2001 funding from the NHIF has been extended to hospital care.

During this stage, the state monopoly in health care was abandoned entirely. As a result of the 1998 Law on Healthcare Establishments, all primary and dental care and the majority of specialized outpatient care shifted to the private sector. The former polyclinics were transformed into medical and diagnostic-consultative centres owned by municipalities. Public hospitals were

re-registered as state or municipal enterprises (see Chapter 10 on Hospital performance measurement in Bulgaria).

The organisation and structure of the health system also changed. The Law on Healthcare Establishments stipulated the separation of outpatient from inpatient care and the introduction of General Practitioners (GPs). In addition, the national system for emergency care was reformed through projects financed by the European Commission and the World Bank, and a national system for transfusion haematology was created. Occupational medicine facilities were also established, replacing the previous “workers’ health care” network.

New economic principles were introduced with the introduction of contractual relations between health insurers and health care providers, and new payment mechanisms for health services (see Chapter 10 on Hospital performance measurement in Bulgaria). Medical services provided by health care organizations, irrespective of whether they were public or private, were paid by the NHIF and voluntary health insurance companies (and, until the end of 2005, by the state) according to contracted prices. Thus, there was a change from financing “inputs” and structures towards financing activities and “outputs”. In terms of compulsory health insurance, the benefit package, prices of services and payment mechanisms started to be defined each year at national level through the National Framework Contract.

Another major change was the decentralization of the management of health organizations. Providers became relatively autonomous; their managers received extended rights for decision-making and freedom to run their organizations’ activities. Additionally, in accordance with the Law on Healthcare Establishments, organs with advisory functions, such as the Medical Council and the Nursing Council were involved in the management of health care providers.

Furthermore, the professional organisations of doctors and dentists were given certain rights and liabilities for the regulation of the health system. The Union of Bulgarian Physicians and the Union of Dentists in Bulgaria acquired significant rights and responsibilities related to the qualification and ethical behaviour of their members. They also became a legitimate party in the negotiation, signing and implementation of the National Framework Contract.

Another important novelty at this stage of the reform was the establishment of a national system of quality monitoring and control, the main part of which was the accreditation of health care providers. It was initially compulsory for hospitals and diagnostic-consultative centres, and later for an extended list of providers.

### ***Third stage: 2002–2010***

In contrast to the previous period, this stage was characterized by delayed and hesitant changes, often associated with inconsistent and contradictory measures which altered the initial direction of the reform.

The most essential result was the completion of the legislative basis of the health reform. This included the design and adoption of new laws and regulatory acts, as well as amendments of existing legislation. Several key legislative acts were of crucial importance.

The 2004 Law on Health completely replaced the 1972 Law on People's Health. It contained several elements to support the successful implementation of the health reform, including the regulation of the structure and management of the health system at both the national and the regional level; the regulation of the content, organisation and institutions of State Health Control; the regulation of the organisation and procedures of mental health services, unconventional methods of treatment, and patient rights; and more stable normative requirements for medical professions, education and science.

The 2005 Law on the Professional Organisations of Nurses, Midwives and Associated Medical Specialists outlined the functioning of professional organisations in the field of nursing care.

In with these new laws, the basic laws adopted in the previous stage were brought up to date. The Law on Health Insurance was amended several times. Changes in 2002 aimed to support the development of voluntary health insurance. Changes were also introduced to the management of the mandatory health insurance system in 2002 and 2009, restricting the relative autonomy of the NHIF and significantly strengthening state control. In 2009 mandatory health insurance contributions increased from 6% to 8% of income, split between employees and employers in a 40:60 ratio.

The 2010 Law amending the Law on Healthcare Establishments changed some types of health care providers. The former dispensaries were reclassified as mental health centres, cancer centres, and centres for dermato-venerological diseases. Centres for medico-social care for children were changed into general nursing homes for chronically ill patients. The compulsory accreditation of health care providers was ended in 2010, when accreditation became an elective, voluntary process.

In addition to these legislative changes, there were many other amendments and additions which did not significantly affect the overall design and functions of the system. Some of them were related to the necessity of harmonizing Bulgarian legislation with EU directives. The change which is expected to have the largest impact on the Bulgarian health system in this context is related to the recognition of Bulgarian medical diplomas in the EU, based on the mutual recognition of professional qualifications within the EU. This facilitates an increased mobility of medical professionals, with consequences for the supply of medical personnel in Bulgaria.



