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PERCEPTIONS OF A SAMPLE OF PHYSICIANS FROM BUCHAREST UPON ROMANIAN HEALTH POLICY[1]

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Abstract: *This article is part of a broader analysis, which is based on qualitative data collection by interviewing a sample of physicians. Data collection was conducted from November 2014 to March 2015. There were interviewed a total number of 40 physicians in Bucharest. Most of those interviewed are specialists working in state hospitals or are family physicians. Their perceptions upon how the medical system works show their displeasure against low wages, disorganization in the system, less efficient management of financial and human resources in the system. They pull the alarm on the phenomenon of massive migration of physicians and health indicators of the population. Rates of morbidity and mortality in Romania are a blend of specific indicators for developed countries with specific indicators for developing countries. Although most health indicators have improved over the last two decades, a number of indicators are still very problematic, with significant gaps compared to the EU average.*

Keywords: *perceptions, Romania, health policy, physicians, health indicators.*

Introduction

The medical system in Romania has gone through some changes over the last 25 years, but it has not improved the quality of services at the level expected by public and by medical personnel, taking as reference the European average performance. The average life expectancy remains among the lowest in the region (74.4 years versus 80.3 EU27 average) and healthy life expectancy at birth (57.9 years, Romania 2013, compared to 61,5 years the average UE28) experienced a slight decline from 2007 to 2013 in

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Romania, both women and men (62.9 years in 2008 to 57.9 in 2013) (EUROSTAT, 2015)

Rates of morbidity and mortality are in Romania, a combination of specific indicators of developed countries (mortality from cardio-vascular diseases, the increase in cancer morbidity rates) with specific indicators of developing countries (the rate of infectious diseases, the increased rate of TB and rate of sexually transmitted diseases). Although most indicators have improved all along the period of 25 years after the revolution, a number of indicators still remains very problematic, far behind the EU average: the highest infant mortality in the EU (9 at 1,000 live births compared to 3.8 EU27 average in 2012) and the highest incidence of TB in EU (87 per 100,000 population in 2013, 10 times higher than some Western EU countries). (EUROSTAT, 2015)

The main cause of death in Romania are cardiovascular system diseases. In the West Europe, the trend is to reduce this rate; in Romania, it is growing. Deaths attributable to malignancy are below the EU average, but one should note avoidable deaths: the highest rate of death from cervical cancer in the EU, reflecting the inadequacy of the system to the needs of the population. Infant and maternal mortality indicators are also a strong correlation with the performance of the health system.

Also, in developed countries, health resources began to demand considerable effort. Life expectancy has increased in the European Union and the share of population aging (the main consumer of services in total), also modern drugs/interventions are costly. All these are important fiscal pressures. Although the Romanian state's financial efforts have increased over the last 10 years, in absolute numbers and percentage, the system deficiencies persist and, in the European context, Romanian health finance remains low. Romania continues to be one of the last places in the EU in terms of health resources. (4.36% of GDP government allocation, including social security funds, that is half of what countries like Germany, France, Belgium and the Netherlands allocate). The allocation of health finance should reach a minimum of 6% of GDP. (EUROSTAT, 2015)

In spite of statistical indicators, interviewed physician show that Romanian population's state of health is not overall known. A national screening was done couple of years ago, with the aim of knowing population's health state. Unfortunately, only a part of population, including a large part of the old age generations have responded, as the screening was not compulsory.

> "Before 1990, there were mandatory checks, even if it was a reduced screening, but they did some research and population was known. Now, I organized a workshop for gastric cancer, where I invited some teachers from Japan. We are in an embarrassing situation because, in spite all the relationships we have in Ministry of Health, the Health Insurance Fund, I cannot say which is the incidence of gastric cancer in Romania. There is nothing to tell us what is happening in Romania with this rate. Basically, we do not even know what is happening in our health system."

> "We do not know the real situation of the health of the population. We are influenced by what we saw on TV that everything was dramatic. Perhaps the

> situation is not so dramatic or it is even worse than we think. Media campaigns have always media interest on their back. There are not aimed at sustaining the health of the population. During the workshop on cancer I am organizing, I invited the biggest names in the field in the world. Nobody from Minister was interest. Everything that is done, is done through my own efforts."

It is known that a sick society brings monetary and social costs on the long term, by the consequences upon human capital, directly related to productivity and the system of social assistance. Thus, solving health problems only punctually, marginally, poorly funded has long-term consequences.

