

LETTER TO THE EDITOR

**A comment on the article: *Stošić S, Karanović N. Health care economics in Serbia: current problems and changes. Vojnosanit Pregl 2014; 71(11): 1055–1061.***

Komentar članka: *Stošić S, Karanović N. Ekonomija zdravstvenog sistema Srbije: tekući problemi i promene. Vojnosanit Pregl 2014; 71(11): 1055–1061.*

To the Editor:

In the latest November 2014, issue of the *Vojnosanitetski Pregled* I was pleased to read a remarkable article by Stosic S. and Karanovic N. entitled: „Health care economics in Serbia: Current problems and changes“¹. This current topic paper analysed a variety of issues relevant to the health care funding and provision in the Republic of Serbia during the past few decades. It gave a thorough insight into the patterns of funding common to European national health systems as well as their common strengths and weaknesses. The case of Serbia as the largest Western Balkan market was dealt with particular attention. Some of the key weaknesses of current national management and financing practice were properly addressed. Authors provided an excellent insight into the current revenue collection strategies deployed by the National Health Insurance Fund. Key changes such as the introduction of capitation payment for physician salaries and diagnosis-related groups (DRG)-based hospital payment were presented. Particularly interesting was media coverage provided in the article and an explanation of accumulated health care attributable public debt due to delayed payments of drug wholesalers to the manufacturers. Although highly valuable for regional professional audience, according to my opinion this piece of contribution omitted several core developments in the national health economics. Clarification of missing issues is crucial for this current topic paper to be fully comprehensive and up-to-date.

One of such issues is the remnant of top-to-the-bottom thinking so characteristic of former centrally planned socialist economies. With regards to provision of medical services this means that Serbian system tended to be poorly responsive to the real population needs². Demand-based planning of resources to health care although attractive to policy makers couldn't become reality simply due to lack of local evidence. Some of the pioneering cost-of-illness assessments have been conducted and published in high impact journals over the course of the past decade. Prosperity illnesses encompassed by these efforts were risky pregnancies³, alcoholic dependency⁴ and detoxification procedures⁵, opioid addiction⁶, diabetes mellitus⁷, community acquired pneumonia⁸, malignant disorders⁹, COPD¹⁰, hepatitis C¹¹ and few others. Many more remain untouched. Reliable field studies on the resource use patterns and costs of care attri-

butable to major illnesses in a peculiar Balkan hospital setting have become a necessity. This fact is emphasized by the substantially different microeconomic setting of high income markets where most health economic assessments are published. It has been proven that such cost-effectiveness conclusive remarks are not simply transferable to the Eastern European health systems. A large part of these Serbian national efforts were orchestrated by the Academia in trials non-sponsored by industry but conducted by one of the two major 5-year fundamental research projects funded by the Ministry of Education Science and Technological Development of the Republic of Serbia (2006–2015). Smaller scale research is being conducted by a variety of state- and private-owned universities and institutes throughout the country funded by internal resources of these facilities.

In a health system showing concerning signs of financial unsustainability as authors properly emphasized, some cutting edge technologies with substantial budget impact might have higher relevance compared to mature economies. Although quite an issue even in markets most abundant with resources such as Switzerland or Japan, these novel technologies in middle income countries of Western Balkans might affect access to other affordable but essential medical services. Back in the 1990s economic assessment of exact burden of these medical technologies in Serbia were virtually unknown and only approximately evaluated based on Western sources. Today academic research cores around the country have made their contributions on radiation oncology¹², monoclonal antibodies¹³, implant technologies used in orthopedics and interventional radiology, imaging diagnostics¹⁴ and several other high cost branches of clinical medicine. Such data open opportunities of the first evidence-based resource allocation in Serbian health care¹⁵. One step further it was proven in a sound methodological design that it is possible to contain costs of care in domestic university hospitals without bargaining for quality by using cutting-edge good clinical practice guidelines¹⁶. Another successful strategy to cut drug acquisition costs to the system already proven in largest global pharmaceutical markets is generic replacement of brand name medicines¹⁷. As authors have noticed DRGs based hospital payment and capitation based physician salaries introduction, regardless of few setbacks, will most likely present the bold moves forward for the system, beyond current limitations.

