MANAGEMENT IN HEALTH CARE PRACTICE A Handbook for Teachers, Researchers and Health Professionals	
Title	**INVESTING IN HEALTH AND MARKET REGULATION IN THE EUROPEAN HEALTHCARE SYSTEMS**
Module: 1.7	**ECTS (suggested): 0.2**
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Keywords	Healthcare economics and organization, healthcare market, healthcare reform, financing, regulation
Learning objectives	After completing this module students and public health professionals should: • Increase their knowledge related to financial and regulatory principles in European health systems; • Be aware of recent challenges and opportunities in front of their health systems; • Recognize the necessity for investing in health; • Understand the basic mechanisms of market development in healthcare and its regulation. • Identify different methods and types of regulation in the healthcare market.
Abstract	The authors analyze the basic financial principles and the regulated entrepreneurship in the healthcare systems in Europe. They point out that the European countries organize, manage and finance their health care in different ways. Thus the health systems vary not only in the financial methods used, but also in the payment scheme of the insurance institution and the healthcare providers as well as the ways in which the state regulates the health services provision and the development of market relations in healthcare. Some of the most up-to-date challenges and opportunities in front of European healthcare systems are overviewed. An example case study is presented in order to illustrate the need for investing in health as well as for careful financial and regulatory planning and management.
Teaching methods	Teaching methods include lectures, interactive group discussions, case studies, internet searches, group work, and comparative analysis.
Specific recommendations for teachers	• Work under teacher supervision/individual students' work proportion: 40%/60%; • Facilities: computer room • Equipment: computers, LCD projection equipment, internet connection, access to bibliographic data-bases; • Training materials: recommended readings or other related readings; • Target audience: master degree students according to Bologna scheme.
Assessment of students	Assessment should be based on the group-work, seminar papers, and case-problem presentations.

INVESTING IN HEALTH AND MARKET REGULATION IN THE EUROPEAN HEALTHCARE SYSTEMS

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THEORETICAL BACKGROUND

Investing in health – an ethical necessity or economic demand

Health is already widely accepted as a basic human necessity and right. The aspiration for good health is natural and leading in almost every human being. At the beginning of the 21st century the World Health Report 2000 was issued "Health systems: improving performance". Despite the controversial and much discussed analyses and comparisons of different countries' healthcare systems, it draws the attention to the cost of ill health or illness – not only physical and psychological, but also social and economic (1): "… illness itself… can threaten people's dignity and their ability to control what happens to them… Health systems have a responsibility not just to improve people's health, but to protect them against the financial cost of illness…" It stresses on the state's responsibility for investing in health and preventing economic losses due to unexpected disease.

The role of health as a driver of economic growth has been recently acknowledged in Europe. It's already considered to be of great importance for the commitment of Europe's governments to make Europe the most competitive and dynamic knowledge driven economy by 2010 (2). Several years ago, the Commission on Macroeconomics and Health concluded that ill health was contributing to the low level of economic growth in poor countries. The report showed that investment in health interventions would lead to substantial economic growth (3). Despite increasing recognition of the link between health and economic development in low-income countries, the relationship has received attention in rich countries as well (4). Nevertheless reasons for investing in health in rich countries may differ in detail from that in low-income countries, there is considerable and convincing evidence that significant economic benefits can be achieved by improving health not only in developing, but also in well-developed economies. In spite of the remaining evidence gaps policy-makers in developed countries should consider investing in health as one (of few) ways by which to achieve their economic objectives (4).

Several mechanisms, falling into four main categories, could account for the relation between the population health status and national economic growth (5):

- *Productivity.* Healthier populations tend to have higher labour productivity, because their workers are in good physical and mental condition. They also suffer fewer lost workdays.
- *Education.* Healthier people who live longer have stronger incentives to invest in developing their skills, which promotes greater productivity and, in turn, higher income. Good health also promotes school attendance and enhances cognitive function.
- *Investment in physical capital.* Longer life-expectancy creates a need for savings for retirement. Increased savings lead to increased investment.
- *"Demographic dividend."* Transition from high to low rates of mortality and fertility in many developing countries in recent decades. This gradually gives way to an increase in the proportion of the population that is of working age. Income per capita can rise dramatically, if people are engaged into productive employment.