This article is part of a broader analysis conducted by the author, based on an analysis of qualitative data collection by interviewing a sample of physicians in Bucharest. Qualitative data collection was conducted from November 2014 to March 2015. There were interviewed a total number of 40 physicians from Bucharest. Most of those interviewed are specialists (32 physicians), working in state hospitals (28), physicians in private hospitals (4), or family physicians with individual practice cabinet (8).

The used research instrument was an interview guide with open items, which included topics related to health policy in the health system since 1990, the weaknesses / obstacles that physicians encounter in the daily exercise of their profession, financing the system, policies for health professionals, social costs of current health policy.

Physician have left the country massively in the last years. That should be a warning to health policy. The government should realize that an investment in public health is absolutely necessary and set as a priority for Romania. That it should not be delayed just because it does not bring results on short term, with electoral impact. It requires taking political responsibility and prioritization of investments. Currently, employees in the system complains not only about the low level of salaries and low funding for the needs of the system, but about the fact that studies of cost–effectiveness are not used in policy decisions, there is not proper a prioritization in investments and there is no transparency in the allocation of funds.

The process of health policy must be a real answer to current health problems

Analysis of health policy should be studied in social and historical context of national social policy. In Romania, the policy adopted, on the background of limited financial resources, granted marginal positions to health system and education system, in terms of funding, after 1990. At the same time, the policy of reforming the health system was not bold enough to achieve major reform, as other former communist countries did, reforms that have succeed to improve services quality. Social and political history, ideology of each state and the role of unions or professional organizations shape the evolution of systems in Europe.

The process of health policy must be essentially a pragmatic response to a range of health and social problems and it must be based on a set of values. Based on an assumed set of values, there is determined a set of prioritized problems. Public policy is

therefore that course of action (or lack of action), chosen by the public authorities in response to a particular issue or set of issues. Public policies offer a path forward for a whole range of interrelated actions. Thus, policies are tools that solve community problems. Not everything that governments do is the result of a policy. Faced with a crisis, there is a tendency to adopt emergency solutions that bring temporary solutions and whose impact is not measured on long term. (Drummon M. F *et al.*, 2005; Hunink M. G., 2014)

Cost control should be considered and the current state of the system assumed, as well as the consequences of long-term underfunding of some subdomains. Otherwise, the health system adjusts itself, as it happens with the Romanian one at the moment, because funding ends and the services / products are not free anymore, as stated legitimately by the law, limiting access to those without out of pocket resources. Therefore, the damage caused by reduced funding cannot be controlled, because they are not legitimately recognized. Legally, everything is free in the system based on quality of insured; many services are not free, in fact, because it cannot be accessed without out of pocket money, when funding is over.

It is better to have a strategy and a hierarchy of problems to be solved on the basis of how current resources allow, an acceptance that the current funding cannot maintain functional European standards for all its components, because finances are not enough for this level. Thus, there is developed a hierarchy of damage and problems remaining unsolved, served at lower standards or provided with copayment. It is preferable to the inability to assess collateral damage and losses and not be able to prioritize direct costs and social costs of the system. The example below is of one of a surgeon in a great emergency hospital in Bucharest. He shows that there are serious shortcomings in the system, even for simple, basic materials in one of main hospitals in Romania:

> "It's terrible what I am going to tell you. Today in my hospital I did not have serum, I did not have glucose and to discuss the order of magnitude, to understand the chaos in the system, a bottle of saline serum is 1leu (leu in one unit of Romanian money);but there are spent millions of lei on things that are locked and not used and this serum is 1 leu and it is missing. It is a total chaos." (…)
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> "I cannot prescribe the same antibiotic two days one after the other. Once I started antibiotic treatment, treatment guidelines force me to follow that treatment for 5-7 days. Unless the answers of the body requires exchange of treatment. But I have patients who received 5 different antibiotics in 5 different days. It is an abomination. I have no hope that things go well and that the patient go well. Furthermore, under the new law, I cannot prescribe recipes, while they are hospitalized, which I think it is perfectly legal, the patient have already paid health insurance and it seems natural that during he is in hospital, the medication should be provided for free. But in fact, there is not an optimal provision of drugs and I cannot release prescription, in order that he buys antibiotic from the pharmacy. Maybe basic package should be really functional. Let us know what we can do and what we can do for patient. What can I offer to the patient and what can I not offer him. We say that we offer what we actually do not offer."

