Private and public financing – health care reform in eastern and central Europe

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There are conspicuous limits to what privatization and the free play of market forces can do for health care. In particular, they cannot ensure access, adequacy and affordability for users. Therefore, in moving from a centrally planned economy, governments need to take care to avoid some of the costly mistakes that have been made in western countries.

Social and economic reforms are reshaping the health care systems of the countries in eastern and central Europe. These systems have inherited problems of central planning and financing, underfunding, and poor performance in terms of health indicators and quality of care. The table shows how they compare unfavourably to six western countries in terms of income and health status, despite their higher ratio of physicians and hospital beds to population. At the same time, however, the former system offered the major advantages of universal coverage, affordability to users, and emphasis on primary health care.

Eagerness for reform has sometimes led to rapid privatization, decentralization, health insurance paid for by employers and employees, and reduced government funding. The models now being used or planned in eastern and western countries alike are based on private insurance, public not-for-profit insurance, social insurance, or some combination of these three. The choice depends to a large extent on the social and political environment, and the interaction between policy-makers, providers and consumers with their various powers, pressures and preferences.

All health systems around the world face escalating costs caused by advances in medical technology, the aging of populations and the rapid inflation in medical prices, which is often double that of the general inflation rate. In eastern and central Europe this is added to the problems inherited from the former system, and makes it very tempting for governments to put less money into health. It is also used as an argument for rapid privatization, although this may be premature, as most employers are still government agencies, which does not fit the employer-based insurance model. At the same time, soaring prices make employees unwilling or unable to share the cost through mechanisms such as premiums, co-insurance, co-payments or deductibles.

Free markets and government systems

Although privatization and the free market system is an appealing model for the eastern and central European countries, western experience with this approach to health care has been mixed. The idea is that the consumers’ freedom of choice and the providers’ autonomy will maximize quality
### Health systems in selected Western countries compared with East/Central Europe

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Western Europe</th>
<th>United Kingdom</th>
<th>North America</th>
<th>East/Central European Countries a</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health expenditure per capita (US$, 1990)</strong></td>
<td>1,449</td>
<td>1,511</td>
<td>1,039</td>
<td>2,763 1,945 142 (26–205)</td>
</tr>
<tr>
<td><strong>Health expenditure as % of GNP (1990)</strong></td>
<td>7.5</td>
<td>8.7</td>
<td>6.1</td>
<td>12.7 9.1 3.6 (3.0–6.0)</td>
</tr>
<tr>
<td><strong>Physicians/1000 population (1986)</strong></td>
<td>3.2</td>
<td>2.8</td>
<td>1.4</td>
<td>2.3 2.2 4.1 (1.4–4.7)</td>
</tr>
<tr>
<td><strong>Outpatient visits/year (1990)</strong></td>
<td>7.4</td>
<td>10.8</td>
<td>5.7</td>
<td>5.5 5.5 –</td>
</tr>
<tr>
<td><strong>Hospital beds/1000 (1989)</strong></td>
<td>8.3</td>
<td>8.7</td>
<td>6.3</td>
<td>5.3 6.9 11.4 (4.1–13.8)</td>
</tr>
<tr>
<td><strong>Average length of hospital stay/admission</strong></td>
<td>14.4</td>
<td>16.2</td>
<td>14.5</td>
<td>9.1 13.9 –</td>
</tr>
<tr>
<td><strong>Life expectancy at birth (1990)</strong></td>
<td>76</td>
<td>76</td>
<td>76</td>
<td>76 77 72 (67–73)</td>
</tr>
<tr>
<td><strong>Infant mortality rate/1000 (1991)</strong></td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>9 7 18</td>
</tr>
<tr>
<td><strong>Low birth weight per 1000 deliveries</strong></td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>7 6 10</td>
</tr>
</tbody>
</table>

Sources: World Bank, 1993 (1)
Organization for Economic Cooperation and Development, 1992 (2, 3)

a Numbers in parentheses refer to the range for all eastern/central European countries (Belarus, Bulgaria, Czechoslovakia, Hungary, Lithuania, Moldova, Poland, Romania, Russia, Ukraine and Yugoslavia)

and minimize cost through competition (3). In practice, however, this approach has often led to financial inequity and economic inefficiency. In the United States, for example, direct expenditures on private services are the same for all users, despite the vast disparity of incomes. At the same time, health care providers can form monopolies which keep prices rising indefinitely unless they are capped, and private insurance companies can skim the market so as to minimize their own risks and maximize their profits.