Thus the design of the national healthcare system and the financial resources allocated to its development and improvement appears to be crucial for population health, which on its side has a major influence on the economic growth of certain country. Every health system has developed on its own way, influenced by cultural, historical, social, economic and technical factors. Grounded on this, the healthcare in the European countries differs mainly in two aspects:

1. The financing mechanisms: types of health provision (insurance) models, payment mechanisms, revenue distribution etc;
2. The regulation of the healthcare services and market development: public – private balance and level of entrepreneurship regulation.

Basic financial principles and challenges in the European health systems

A health system is complex structure, consisting of people, institutions, and organizations, which interact to mobilize and allocate resources for prevention and treatment of diseases and injuries. This structure is based on certain fundamental pillars - essential elements that enable the healthcare system to function: *information, management, human resources, and financing* (6). In the present paper we shall discuss only aspects of the forth pillar – healthcare financing.

The European countries organize, govern, manage and finance their healthcare systems in different ways, but all of them are based on few common principles:

1. Universal access to medical care;
2. Solidarity in the distribution of resources and expenditures;
3. High standard (quality and safety) of healthcare services.

The challenge of healthcare financing is twofold: to mobilize sufficient funds for the health system and to apply (manage) those funds well (6). Mobilizing funds to finance public health interventions is difficult both because health services are becoming more and more costly and because raising revenues in low- and middle-income countries is not easy. Choices of different financing mechanisms also have important implications for that who will bear the costs of health care: the population at large may share spending; thereby providing effective insurance to those who become ill, or it may fall most heavily on the sick ones. There are also a number of initiatives to promote health insurance coverage through voluntary schemes. Strong arguments can be made in favour of pooling the financial risk associated with paying for health care among the widest population possible, effectively paying for the health care of the poor and the sick with taxes and premiums paid by those who are healthier and wealthier.

There are two main financial sources in healthcare:

- Public: state (governmental, semi-state) / insurance / mixed;
- Private: out-of-pocket (official and unofficial) / private insurance / mixed.

Private health insurance exists in a number of countries and is most often used as supplemental or complementary. In Denmark, Germany, Greece and the United Kingdom, many patients use private health insurance so they can be treated by the physician of their choice or escape waiting in patients' lists in the public sector. The available empirical evidence shows that income is the key parameter in the decision to buy additional health

insurance and not health status or "need". High premiums may make it impossible for poor patients to buy private health insurance and this problem is further exacerbated if premiums are risk-based where less healthy individuals, who are disproportionately poorer, pay more. However, in most countries, due to the fact that insurance is often bought in group settings, premiums remain more or less independent of health status and may therefore remain affordable for large groups of the population (6).

The process of financing and provision of health services can be simplified into two inter-related and complementary processes – transfer and exchange:

- The providers transfer health resources (products) to the patients (customers);
- The patient's transfer (exchange) financial resources towards the providers – directly or through a third party (insurer).

The relation between the financing and the health results (outcome) can be resumed in figure 1 (7).

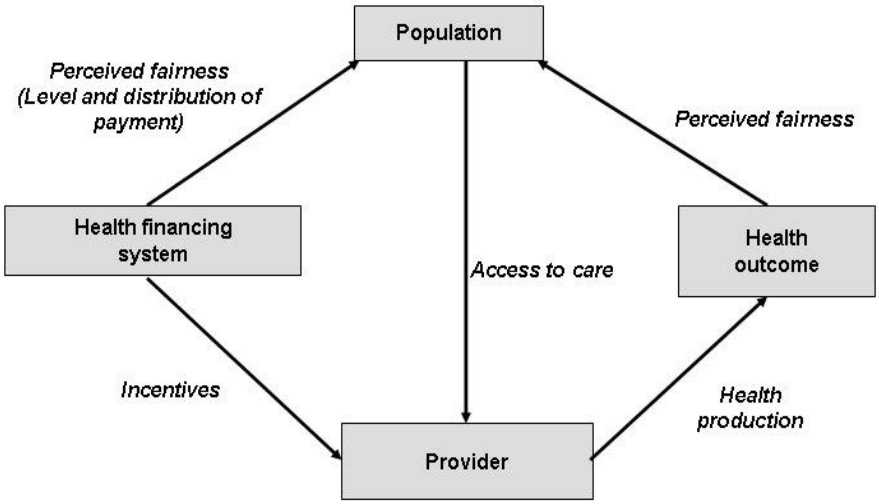

Figure 1. Influence of healthcare financing on the outcome (7)