Apart from these main changes to health legislation, several strategies, concepts and plans (such as for restructuring hospitals) were developed at different stages, but few of these were implemented.

## **Assessment of health reform outcomes**

We base our assessment of health reform outcomes on the degree in which the reform goals regarding the health status of the population and the broader health system characteristics were achieved.

### ***Health status***

Although health is determined by multiple factors and does not only depend on the health system, major population health indicators suggest that the health reform did not reach its main goal, i.e. to discontinue the deterioration of the population's health status.

Life expectancy at birth, after falling to 70.3 in 1997, has since increased to 73.4 in 2009, due mainly to the significantly decreased infant mortality. Nevertheless, life expectancy at birth in 2009 was still far below EU average of 79.6 years (WHO 2011). A major reason for the much lower life expectancy in Bulgaria is the comparatively high premature mortality rate among those aged 40-59 years (Table 3.1).

**Table 3,1 Mortality by age groups (per 100,000 population of the same age group)**

Year	Total	Age groups								
		Under 1 year*	1-9	10-19	20-29	30-39	40-49	50-59	60-69	70+
1970	9.1	27.3	0.8	0.6	1.0	1.5	3.2	8.1	22.4	84.2
1980	11.1	20.2	0.7	0.6	1.0	1.6	3.6	9.1	24.3	88.1
1990	12.5	14.8	0.6	0.6	1.1	1.8	4.3	10.0	23.5	93.4
2000	14.1	13.3	0.5	0.4	0.8	1.7	4.3	10.1	23.8	84.5
2005	14.6	10.4	0.4	0.4	0.8	1.5	4.2	10.4	22.4	80.2
2006	14.7	9.7	0.4	0.4	0.8	1.5	4.1	10.4	21.9	80.4
2007	14.8	9.2	0.4	0.4	0.8	1.4	3.9	10.2	21.4	80.8
2008	14.5	8.6	0.4	0.5	0.8	1.4	3.8	9.8	20.5	79.4

Notes: per 1000 live births

Source: National Center of Health Informatics 2009

Mortality rates from the diseases of the circulatory system and cancer accounted for over 80% of deaths in Bulgaria in 2009. Age-standardized death rates from diseases of the circulatory system in Bulgaria were the highest in the European Union in 2008. Although age-standardized death rates have been declining from their peak of 814 per 100,000 population in 1997 to 611 in 2008, this was several times higher than the EU average of 234 per 100,000 population in 2009 (WHO 2011). This indicates substantial scope for health system interventions, in particular those related to public health and lifestyle changes, but also treatment of hypertension and stroke. Age-standardized death rates for malignant neoplasms increased from 151 per 100,000 in 2000 to 172

in 2008, while the EU average decreased in this period (WHO, MBD 2011). Death rates for cervical cancer in Bulgaria, for example, stood at 7.03 per 100,000 in 2008, which was more than double the EU average of 3.31 in 2009 (WHO, HFADB 2011).

While not becoming apparent in national averages, there are also significant inequities in health outcomes across the population, such as between cities and villages or between the Roma minority and the rest of the population (Rechel et al. 2009a; Rechel et al. 2009b; Atanasova et al. 2011).

Positive developments can be detected with regard to both infant and maternal mortality, which have both fallen over the last two decades. Despite the overall decrease, in 2008, the infant mortality in Bulgaria was near two times higher than EU average. There are also significant regional differences in infant mortality across the country, and mortality is nearly twice as high in rural than in urban areas. After wide variations during the years, the maternal mortality fell to 6.4 per 100,000 live births in 2008, which is near to the EU average of 5.9 for the same year (WHO HFADB 2011).

The morbidity from chronic non-communicable diseases has not changed significantly in terms of structure and incidence (Table 3.2). Moreover, as in some other countries of Central and Eastern Europe, some major health problems resurfaced after 1989, in particular infectious diseases such as tuberculosis. Although the percentage of children vaccinated against tuberculosis and measles was traditionally higher in Bulgaria than the EU average (WHO, HFADB 2011), tuberculosis incidence increased from 106 per 100,000 population in 1990 to 173.4 in 2000, while there was also a measles outbreak in 2009 (29.7 per 100,000 in comparison with 1.7 per 100,000 in 1990). The latter outbreak raises serious concerns about the quality of preventive health services in Bulgaria. Measles incidence increased in 2009 mainly among the Roma

population, which suggests major gaps in immunization coverage of minority groups, underlining the substantial health inequalities existing in Bulgaria.