In addition, if providers and hospitals are paid on a fee-for-service basis, they can initiate unnecessary diagnostic and therapeutic procedures unless they are curbed by an aggressive system of utilization review and quality monitoring. Another factor associated with competition is the high cost of marketing, together
with the expenses involved in profit-making and administration. Moreover, a competitive market should ensure that the consumer can make a free choice on the basis of knowledge and experience. This is practically inapplicable to medicine since consumers’ knowledge of health and medical care is usually inadequate to make informed decisions (4).

Government and social insurance systems, on the other hand, can ensure universal coverage, equitable financing and cost control. However, these advantages are liable to be offset by less choice, bureaucratic management, queuing for services, limited access and lower quality.

Thus health policy-making is a matter of navigating through all these factors. The policies finally adopted are the outcome of interactions between all the powers involved, especially those wielded by providers, consumers and the various interest groups with a stake in health care. Whatever the situation, governments can never withdraw from health policy-making under the cover of privatization. They have to play a part in regulating health care, controlling costs, ensuring equitable financing and contributing at least to some form of public health service and the cost of care for vulnerable groups.

**Lessons learnt from health care reforms in western countries**

An analysis of problems and new policy directions in western Europe and North America could be useful for countries in central and eastern Europe. The main features of the current actual and proposed policies in Belgium, Canada, France, Germany, the United Kingdom and the United States might be summarized as follows.

- In all these countries the government has the major role in health policy-making, and imposes regulations to control costs by setting caps on health spending, negotiating fees, making insurance mandatory for all citizens, regulating medical care practices and monitoring the quality of care.

- The most commonly used schemes are social insurance, paid for mainly by taxation, and employer-employee insurance with a government contribution. Statutory insurance coverage is usually provided by public not-for-profit or government agencies, with private companies being used only to provide supplementary insurance. The exception to this rule is the United States, in which private insurance companies are the main third party payer. This may be why that country’s health system is the most expensive, has the lowest coverage and makes the least use of conventional hospital services. Current proposals for reform in the United States aim either to create regional health alliances at the state level to act as public insurance agencies or to allow large employers to provide their own health insurance through corporate alliances.

- In the western countries examined, most of the hospitals are run either by the government or by public not-for-profit agencies funded from a global budget. It has been found repeatedly that reimbursing hospi-
nized that most not-for-profit hospitals behave in the same way in the market as the for-profit ones. This is because of excessive capital borrowing and the desire of the local hospital boards to obtain more “surplus” funds in order to expand their operations (5).

- In most western systems, hospital physicians are employed on a salary basis to avoid provider-initiated services or procedures. The United States is an exception.

- Since aggressive cost containment can adversely affect the quality of care, steps are being taken in most systems to formalize procedures for active quality monitoring, peer review or medical audits.

- The providers’ freedom of choice is preserved to a variable extent, but some countries are moving towards the model in which primary care physicians are the gatekeepers of medical care, and sometimes the fund-holders as well.

- The introduction of managed care models is being considered in most of these systems, to allow for “managed competition” between providers.

- Government-run systems such as that of the United Kingdom are encouraging cost-consciousness and competition among providers. This is being done by setting up group family practices which act as gatekeepers and fund-holders, and turning the big hospitals into self-governing bodies. The main criticism of this strategy in the United Kingdom has been that it is being implemented too abruptly, causing unnecessary risks.

**Examples of learning by doing in eastern and central Europe**

With the recent revolutions, the new governments in most of the central and eastern European countries adopted the general concepts of a free market economy. They enthusiastically began to explore policies of privatization and reducing the role of governments. In 1990 and 1991 many countries drew up plans to privatize or at least decentralize the health services and set up insurance systems.