Demographic change in Europe presents further economic, budgetary and social challenges in coming decades due to people living longer and a potential drop in the workforce from the falling birth rate. While in many ways this can be seen as a triumph for public health, it also poses a particular challenge for the health and social sector. Predictions are that the ratio of elderly, economically inactive people (> 65 years) to people of working age could more than double between 2005 to 2050 in the European Union. It is more important than ever that people remain healthy and independent to as late in life as possible, so that premature deaths among the middle-aged working population are avoided and morbidity is "compressed" towards the end of life. As a result of these tendencies, in the last decade, most of the European health systems, especially in well-developed market economies, are characterized by an increasing financial deficit, despite the considerable amount of resources allocated for healthcare. The gap between the health expenditure and health resources is increasing due to mostly three main factors (7):

- Aging of the population and epidemiological transition to chronic, life-long morbidity,
- Fast development of health science and technology and
- Incompetent health policy, governance and management.

Facing this constant increase in the financial deficit, governments worldwide are facing the dilemma: increase in the resources (revenues) or restriction of the expenditures. In general, there are two mechanisms possible (8):

First option: increase in the revenues – insurance contributions, co-payments, fees, taxes etc. This can eventually lead to decrease in the number of insured people, especially in systems with voluntary health insurance.

Second option: restrict the resources for medical care. This may eventually cause decrease in the quality of health services and in the human capacity in health.

When taking decision on investing in healthcare and distribution and re-distribution of resources and spending, we should not forget that the provider of health services is mainly aiming at profit while the user (patient / customer) is orientated towards higher utility (effective care) (8). The goal of all European countries is achieving balance between profit and utility (fig. 2).

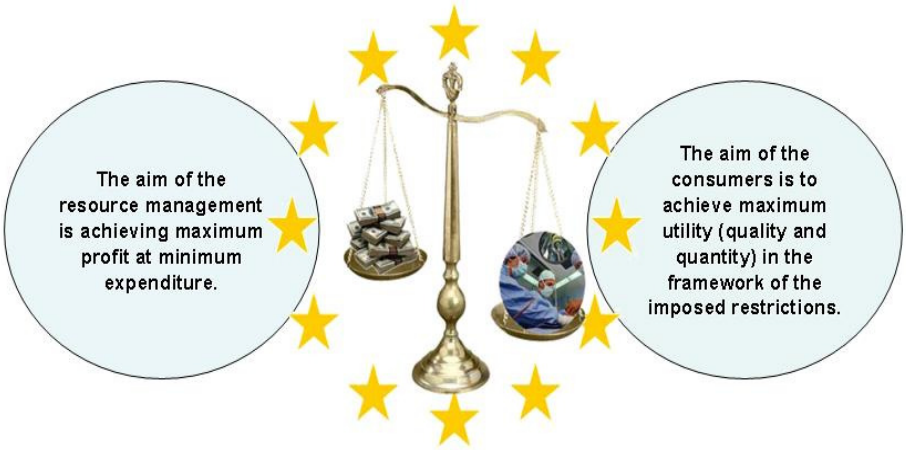

Figure 2. Balance between profit and utility in the health sector (8)

In general, the challenges for the European health systems can be summarized as follows:

1. The costs of medical care increasing more than costs in other social and economic sectors - scientific innovations, information, communication, diagnostic and treatment technologies etc;
2. Excessive demand of health services by the population:
   - increased life expectancy and aging;
   - increased awareness, education, expectations;
   - increased income and financial stability of the population.
3. Free market and competition is not a reasonable option for a healthcare system;
4. Difficulties in maintaining solidarity principle and universal access to healthcare;
5. Difficulties in maintaining high quality and safety of health services;
6. Free movement of goods, services, people and capital in the EU.