Basically, at the moment, according to interviewed physicians, there is a discrepancy between what it is stated that is offered and what is really offered. Also, it is a major dispersion of the few physicians and few financial resources in many health facilities, without a strategy. Everything starts from a policy unable to assume reforms which have a political price. The common shortcomings reported by interviewees include: lack of a system to monitor the quality of health services; lack of awareness of the real costs of the system; chronic sub-financing of some areas of the health system; inability to have a coherent long-term strategy for hospitals' development; professionals that are leaving the system.

> "It's hard to take things forward when things are judged in following terms at Ministry of Health: it is an election year or it is a pre-election year. So, it is better not to take decisions that would cost us politically. To close a hospital means to pay a political price, even if you actually raise the quality of services in the area, on a long run. And so, because we avoid to pay a political price, money is wasted unnecessarily. Senior hospitals have not enough physicians, nor do minor hospitals have enough physicians. Let's be serious: a hospital with 5 physicians is not hospital, a hospital must have at least 5 emergency line physicians. You cannot do emergency line with 2 people. Things are not done properly, with direct consequences for the patient. But they do not recognize this officially. I think the society could understand that some reforms are essential, if a real discussion and an effective information could be made."

Part of the problem seems to be therefore lack of political assumption, combined with a certain mindset, things dragged under the same form year, after year. One of these assumptions relates to the closure of hospitals that are below the national imposed rules, because they have no equipment required, nor necessary medical staff. A second type of political accountability that is expected by the medical staff is increasing/changing medical status in society. Firstly, by increasing the wages. But not only wages are important, doctors say, but also social recognition of the social role of physician. The physician is a person who has invested a lot of time/resources in education, the society also has invested a lot of resources in his education. A specialist physician reaches the age of 30-years and barely finish his residency, while in other specialties on the labor market, people reach a career and financial advancement, faster at this age. Romanian society loses its entire initial investment in educating physicians, because the state fails to provide decent salaries and a social deserved status thereafter. It is a social problem that must be raised. Does the society want not to have competent people to assist it in ensuring health? Valuing health is essential for most of people. Does the Romanian society want to lose previous investment in educating medical personnel?

> "The main fears of the people are death and disease. Any nation with a good judgment ensures itself that the members of that population are assisted in front of the main fears: disease and death, by the most competent people. Romania does not do this. It selects, up to a certain point, the most competent people and then, no longer cares for them, it lets them go… "

Making the list of priorities

The struggle for resources between the various issues to be resolved is another fact. Hence, the need for prioritization. Through the intervention of social policies, we are dealing with a process that decides assigning values to a group. The number of values assigned is smaller than the number of existing stock of values, which leads to competition between values and recipients: either economy does not have sufficient resources or just certain values are considered more desirable in society. Physicians interviewed talk about lack of prioritization in present Romanian health system. Do we know which the priorities of Romanian society are? Do we know what does Romanian society want to finance? Physicians explained that several mechanisms occur: those in decision facilitate their medical specialty and their own interests, when they come at governance, and the real costs of the system are not known.

> "Society must decide. Does it want to fund people who do not return any money into the society, or to what extent does it want to fund? You cannot finance anything, to anyone, even if he does anything for society later. Nor can be financed any type of ideas for everyone, even if one contributes more ".

> "Lack of prioritization of health. Each one that gets minister, each puts in the forefront of budgeting, the specialty where he comes from. That is not okay. The society has some priorities. They differ from one society to another. Nobody asked the society, which are its priorities and where you want to give money to. If we look, for example, in the newspapers, we see that one of the priorities is childhood cancer. Most ads requiring money, otherwise honest, are for such cases. For better treatment abroad. So this seems to be the number one priority. It must be funded, not different kinds of nonsense. So prioritizing is important and it is not done. "

Priorities of different social groups differ. On the other hand, Romanian society's values have been changing in the last 25 years of transition. Some 20 years ago patient from urban areas, is now no longer the same patient, physicians say. The patient of urban areas, especially large urban areas, wants to save time and solve things quickly. There are some people who refuse medical leave, while two decades ago, medical leave was a priority. Methods of financing some subdomains of the system should take into account these.

> "Priorities vary greatly from one social group to another. For example, for the Roma people, the most important is the treatment of pain. So if they have a pain, they are extremely aggressive in finding a solution for the rapid treatment of pain. But, it is not so important treating elderly, treating heart failure or care of a person with terminal disease. Pain is more important (...)