**Table. 3.2. Selected nation's health status indicators**

<b>Indicator</b>	<b>1995</b>	<b>2000</b>	<b>2005</b>	<b>2008</b>	<b>2009</b>
Life expectancy at birth, total (years)	70.6	71.7	72.6	73.0	73.4
Total mortality rate (per 1000)	13.6	14.1	14.6	14.5	14.2
Mortality rate, urban areas (per 1000)	10.7	11.5	12.0	12.1	11.9
Mortality rate, rural areas (per 1000)	19.9	19.6	20.8	20.4	20.1
Crude mortality rate by cause of death, per 100,000 population					
Mortality rate, diseases of the circulatory system	867.6	933.8	968.1	937.8	940.1
Mortality rate, malignant neoplasms	192.0	187.8	231.7	238.5	226.2
Mortality rate, diseases of the respiratory system	62.9	55.1	57.7	58.6	54.8
Mortality rate, external cause injury and poison	65.8	56.9	50.8	51.1	45.1
Age-standardized mortality rates by cause of death, per 100,000 population*					
Mortality rate, diseases of the circulatory system	726	737	677	611	
Mortality rate, malignant neoplasms	162	150	171	172	
Mortality rate, diseases of the respiratory system	56	47	44	42	
Mortality rate, external cause injury and poison	63	52	45	45	
Infant mortality rate (0-1 per 1000 live births)	14.8	13.3	10.4	8.6	9.0
Infant mortality rate, urban areas	14.0	12.4	8.9	7.6	7.7
Infant mortality rate, rural areas	16.7	15.5	14.6	11.6	12.9
Maternal death rate (per 100 000 live births)*	13.9	17.6	11.3	6.4	n/a

*Sources: National Centre of Health Informatics, selected years*

*\* WHO HFADB 2010*

### ***Characteristics of the reformed system***

The health reform in Bulgaria aimed to create a health system that would be liberalized and economically stable, and focused on the patient. The envisaged health system would strike an acceptable balance between market forces and administrative regulation, comprise both private and public providers and payers, and enable the development of entrepreneurial initiative within a context of state regulation. As shown above, the new Bulgarian health system possesses these characteristics. It is no longer a state monopoly and the private sector in both outpatient and inpatient care, as well as pharmaceutical production and distribution, is highly developed. Some state functions in the health sector have been shifted to regional and municipal administrations. There are contractual relations between third-party payers and health care providers. Individual participation in health financing is gradually being developed. However, during the third stage of the reform, some measures taken were contradictory to these principles, and this has taken the health system in a new direction.

Demonopolisation is an essential step in the implementation of a liberalised health system. The most important monopoly in Bulgaria's health sector is in the field of health insurance, in which the NHIF has been granted a monopolistic status for mandatory health insurance. At the same time, originally established as an autonomous public institution for mandatory health insurance independent from the executive power, the NHIF has lost a great deal of its independence in the years since 2002. Initially, the state, employers and insured were given equal in rights in the NHIF supreme governance body (the Assembly of Representatives). In 2002, with an amendment on the Health Insurance Act, the number of employers' and insured representatives was reduced, increasing significantly the role of the state in the management of

the NHIF. In 2009, other changes included the removal of the Assembly of Representatives and the Control Council, and a further reduction of citizen and other non-government representatives in the NHIF managing body, practically turning the NHIF into a subordinate institution of the Ministry of Health.

As mentioned above, in the first stage of the reform the establishment of Regional Healthcare Centres supported the decentralization process, but at the same time their functions were limited to elementary administrative and bureaucratic responsibilities. In order to function as fully-fledged centres in the process of decentralisation, Regional Healthcare Centres would need to possess considerably broader authority and managerial competences than stipulated in the Law on Health. Two of the most essential managerial functions, planning and regulation of the health system, are performed entirely at the national level.