Regulation, entrepreneurship and market development in healthcare

„If it moves, tax it.
If it still moves, regulate it.
If it stops moving, subsidize it“
Ronald Reagan

The 1990s witnessed a dramatic upsurge in the scale, character and calibre of entrepreneurial initiatives within European health care systems (9). A wide variety of market-inspired efforts to stimulate service innovation, including increased quality and greater efficiency, have been launched in both public and not-for-profit private sectors, and in core health service activities as well as in more peripheral supplies and services. In practice, the last 10 years have been a period of substantial organizational reconfiguration in the health sector, and increased entrepreneurial activity has been at the core of that process of change (10,11).

Entrepreneurial behaviour is perceived to stimulate innovation and initiative. The conceptual and practical emphasis on entrepreneurialism can have a positive impact on health systems when the changes undertaken help strengthen the ability of national policy-makers to achieve their stated policy objectives (12). At the organizational level, entrepreneurialism seeks to modernize and rationalize organizations to increase their operating efficiency. The powerful impetus to innovate generated by entrepreneurialism can have decidedly less positive effects, however, when it has not been adequately fenced in by effective state regulation. Entrepreneurs inevitably seek to segment markets so as to exploit profitable niches, while publicly accountable regulators try to ensure that the entire market is served efficiently and affordably (12).

Health care has a unique character as a social as well as a private good, which increases the importance of the regulatory role in the health sector. What is obvious from the last decade developments in European health systems is that a substantial volume of new regulation has been generated. Most European countries established new types, as well as expanded the existing range, of what can be termed steer-and-channel regulation. Thus, as areas of entrepreneurial activity grew, they were accompanied by a parallel growth in related state regulation. At present, the state is expected to ‘row less but steer more’, its role in driving the health sector forward has to increase in scale, scope and sophistication. The state’s supervisory responsibilities have evolved to the point that the term ‘stewardship’ has now been applied to its overall policy and management obligations in the health sector (13). The concept of stewardship obliges the state to steer overall health system activity in an ethically grounded as well as a financially efficient manner. Regulation, as a central instrument of stewardship, must from this perspective similarly satisfy these two basic requirements calling for ethical and efficient state behaviour. Failing to regulate entrepreneurialism adequately in the health sector would be a serious breech of the state’s role as a responsible steward (9).

The mechanisms of regulation

Despite wide-ranging definitions and contradictory rationales, there is broad agreement about the source and general mechanisms of regulation. Regarding who regulates, we can find national level as well as regional and local levels of administration. With the emergence of new pan-European agencies, European Union regulation can also be supranational. While most regulation in Europe is conducted by some form of government department, it can be undertaken by independent regulatory agencies or by self-regulatory

bodies (9). Regulation to ensure health gain necessarily addresses actors outside as well as inside health care and intersectoral collaboration is a necessary tool for successful regulation. The mechanisms of regulation can be grouped into three basic categories, tools and strategies, which can in turn be combined in various mixes (9). The major categories are legislation, administrative decree and judicial order, one for each of the three branches of government (legislative, executive and judicial). Each of these three can be generated in many different forms and formats, particularly administrative decrees (advisory regulations, guidelines, etc).

Two dimensions of health sector regulation (9):

1. Social and economic policy objectives. It is normative and value-driven in nature, concerned with specific policy goals and with the broad public interest (which may be different in different countries). These broad policies also need to influence government decisions in other sectors such as education, transport, employment, housing and agriculture (14). These objectives are:

- *Equity and justice*: to provide equitable and needs-based access to health care for the whole population, including poor, rural, elderly, disabled and other vulnerable groups;
- *Social cohesion*: to provide health care through a national health care service or to install a social health insurance system;
- *Economic efficiency*: to contain aggregate health expenditures within financially sustainable boundaries;
- *Health and safety*: to protect workers, to ensure water and food safety;
- *Informed and educated citizens*: to educate citizens about clinical services, pharmaceuticals and healthy behaviour;
- *Individual choice*: to ensure choice of provider, and in some cases insurer, as much as possible within the limits of the other objectives.