> For active and appropriate earning persons, price treatments not important, but the speed of effect of the treatment. This has been changing, comparing to 15 to 20 years ago. At that period, 20 years ago, it was important to get a medical leave, as long as possible. Now, the contrary, there are groups who simply refuse medical leave. Priorities change. They have to be seen. And when you have that list of priorities from top to bottom, a government may announce priorities and will have

> a lot of back up from the population. Because it is what the population wants. But now, they actually finance where it can obtain more bribes."

According to Gilliam S. and Yates J. (2012), prioritization should be a transparent process based on a clear set of criteria. Is it required that service? Is the intervention suitable for that health system? Is service efficient in terms of cost? Setting priorities must take place within a clear ethical framework (Gilliam S et al., 2012:115). All systems have limited budgets and not every service can be financed. Those responsible for providing assistance facility should be able to explain how taxpayers' money was spent. Some more appropriate decisions are taken locally, but the need for some specialized services may be at low level for small populations. What factors should take into account when comparing options? As Stephen Gilliam S. shows, the first step would be to identify the needed services. It sounds simple, but in practice it is difficult because many of the services continue to be funded on "historic" basis. The last year work is funded the same this year plus perhaps a little extra funding, which takes into account couple of factors, as ageing or increase of population. The new interventions and service options are always potentially available but rarely decisions are made that lead to the withdrawal of a service investment and promote investing in new ones. (p.116). Secondly, establishing needs is very important. It is important to determine types of interventions of which services /goods will benefit most people and therefore, become priorities. The role of health professionals is to ensure that services are aimed at those who most need them. Most often needs are better assessed locally.

Evaluation of evidence of efficacy and cost-effectiveness evaluation are the next step. What action does not work, it should not be provided by a publicly funded facility. Often, however, the evidence is difficult to obtain. There are many health interventions for which quality and quantity of evidence are limited because they are a category of interventions that have multiple facets. The results are only partly owing to that intervention that we are concerned with. For example, the reduction in lung cancer mortality at men can be attributed to services as anti-smoking campaigns or tobacco taxation? Hard to say which of the interventions must be stopped or reduced (p.117).

The value is not counted only in money units and saving lives is not the only benefit. Costs and benefits should be carefully measured and compared between different interventions results. How to determine whether 100 lei spent on treatment for improvement of cardio-vascular diseases are more effective than 100 lei spent on cancer treatment? The results of interventions are competing in relation to the resources they consume. Relevant results and costs should be measured (p.119). Economic evaluation, on the other hand, may be defined as a comparative analysis of the action alternatives in terms of costs and consequences. Costs are generally of two types: direct (associated with the activity, i.e. the cost of 10 minutes for a GP consult) and indirect (are more difficult to measure, may include i.e. the cost of maintaining an office where physician works). Opportunity costs are the amount lost by not using resources (labor, capital) in the best alternative of use.

These types of cost-benefit analyzes are difficultly conducted in the medical systems, because of their complexity, shown above. The Romanian system took evaluation analyzes made in other health systems, put them into its system, adjusting as far as it

could to the Romanian reality. The result is inconsistent with the needs of Romanian health services.

"Manner of disbursement of a medical service in Romania are currently extremely random and contain 99 % incompetence and 1% malevolence. Normally, they must go hand in hand with the desire that health system has, that service is to be used more or less. If me, as a society am very interested in cervical cancer, then disbursement for that screening I do it bigger, in order that physicians draw patients for checking. This way must be made. All these settlements should take into account social priorities.

Currently disbursements are generally to ensure a number of patients evaluated, to give something to the patients who have paid insurance, without taking into account the complexity of the procedures by which, those patients should be given, or quality of service that reach to them."

„For example, in the UK, if you are in a hospital, let's say that it is a hospital of obstetrics and gynecology. This hospital receives from institution that pays an amount of money. They say: with that amount of money we pay such and such and we can produce 10 baby deliveries. The 11th birthday we cannot provide because there is no money. In our system, it is reversed. They say that for paying you wages and all costs, you should do in the first month a total of 10 baby deliveries, but in the second month, you can make a total of 12deliveries. In the third month, they decide that you can make 20 deliveries. So, it has nothing to do with working hours, with material consumption or with reality"