Although preliminary policies have been formulated in most countries, practicable plans have yet to be developed. For example, Russia, the largest of the 15 states of the former Soviet Union, has adopted a new approach to decentralization and regionalization known as the Territorial Health Association. In this system the health care budget is allocated to a territory from the health district, with physicians of the polyclinics assigned to the role of gatekeepers and fund-holders for the Association. Their attempts to control costs often led to the restriction of referrals from polyclinics to hospitals, the denial of some diagnostic procedures, and the practice of conducting outpatient surgical operations in the polyclinics. In the absence of quality monitoring, the hospital physicians and consumers alike complain that a growing number of patients are being put at risk or suffering serious complications as a result of these cost-saving efforts. This approach was probably based on the health maintenance organization model used in the United States, or the large general practice model used in the United Kingdom.

Another step taken in Russia was to make health insurance mandatory for all citizens as of 1 January 1993. To date, this has not been
achieved. Some large corporations introduced private health insurance for their employees, but the newly formed private insurance companies are suffering from low revenue, since the employers contracting with them allocate only about 3.5% of employees' wages to health care. In Germany the corresponding figure is 12.5%, and in the United States 10%. Private insurance companies contract with public hospitals providing inpatient care. Owing to the scarcity of resources in these hospitals, those enrolled in the public scheme are liable to receive less care, since physicians and institutions tend to give higher priority and better attention to those enrolled in private insurance schemes (5).

The Czech Republic also provides an example of rapidly implemented new policies. In 1990 the basic principles of health care were set out in two stages: first, to eliminate unnecessary bureaucratic barriers and deformations and release latent resources for health care; second, to reform management and make communities the owners of health institutions. After introducing several experiments in regionalization, the second stage faced many problems which led to several redesigns, and its implementation was rescheduled for the end of 1993.

Similarly, in Hungary, national health policies formulated in 1990 abolished national and regional authorities and replaced them with autonomous health facilities. The National Renewal Programme emphasized the principle of privatization by stating that “putting institutions in private hands, we give impetus to enterprises flexibly in meeting the needs of the population. The restructuring of the service system will be integrated with the diversity of ownership” (6). These plans could not be implemented as originally scheduled, and have recently been modified towards a slower and more practicable approach with a more balanced mix of public and private financing.

Conclusions

The eastern and central European countries are generally moving towards the logical course of reform but it should be emphasized that nowadays learning by doing in this domain is too expensive and too risky. A careful examination of the experience of western countries seems highly advisable. At the same time, since the organization and delivery of health care cannot be transplanted, each country has to design and build its own system.

The following approaches are suggested.

- Long-term planning is preferable to rushing into a new system. A period of at least 7–10 years is needed to bring about a reform of this magnitude effectively.
- This long-term plan should be based on a careful examination of other market economy health systems, focusing especially on their mistakes, since more can probably be learnt from these than from the successes.
- A thorough analysis of the current experiments in eastern and central European countries since 1989 is badly needed as a reference point for future planning.
- Nowadays, it seems evident that the most adequate concept for building a successful health system is a gradually developed public and private mix, rather than the enthusiastic destruction of existing government-run systems.

The most adequate concept for building a successful health system is a gradually developed public and private mix.

- The private profit-making sector in these countries should be allowed to develop within a regulated and monitored environment; if left entirely to its own devices it
Health Systems

would become extremely difficult to regulate after a few years.

However these systems are organized and financed in the future, some prerequisites for their success, which are fully recog-

ized in most of the countries concerned, are as follows:

- strengthened managerial capacity in the health system;
- improved competence among providers, achieved by better basic, postgraduate and continuing education;
- an effective yet simple health information system to facilitate the planning and implementation of change;
- reduced excess of hospital beds and doctors;
- public education to empower the community to ensure the proper use, management and financing of health care.

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References


Most costly: staff and medicine

In the social insurance and ministry of health budgets, the highest line item is always personnel, particularly physicians, who not only have the highest salaries but also enjoy exceptional fringe benefits often gained through strikes. …

The next highest item in health budgets in Latin America and the Caribbean is materials and supplies. … In this category, the most important expenditure is medicines, whose costs have gradually increased partly due to such factors as overprescription, unnecessary diversification, sale promotions that induce users to demand specific brands, and new discoveries that make the existing stocks obsolete.