2. Health sector management mechanisms. This level is practical and operational and is concerned with the specific regulatory mechanisms through which decision-makers seek to attain the type of policy objectives set out (9). These means are largely technical in nature, concerning efficient and effective management of both human and material resources:

- *Regulating quality and effectiveness*: assessing cost-effectiveness of clinical interventions; training health professionals; accrediting providers;
- *Regulating patient access*: gate-keeping; co-payments; general practitioner lists; rules for subscriber choice among third-party payers; tax policy; tax subsidies;
- *Regulating provider behaviour*: transforming hospitals into public firms; regulating capital borrowing by hospitals; rationalizing hospital and primary care/home care interactions;
- *Regulating payers*: setting rules for contracting; constructing planned markets for hospital services; developing prices for public-sector health care services; introducing case-based provider payment systems (e.g. diagnostic-related groups); regulating reserve requirements and capital investment patterns of private insurance companies etc;
- *Regulating pharmaceuticals*: generic substitution; reference prices; profit controls; basket-based pricing; positive and negative lists;

- *Regulating physicians*: setting salary and reimbursement levels; licensing requirements; setting malpractice insurance coverage.

Rules of the regulatory road (9):

Regulate strategically

- Regulation is part of strategic planning;
- Regulation is a means rather than an end;
- Regulation should further core social and economic policy objectives;
- Regulation is long-term not short-term.

Regulate complexly

- Regulation involves multiple issues simultaneously,
- Regulation can combine mechanisms from competing disciplines,
- Regulation requires an integrated approach that coordinates multiple mechanisms,
- Regulation should fit contingencies of each health system,
- Regulation requires flexible public management.

No deregulation without re-regulation

- Deregulation requires a new set of regulatory rules,
- Re-regulate before you deregulate.

Trust but verify

- Regulation requires systematic monitoring and enforcement,
- Self-regulation requires systematic external monitoring and enforcement.

Regulatory approaches in the health sector (9)

Regulating capacity

Many countries have adopted some form of regulation aimed at limiting the capacity of the health system.

Regulating prices

Regulation can also be aimed at prices in the health system, for example by using centrally determined fees or differential payments such as the diagnosis related group (DRG) method. Government can also use 'price' regulation in the health insurance sector by regulating contributions, premiums and risk-adjustment mechanisms as well as the terms under which such insurance is provided.

Regulating quality

Government can also regulate the health sector through the collection and dissemination of information on provider performance. A different aspect of quality of care that can be regulated is implementation of patients' rights.

Regulating market structure and levels of service

Regulation often takes the form of establishing the 'rules of the game' for the participants in the health system. Most prominently, this involves establishing conditions for entry into health markets and setting levels of service. One method of regulating the incentive to

'cream skim' is to offer health insurers per capita payments (e.g. capitation) adjusted for the risk of each enrolled citizen. The prevalence of such practices depends on the incentive structure offered by government and, in particular, on the level of actual risk-sharing. On the other hand, governments may have less success monitoring so-called 'quality skimping', in which chronically ill and elderly patients fail to receive adequate care (15).

Regulating entitlements

Once citizens are covered, the entitlements available to them may be subject to government regulation. Many countries are struggling with the issue of determining a package of health services that sick funds are obliged to provide. In addition, various supplementary insurance policies may be available for services not covered under national health insurance. This raises perplexing problems of differentiating between what is provided and how it is provided under the different schemes. This is another example of how difficult it can be to develop and apply regulations aimed at supplementary insurance.

We can summarize five major forms of regulation, found in European countries:

- Decentralization;
- Compulsory self-regulation;
- Accreditation and licensing;
- Independent regulatory institutions;
- Regulation through inter-sect oral collaboration.

Who is regulating? Regulatory organs:

- Parliament;
- Governmental institutions (Ministry of health, National Institutes);
- Independent regulatory bodies (Accreditation, audit agencies; professional organizations etc);
- EU structures (European Commission);
- Courts;
- Self-regulation.

In terms of the conceptual framework outlined above, it could be said that health systems have been moving from control by standardization of professional norms, to various forms of command-and-control, and on to attempts to standardize outputs and evaluate outcomes. Moving away from command-and-control, however, did not necessarily mean less regulation. The evolution of regulation in the health sector, therefore, is not a matter of a linear progression from one mechanism of control to the next, but rather a constant mixing and remixing of regulatory tools that have accumulated throughout the years of a health system's development (9).