Although the role of the private sector has increased, the state remains in ownership of many health care providers. It owns all university hospitals and national centres, the specialised hospitals at national level, the centres for emergency medical care, the psychiatric hospitals, the centres for transfusion haematology and dialysis, as well as 51% of the capital of regional hospitals.

The introduction of market relations into the health system has been a significant step toward its liberalization. However, except for the pharmaceutical sector, the market for health services has not yet been comprehensively developed. There are several obstacles to the implementation of market principles in the health sector, including the considerable share of state ownership, and administrative requirements for health care providers, and payment mechanisms, which results in lack of real competition and restricted possibilities for technological innovation. Due to the monopolistic status of the NHIF, there is also no proper competition and market in the

health insurance sector and health care providers do not have the power to negotiate the scope and price of services provided.

Civil participation in the formulation of health policies and the management of the health system is not only a manifestation of accountability, but is also beneficial for making the health system more oriented towards citizens' needs, desires and expectations. The role of citizens in the management of the NHIF has declined and, throughout the entire reform process, communications with citizens and health professionals regarding the objectives, content and terms of the health reform have been neglected, leading to public confusion and dissatisfaction.

Although many patient organizations have been established over the years, their potential to influence health policy has been insignificant. An encouraging development, however, is that the 2009 additions to the Law on Health envisage the establishment of a civil council on patient rights at the Ministry of Health. The council has a consultative function and includes representatives of different patient organizations.

Financial sustainability is a major challenge for almost all health systems in Europe. In Bulgaria, it was hoped that the diversification of health financing sources would help to make the health system more economically stable. Currently, the country's health system is financed from compulsory and voluntary health insurance contributions, taxes, out-of-pocket payments, corporate payments, donations, and external sources of funding. However, in spite of multiple financing sources and an increase of health expenditure in both absolute values and as a percentage of GDP (Table 2), the health system still suffers from chronic "underfinancing", which affects most visibly hospitals, as main consumer of health financing. While "underfinancing" had also existed in the previous system, the introduction of mandatory health insurance and patient co-payments have proved insufficient to overcome this problem and ensure the long-term sustainability of health financing in Bulgaria.

The significant share of private (mainly out-of-pocket) expenditure, amounting to 39.2% of total health expenditure in 2009, illustrates the deficit of public resources for health (Table 3.3). Although voluntary health insurance was introduced together with mandatory health insurance, its market is still very small, covering less than 5% of the population in 2009 (Zastrahovatel.com, 2010).

**Table 3.3. Trends in health expenditure in Bulgaria, selected years**

<b>Expenditure</b>	<b>1995</b>	<b>2000</b>	<b>2005</b>	<b>2009</b>
Total health expenditure in \$ PPP per capita	285	373	719	858
Total health expenditure as % of GDP	5.1	6.0	7.3	6.4
Public expenditure on health as % of total expenditure on health	73.3	59.6	58.4	55.4
Private expenditure on health as % of total expenditure on health	26.7	40.4	39.1	39.3
Government health spending as % of total government spending	19.8	8.5	11.6	9.1
Out-of-pocket payments as % of total expenditure on health	26.7	40.4	37.9	38.1
Out-of-pocket payments as % of private expenditure on health	100	100	96.9	96.9
Voluntary health insurance as % of private expenditure on health	0	0	0.7	1.0

*Source: WHO, NHA 2011*

Another important issue in terms of financial sustainability is the collection of social health insurance contributions. Despite its compulsory nature, nearly 1.2 million people were not insured in 2010. This number has remained relatively constant over the years, undermining the solidarity principle and the financial stability of the system.

A fundamental reason for public “underfinancing” of the health system are the low prices for health services, based not on real costs but on financial capacity of the NHIF. The “contracting prices” for health services are mostly determined between monopolistic



organisations, with no regard to market forces or economic methods. This reminds strongly of the “residual principle” from the state budget in the past. The “market price” is determined in a non-market way. Furthermore, medical labour, which is a major cost factor for medical services, is not costed, and this is the main reason why payments made by the NHIF are lower than the actual value of performed services. This was confirmed by almost all directors and managers of health care providers interviewed in our survey in 2006, and has also been pointed out in scientific publications and the media (Ministry of Finance, 2010 and 2010 a, *Trud* daily from 20.03.2003). As a result of this price formation, the financial resources received by hospitals, are typically smaller than the costs they incur when delivering the services. This underfinancing has several far-reaching consequences: hospitals have considerable debts to various suppliers, mostly for medications; the quality of medical care is unsatisfactory; there are no incentives for staff to improve quality or productivity; and there is an overall lack of investments for the development of the health system.