"How do they decide? I do not know how. The system was initially started to budget according to Australian system, where someone has calculated which priorities are to budget. Then transposed in Romania, physicians were astonished, because apparently trivial procedures were very well paid. And important things were not paid at all. Trivial things as high cholesterol. Increased levels of it means that, at some point, some one is going to do heart attack or stroke. If you do not die, you will be expensive for the health system in the near future. So, it is very important to do something for this little thing. It was paid more points. But things that for us were very important, as is osteoarthritis, which is pain, suffering, distress, but never recover and to us it was the bulk of patients, in my specialty (patients sat for days in hospital) but for society this does not have an importance and hence the discrepancy."(…)

"And then began the rebellion of physicians, that did not understand why some are better paid and more, less and someone from Health Ministry started to adjust, but adjusted them according to his own interests. If someone was gynecologist and now at power, he adjusted up everything from gynecology and down the rest. It did not matter that neurology hospitals groaned with patients with strokes. Important was that the money went to gynecology and things went well. And so on. "

> "Solutions? The first solution is not applicable: people to be told the truth. To receive for the money they contribute. At the moment, everyone lives under the impression that it can receive anything for the money they contribute. Few people know that with the money they contribute, they support 4-5 people that do not contribute to the system. And they think they can receive anything because it is their right. "

On the other hand, people expect that governments always take smart decisions and these decisions are the result of a vision. Taking smart decisions is to operate in a coherent framework, which often does not happen. The mere fact of selecting a right issue is actually based on some values. Typically, the policies do not respond to an isolated problem, often they meet a set of problems. It's what governments choose to do or not do. On the other hand, governments have a wide range of instruments of which must choose whose implementation will differently solve the identified problem. For example, to discourage smoking, governments can appeal to different tools such as information (through advertising campaigns), taxation, subsidy, regulation, setting up agencies to tackle directly the issue. Currently, physicians say a lack of vision dominates present Romanian system.

> "I worked outside the country, I saw what happens outside. We're not inferior in terms of medical training as compared with outsiders. What characterizes us is a lack of vision and total disorganization, nobody knows what the other does. "(..)

> "It has not changed anything since 1990, in my opinion, apart from the fact that the equipment began to appear, but the way it appears is totally chaotic, disproportionate and unrealistic. It appears where no equipment is needed and there are spent millions of Euros on that and the one we real need it does not appear "(...)"

Allocations are based almost exclusively on historical background

The inertia of all policies in itself is a thing to be taken into account. The budget from year to year, works on historical grounds. Innovation, the introduction of new measures, the increase of funding system face bottlenecks. Although policies may change gradually, in small steps, policy instruments have their inertia. Policies need to show internal consistency and coherence vertically, therefore activities arising from interrelated policy must be logically consistent. Horizontal consistency is manifested by coherence between policy areas.(Cleverly W.O., 2011; Drummon M. F et al., 2005; Gilliam S. et al., 2012;Hunink M. G., 2014)

> "The budget is something historic and budget allocations are based almost exclusively on historical background. What the budget had last year, it got this year. It uses an index to multiply with and it is the last year's budget multiplied with this index. If the money are not enough, at rectification, there is a little complement. But this is not a problem of Ministry of Health, it is a mode our administrative is generally functioning. It is very hard to bring something new, to move things forward, towards something important because this historical ballast hangs. Budgets

> are often late. There are following election, and prime minister says: I do not do the budget, it will be prepared by the next prime minister. I do not know what will be the philosophy, I do not do it now, and it is to be done after the election. If the elections are on 15th of November, there will not be debate on the budget before the end of January. We're having budget in the second quarter of the year. "

Unfortunately, as shown by several physicians in Romania, at this moment, we do not have an estimation of actual costs of medical services in the system, fact that is reflected upon the entire political system. Not knowing the real costs of the system, you cannot make proper funding. This leads to some areas losing money and others are over-financed where not appropriate.

> "First of all, Romania has no way an estimation of the actual costs of the health services they provide, for a good period of time. This is about the laboratories or hospitals (outside the area Pharma/drugs, which is quite regulated); all the others, except Pharma are legacy costs, with historical background. I do not know on what basis they are placed. In hospitals, the real price of the intervention is a mixture imported from Australia, with one taken by Canada and with a Romanian contribution. Basically, we have no idea how much a medical act in a hospital costs. The cost of a day of admission in hospitals, this calculation was not done. There were some European projects commenced but withdrawn, there were not final adjustments to those calculations."