We can also suggest that most European healthcare systems will achieve a slower but steady growth in the number of social entrepreneurs, working in the public sector but importing a variety of private sector concepts and incentives. Policy-makers would become more and more comfortable with this situation. There should be a noticeable increase in what was termed 'social entrepreneurialism' (16). This middle territory between purely bureaucratic public and purely for-profit private may itself blur the public-private boundaries by incorporating, elements of not-for-profit private in partnership with independently managed public-sector organizations. In such system the regulatory challenges will be considerable, and successful outcomes will depend on the evolution of strict regulatory arrangements. One potential regulatory framework that has yet to be

adequately explored in the health sector is the application of the notion of independent regulatory agencies (9). As the overall entrepreneurial level increases within health systems, the range, scope and capacity of state regulation will have to increase with it. The challenge to policy-makers will be to concentrate on designing a better framework with which to conduct that supervision.

The state and the market in European healthcare:

1. The European Union analyses regarding the benefit and damage from the free market competition in health care are contradictory.
2. The market competition in health care requires strict regulation through specific legislation.
3. The final goal of the market regulation in healthcare is to assure that every decision and initiative taken is in the public (social) interest.
4. The mixed public-private model of healthcare is evaluated as the most efficient way for reorganization of the European health systems.
5. The future belongs to a market-orientated, patient-centred healthcare system.
6. One of the most effective ways to achieve better health for the whole population, in conditions of restricted resource, is through health promotion and preventive medicine.
7. The long-term experiences of certain countries as well as international analyses suggest that the choice for a health insurance model should be made on:
   - The level of economic development of the country;
   - The level of the social moral values and ethics;
   - The level of political responsibility to health issues;
   - The tested models in international experiences.

CASE STUDY

Healthcare financing and reforms in Bulgaria on the way to a modern market-orientated health system

General introduction and context

In the period since 1989, the countries of south-eastern Europe have invested significant efforts in the pursuit of wide-ranging reform of their health sectors, addressing issues of financing, organization and management of health care services. These efforts were a reaction to the inadequacies of the health systems inherited from the communist era, the pressures arising from political and economic transition, a collapse in the funding available for health care and, to differing degrees, the effects of wars, conflicts and economic sanctions. While the countries have followed different trajectories, their overall aims in the health sector have often been similar in the process of reform. With the exception of the former Yugoslavia, all the SEE countries followed the Semashko model of health care provision developed in the USSR in the 1920s, till the 1990s. In the 1990s, health funding collapsed in all countries of the region (17).

Transition in health financing and system in Bulgaria during the process of reform (18)

In general, the health care reforms in Bulgaria were aimed at changing the health system financing methods in order to: ensure sufficient and sustainable health care budget; guarantee equity in the public health sector; enhance efficiency and quality of services;

reorganize primary health care and rationalize outpatient and inpatient facilities. The health reform remained on the periphery of public sector reform until the late 1990s and little changed until 1997. The health insurance system was introduced in 1998 when the Health Insurance Act was adopted, introducing compulsory and voluntary health insurance. The contributions were set at 6% of an individual's income, shared between the employer and employee at a ratio of 80:20. The State and the municipalities cover the contributions of pensioners, children and low-income groups. The Health Insurance Act defines direct patient co-payments for using health care services covered by the basic benefits package. Since 2000, patients pay 1% of the minimum monthly salary for each outpatient visit and 2% of the minimum monthly salary per day of hospitalization, up to 10 bed-days per year. The compulsory health insurance system guarantees a basic benefits package of health care services to the insured population; however, this package is not clearly specified, which creates financial burden for the population. Health care financing was separated from health care provision, and contract-based relations were established. Private practice was legalized in 1991, public and private health care facilities were reorganized. Financial reforms were followed by change in the payments to hospital sector providers and the introduction of a scheme based on performance and cases – "clinical pathways" with a single flat rate per diagnosis. The change in hospital financing was supposed to enhance the competition between the health care providers and increase the quality of services. The primary care and GPs as gatekeepers to specialized care were introduced, allowing cost-containment, but also opening a discussion of whether such policies would hinder the free provision and access to health care. Total health expenditure has been increasing since 1998. It accounted for 7.7% of GDP in 2004, i.e. it was higher than the 6.8% average of the EU10 countries (19). However, there was a general decline in levels of public health expenditure, accompanied by a relative increase in private sources from 34.6% in 1999 to 45.5% of total health financing in 2003 (20).