Overall, Bulgaria’s health system is not sufficiently democratic and stable to yield the desired results regarding population health status. Both, users and health professionals, have expressed dissatisfaction with the system. In the survey we conducted in 2006, many respondents assessed the health reform negatively. 36.3 % of respondents believed that the reform had a negative effect on health care. According to another 24.9% of respondents, the reform did not result in an improvement of health services. Only 17.5% evaluated positively the outcomes of the health reform, although many of them shared the opinion that the reform was slower than necessary.

Similar views emerged among participating health professionals. The majority of them (32.1%) did not see any improvements in health care as a result of the reform or believed that it had a negative impact on the functioning of the health system (26.2%).

The survey suggested a deterioration of some main characteristics of health service provision. According to 66.2% of respondents, the reform had a negative impact on the costs of health services. Negative views were also common about the promptness and efficiency of services, access to specialised medical care, care for patients with chronic diseases, and timely prophylaxis. Only about 20% of respondents noticed improvements in the attitude of physicians to patients or the availability of home visits by physicians. The opinion prevailed that the performance of physicians had not changed significantly in the course of the reform. According to the majority of respondents, the main problems with health service provision were the prices of drugs, the shortage of funds allocated to health care, the overall organisation of the health system, bureaucracy, and the lack of medical equipment. Approximately one third of respondents indicated that corruption of medical staff and poor quality of care were major problems of the Bulgarian health system.

Asked about the most important positive changes for health workers, 45.4% of medical specialists believed that there were no positive changes, 22.5% indicated better payment and improved motivation, 16.6% mentioned the introduction of market principles and private health care provision, and 14.4% believed that the reform had brought about more modern working standards. Over half of interviewed medical specialists (51.1%) thought that the reform had not brought about any positive changes for patients. Free choice of general practitioners and other health care providers was mentioned as a positive change for patients by 29.7% of medical specialists, while 10.7% believed that the quality of health services has improved.

Surveys in subsequent years confirmed the persistence of negative attitudes on Bulgaria's health system and the impact of the health reform. In the 2009 Eurobarometer survey on the social climate, 74% of respondents rated health care provision as "bad". Comparing the situation to that in 2004, 39% of respondents believed that health care provision had remained unchanged

and 49% indicated that it had deteriorated (European Commission, 2010). Similarly, a nationally representative survey in 2010 found that 76% of respondents were dissatisfied with the health system and 91% thought that further health reform were needed (MBMD, 2010).

## **Conclusion**

Our findings suggest that the outcomes of the reform so far do not match exactly initial expectations in terms of health improvements or health system characteristics. Several errors were made in the course of the health reform. The first was that the reform began without a comprehensive plan or perspective. Second, implementation of the reform was carried out slowly and hesitantly. A third shortcoming of the reform was that communication with the citizens and health professionals was neglected in terms of objectives, content and process of the reform. Fourth, the reform legislation did not regulate clearly enough the new legal basis of the health system and responsibilities in health care. Finally, the control functions in the regulation of the health system were underdeveloped.

These conclusions suggest that further reform of the Bulgarian health system is necessary. Two of the most urgent challenges are to improve population health and decrease health inequalities. This will require changes to the organizational and financial set-up of the health system. A reform of health financing is particularly important. If health financing relations, mechanisms and instruments are preserved in their current form, the health system will absorb financial resources *ad infinitum*. There is no doubt that more resources need to be channelled to the health system, but in order to achieve the desired effect they have to find place in a correspondingly changed health financing environment.

For successful and efficient health reform, the creation of favourable conditions, i.e. a “reform environment”, is of crucial importance. This would require harmonised efforts of all

stakeholders in the health system, including health care administrations at all levels, health care providers and medical professionals, the scientific community, the private sector, trade unions, civil organisations and the media. Such efforts would be more effective, if directed towards the development and implementation of a stable and sustainable evidence-based health policy, rather than resulting from ad hoc, fragmentary and politically motivated measures. The formation of such a policy would require a continuous and constructive dialogue between all stakeholders, in order to establish a solid foundation for the further reform of the health system.

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