> "In the hospital this calculation is the most difficult to assess, because the prices of materials are non-unified, each hospital makes its own purchases, salaries of physicians are somewhat not uniform and there are not guides and therapeutic protocols, in the budget area. "

Another factor underlying health policies can be considered path dependence. It is the continuity of healthcare policy and other areas, and the importance of making choices for present related to past. Path dependence explains stability and resistance to change options. It is about investment costs, the effects of learning, coordination and anticipation. The change involves investing in learning, the ability to provide new behaviors, expectations change and organizational stress. On the other hand, mandates of those elected are on short-term, making them choose less expensive solution in terms of policy. A completely new solution often show immediate costs for its implementation and learning for long term benefits and therefore is not chosen by politicians. (Pierson P., 2000).

One of the factors Romanian health policy incoherence is in the opinion of those interviewed often change of decision makers from the Ministry of Health, involved in shaping policy.

> "It is very hard to do health policy, given that those who run health destinies are changed in less than a year. In continuous, these changes ... You cannot accuse those that were changed. They have just left, they left the place empty. Not their will. Most of them have not resigned or were forced for respective resignations. He is beginning to understand how things work, understand not know it all, only beginning to understand, and he is leaving. "

There are several common factors underlying policy responses in the health field since the 80s (Mahon A. *et al.,* 2009). One of them is a move toward reforms inspired by the market principles, from the patterns associated with the public service to business models, there is a talk about the new public management. It is about using ideas borrowed from the market in public sector management and breaking the public monopole. Efforts to reform and streamline the government began to be put on the public agenda only in the 80s, while criticism of the welfare state arose.

One of the most important changes is in personnel management. It is noted that traditional systems of remuneration and evaluation of employees in the public system, including the health system, offer the same prizes/salaries, regardless of performance. These are not effective and do not stimulate performance. Secondly, retention in the system regardless of the performance is another issue that is being discussed.

Romanian physicians are not interested to work in the state system, they are concern in moving towards private health sector, say interviewed physicians. Salaries are paid properly and consistent with the performance or the volume of work in private area, fact that is not available in the public sector. It is about level of salaries, also, these are much higher in private area. But, private system development is available mostly only for some medical specialties and for urban part.

> "Physicians are not interested that things go differently. Physicians do not know how to finish quickly the state program, to go to private, where they are better paid and have a responsibility. We do not need to have fixed wages for everyone, everything must be differentiated depending on the results and the individual performance of each. Why would I work more, if I do 10 operations on a day in surgery and my colleague is doing only one and receives the same pay? For what? Differential pay on results and performance. "

Conclusions

Cost distribution and control should be reconsidered in the system. Current state of the system should be assumed politically. We must recognize that we cannot provide any free service to European standards. We must know and accept priorities. Otherwise, the system adjusts itself, an example of this are the financial ceilings ending and then damages cannot be controlled.

Health care costs are increasing in all countries, including Romania. There are therefore two options for systems: decreasing quality of services (systems have perverse mechanisms to regulate deficits) or the allocation of new funds for health as other components of the society may suffer: public administration, public investment etc. In general, the public does not want to pay new taxes.

It is required taking social and political prioritization of health social policy in the entire national health system and determining the list of priorities. As long as you do not know the real costs of the system, underfunding sub domains may prevail. Consultation with specialists working in hospitals/ clinics and with hospital management is very important. They have estimated real costs which they must face in their field.

Generally, when the system costs up, access to services decreases, and the most affected categories remain the socially vulnerable, the poor, the socially excluded, the elderly, the uninsured, those with low standard of living, which is more likely to be sick. Unfortunately, any European health systems failed to reduce totally social inequality in access to services. There are still groups with poor access. Most times, they select among immigrants, poor, uninsured/unemployed. See the criticism of consumerism on the private healthcare market and issues of equity and access to services groups.

It is required a better management of financial resources, given that health care costs are constantly rising, amid the advance in technology and medication. In health policy, taken decisions need better consultation of professional medical organizations. Eliminating services that are not necessarily needed is one way to reduce costs. Reducing the cost of administrating the scheme is an alternative. There is an excess of administration in most systems. The advantage of large bureaucracies in the state system is that they provide many jobs in general and jobs for female labor force in particular. Cutting bureaucracy in the field may mean rise of unemployment. Another strategic policy is absolutely necessary: revising wages of medical personnel and physicians and to stop denigrating them in the media. Keeping the current rate of physicians leaving the country will have long-term consequences on the system, with no reversibility on a short term.

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