Contribution-based financing of health care has not been able to provide enough funding for the system. The fact that 1 million people do not pay their contributions results less resources for the NHIF. In order to cope with these difficulties the contribution rate is planned to be increased and the ratio of employer: employee contributions is intended to reach 50:50 by 2009, in order to provide disincentives for the employer to escape paying contributions, conceal the real income of employees or not to hire new workers. However, at the same time, the planned initiative led to a discussion of whether this might create additional financial burden for the population and public dissatisfaction with the health system (18).

The way forward – opportunities to improve the financing of Bulgarian healthcare system and open a way to more efficient public-private mix system

The analysis of the Bulgarian healthcare financial status reveals chronic lack of resources for health and considerable number of cases of ineffective and inexpedient management of the spent financial resources. Considering the restricted state budget as well as the NHIF incapacity to provide enough finances for the routine activities of the healthcare system, a multifaceted strategy has to be accepted in order to solve the problems of the Bulgarian healthcare. It needs to find new sources and approaches for collecting the necessary funds for healthcare. The specific circumstances in Bulgaria require the introduction of an up-to-date and efficient healthcare financing, which would be able to provide balance and stability in the system at the present situation. Some of the most important prerequisites for this are (21):

1. Surrounded by a constantly changing social, political and economic environment, the Bulgarian people are trying to protect themselves and their families, considering health protection on first place.
2. In correspondence to the widely discussed and already implemented in many European countries Theory of Human Capital, the working force with higher social and health status has higher productivity.
3. Every company and organization would logically prefer to direct certain amount of money for the health of its employees, instead of compulsory paying these amounts as taxes to the state. This payment could be part of the collective labour agreement, which requires respective changes in the taxation legislation system.
4. The policy of the Ministry of Health for savings at all costs in the medical establishments is equalizing the economic effectiveness with the medical effectiveness, which is unfavourable for the patient. In this case the patient should pay the difference, which leads to decrease in the formal income of the medical staff.

Basic principles of the suggested approach (21)

1. Defining a basic package of health services, obligatory covered by the NHIF.
2. Free choice of health services and benefits for the population.
3. Free choice of health insurance fund for supplementary health insurance.
4. Financing of the primary health care, based on the number of actually registered insured and for services done.
5. Free (liberal) hospital prices. The fees should be officially announced by the hospital board. The part, covered by the NHIF basic package should be indicated as well as the amount of the additional payment. The prices vary in certain limits, set by the professional organizations and the state for every year.
6. Free choice of medical establishment by the patient on the basis of quality and price.
7. Regulation of the hospital capacity in response to the health services requirement.
8. Pluralism in the options for and ratio public/private mix, formulated in the health strategy of the Ministry of health as well as by the market necessities.
9. Implementation of DRG financing system in the hospitals, aiming at provision of real funds for real expenses.
10. Competition among the different medical establishments.

Basic concept of the financial model (21)

The model foresees the increase of the health insurance contribution, through implementation of an elaborated three-pillar model, as follows:

- Mandatory basic health insurance, provided by the NHIF as existing at present.
- Mandatory supplementary health insurance, covering the so-called “extended package” of health services and benefits, provided by the NHIF or another licensed HIF.
- Voluntary health insurance, covering the “VIP package” of health services and benefits.

Conclusion

The chance for Bulgaria is to implement a specific for the country health insurance model, in which its own experience as well as that of other European countries has been integrated. The further reforms in the health system should be taken with long-term responsibility by the decision-makers, based on clear evidence, multi-sectoral and international consultations and wide public debate.

EXERCISES

Task 1

The students (divided in groups of 3 to 5) are asked to make comparison between the healthcare systems and their financing between two different European countries. The comparison is presented according to several indicators (criteria) in the form of power point presentation. A discussion is opened afterwards. By doing so, it is possible to distinguish common challenges for the future as well as areas where a greater effort needs to be made in some countries of the region than in others.

Task 2

The students should make a SWOT analysis of their own country's healthcare system and propose a possible Action plan for improvement, especially in economic terms.

Task 3

The students are asked to search (through recommended readings and internet) for different sustainable possibilities for private entrepreneurship in their own healthcare system. A brainstorming is made to point out the strengths and weaknesses of any of them.

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