Education initiatives will certainly remain one more key pillar promising long term successes. This is particularly crucial while bearing in mind lagged capacity building efforts in health economics and other interdisciplinary health sciences around most of the Central and Eastern Europe (CEE)¹⁸. Some of the early shy efforts in this direction were made by establishing first obligatory graduate curricula in Pharmacoeconomics among state owned universities in Kragujevac 2009 to be followed by others. Health economics is slowly becoming an integral part of doctoral programs and there is a growing number of defended doctoral dissertations around the country. Frequency of accredited continuous medical education courses in these interdisciplinary health sciences targeted to the professional audience increased in a parallel manner. An essentially different mindset of traditional academic expert cores around CEE region made these developments more challenging compared to the mature free market economies. One of major moves forward was publishing of the first complete university level textbook on health economics and pharmacoeconomics in Serbian language – pioneering effort for most Western Balkan languages¹⁹. Frankly speaking, in a cradle of health economics among the US core universities similar things were happening as early as in the 1960s.

Although authors have pointed out the lack of official Health Technology Assessment (HTA) in the country, it is relevant to notice substantial, so far unsuccessful efforts invested into HTA establishment in Serbia. In between 2005 and 2008 there have been two consecutive cycles of the World Bank's investment projects on capacity building and the systemic implementation of the Health Technology Assessment (HTA) in Serbia. Governments of the time responded with "Feasibility Study on HTA Agency in Serbia" and the "Basic Benefit Package on the Way towards Evidence-Based Health Care in Serbia" in the framework of the "Serbia Health Project". Unfortunately, even after a decade of joint efforts there is no mature political will for institutional and systematic assessment of medical technologies in terms of costs and benefits. Unlike Serbia, some „light“ or „heavy“ model of official HTA agency is already in place in many new eastern EU members with Hungary²⁰, Poland and Latvia on the lead²¹.

With regards to health expenditure dynamics and long term trends in Eastern Europe authors cited the source which although comprehensive at the time of publishing in 2008, seven years later is seriously outdated²². Some key economic shifts took place in the meantime while the Russian Federation and most of post-2004 EU members became high-income economies, thus capable of spending more for health care²³. Another key consequence of global changes ultimately affecting Balkans is the rise of leading emerging Brazil, Russia, India, China (BRICs) countries and their long lasting impact on reshaping global health care market²⁴. Relying on WHO estimates on total health expenditure per capita in Serbia in terms of purchasing power parity (PPP\$) although falling during key years of global recession we notice serious signs of recovery and increase (PPP\$ 1195 in 2008; PPP\$ 1163 in 2009 and PPP\$ 1250 in 2012)²⁵. These promising developments oppose to the pessimistic forecasts in the source article (Projections for the future do not predict increase of public funding for health care) which at the time when original article was written were fully grounded in reality²⁶.

Many of the bold new advances described in the initial article as well as this comment indicate that the time for changes has inevitable come. Serbian preexisting national difficulties in health care provision only became worsened with accelerated pace of globalization, population aging and worldwide economic crisis. Whether one European health system hosting two centuries of public health tradition shall timely respond to these challenges is yet about to be seen.

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R E F E R E N C E S

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Authors' reply:

After receiving comments of Prof. Jakovljević on our article, we wish to thank him for the explanation in more details of some issues that our article just mentioned, considering that they were not in the main focus, so we had no space to further explore them in the published paper.

Professor Jakovljević pointed out that the Serbian system tended to be poorly responsive to the real population needs. Indeed, the responsiveness, i.e. responding to people's legitimate expectations, as well as improvement of the health of the population they serve and fair financing, are the main goals of health systems according the WHO. The health system is as efficient as it is able to meet these goals, given the resources available to the system.

As Prof. Jakovljević mentioned in the comment, reliable data on the resource use and costs of care in Serbia are lacking, and we would like to add to that transparency of financing, adequate planning and public control are also lacking in many ways. In the comment, based on his outstanding work, Prof. Jakovljević highlights that the assessment of cost/effectiveness of selected groups of interventions may improve the health system performance and we agree that

such data are basic for adequate resource allocation. Of course, education of managers in healthcare and their proper decisions are essential for the functioning of health service provision at local and national levels.

However, in our article we address financial sustainability of Serbian health system in general, from revenue collection to payment to the providers of service. Though it might be not emphasized in the article, we believe that increased financing and providers motivation are crucial for improving the efficacy of the Serbian health system. However, based on negative indicators of Serbian economy, we predicted that the funds for health could not be increased. Unfortunately, according to the state budget for 2015, funds for healthcare are even less than in the previous year. Thus, we could expect more “out of pocket” spending for health service and delay of crucial reforms in healthcare in the next few years. Anyway, as we both agree, even within very limited funds, there are many aspects of the health system performance in Serbia that may be improved.

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