Béatrice M. d’Intignano

Health systems in flux as East meets West

The characteristics of health systems in eastern and western Europe and North America are outlined with special reference to financial control and accountability. The advantages and drawbacks of the various systems are examined and the prospects for new departures and improved services are considered.

A great diversity of health systems exists in the developed world. Some go farther along the road to equity than others. All have problems connected with efficacy, the satisfaction of individual needs, cost control, and employment. As the political gap narrows between eastern Europe and the West it is of interest to consider the prospects for their health systems.

The West

The health systems of Canada and western Europe exhibit a good mix of efficacy and equity. Health insurance is compulsory and poor people are covered by the state, which exercises direct or indirect control over the use of funds and the quality of care. People contribute according to their means and obtain care according to their needs.

The situation is radically different in the USA, where a decentralized approach, strongly biased towards the individual, has been adopted: with the exception of the poorest and the retired, who are covered by special government schemes, people are expected to insure themselves; this leaves 35 million people who are not covered.

In Denmark, Sweden, and the United Kingdom, national health services are financed by taxes, controlled by the countries’ parliaments and managed by government departments. General practitioners are paid a capitation fee for each patient and decide which patients to refer for specialist care. With varying degrees of success, Greece, Italy, Portugal, and Spain have been trying to introduce this system since 1980.

Until the 1980s it was judged that market mechanism, competition and all macroeconomic constraints were inappropriate, and the management of health systems was rarely based on financial incentives, which were considered contrary to medical ethics.

In Denmark, the Netherlands, and the United Kingdom there are flat-rate capitation fees. Free treatment within the
health service is available to every citizen on the list of a general practitioner, who is chosen freely. Family physicians are contract employees, not civil servants. In addition to the capitation fees, incentive payments are available for practising in depressed areas, working in group practices, providing training, and so on. There are also specific payments to encourage night calls, first consultations and the giving of advice on contraception. Private patients pay approximately US$ 25-50 per visit.

Capitation payments, often confused with salary, are well suited to family medicine, which they have helped to promote in various countries of northern Europe. They are highly regarded by the public. In Denmark, where people can have general practitioners who treat them free of charge but control their access to specialists, or total freedom of choice subject to payment of a proportion of the cost, the former alternative is overwhelmingly preferred.

In Austria, Belgium, France, Germany and Luxembourg, health care is financed by employees' and employers' contributions and controlled by representatives of the persons insured. Physicians are private practitioners remunerated on a fee-for-service basis. France has elements of both this system and that prevailing in Denmark and other countries of northern Europe.

General practitioners engaged on a fee-for-service basis work longer, spend more time with each patient, and write more prescriptions than physicians paid capitation fees (1). They also earn slightly more in terms of net income relative to average national wage, except in France. Specialists create an increasing demand for their own services. Twice as many operations are performed in countries where surgeons are paid according to the number of times they operate, than in countries where the profession is salaried. Technical procedures, even more than clinical treatment, have sometimes become a source of large incomes for outpatient physicians.

The fee-for-service system has given rise to a very active kind of medicine, orientated towards cure rather than prevention. Unfortunately, many physicians receiving a fee for each procedure performed have an interest in their patients being ill. The philosophy of modern medicine is to intervene rather than leave alone. The entire health system in countries with private practice strives towards more and more accurate diagnosis, and treatment is often given when there is no evidence of its efficacy; this is particularly true for very old people.

Simple regulatory measures, such as lump sums for fees which were introduced in Germany in 1984, can eliminate the inflationary effect of the fee-for-service system. The health insurance funds and the medical associations fix these lump sums each year for general practitioners, specialists and laboratory staff and draw up a scale of points for individual services. Insured people do not pay for consultations. The lump sums are handed over to the medical associations, which share the money out among individual physicians according to the number of points earned. The monetary value of a point declines as the quantity of services performed increases.

In the countries belonging to the OECD (Organization for Economic Cooperation and Development), health care absorbs on average 7.5% of gross national product and clearly requires proper management. After the economic crises of the 1970s and early 1980s, the principles governing expenditure on hospitals and physicians were revised. As a result, health expenditure is now under control in all
these countries, except France and the USA. The growth in health expenditure relative to that of gross national product has been reduced to unity in Germany, Japan, and the United Kingdom, whereas it is still 1.6 in the USA and over 2 in France. The

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remedies are well known: lump sums for the remuneration of physicians working on a fee-for-service basis, as in Germany; capping of hospital budgets, as in Europe; payment of family physicians who control access to specialist care according to the number of patients on their lists, as in northern Europe; no reimbursement of the cost of drugs of unproven efficacy; control of health expenditure by parliament, or joint management by health insurance funds and physicians. International experience demonstrates that patients cannot regulate health expenditure through demand. Public authorities or health insurance funds everywhere are regulating the supply of health care for the benefit of the citizen or the insured.

The East

The countries of central and eastern Europe have national health systems like those of northern Europe but their budgets are more restricted and rigid. All physicians are salaried. Total expenditure barely exceeds 3–4% of the “net material product”, which itself is very low. There is now a debate in these countries as to whether free market mechanisms could increase access to and the quality of health care, and the size of health budgets. General practitioners who are paid a salary tend to arrive late at their polyclinics, leave early, have few regular clients, take the least possible responsibility and do little work. All family doctors in the Commonwealth of Independent States (CIS, former USSR) work in polyclinics, where they write sick notes for mild cases and refer serious ones to hospital. The richest Soviet citizens, armed with medical certificates, seek out the best physicians and pay them illegally. People who work in large establishments or belong to the political elite have access to the best polyclinics and hospitals. This kind of system combines inequality with inefficiency. Paying the doctors more does not change anything: physicians’ salaries in the USSR were increased by 30% in 1985 but there was no improvement in performance.

Against a background of underdevelopment and excessive bureaucracy, the central and eastern European countries have had unfortunate experiences with systems bearing some resemblance to that in the United Kingdom. The resources allocated to health care have been small, for instance 3% of gross material product in the CIS. Physicians have been underpaid and consequently have lacked motivation. Although health care in these countries is free in principle, medicines are difficult to obtain and are often paid for illegally. It appears that legal private cooperatives account for 3–4% of health expenditure in the former USSR, but illegal payments could amount to much more. Nonsensical situations have arisen: for example, doctors perform more abortions than deliveries because the polyclinics are not regularly supplied with contraceptive pills and because there are plenty of hospital beds. Life expectancy in Czechoslovakia, Hungary, and the former USSR, which was similar to that in the West in 1970, is now five to
eight years less (2). Infant mortality is 17-50/1000 in Romania, as against 7/1000 in France. All of the eastern European countries are aware of the need to reform their health systems, and the World Bank has made this one of its priorities: in collaboration with WHO it has started to provide technical aid. Regrettably, however, it will take years or even decades to rectify the situation, for experience shows that health expenditure is closely correlated with the standard of living. Before good health care can be secured, not only will health systems have to be reorganized but there will also have to be substantial economic growth.

In 1988 the USSR decided to introduce market mechanisms and financial incentives into the state health care system, and a huge experiment along these lines was undertaken in St Petersburg, Kemerovo and Khibishev. The polyclinics now receive capitation fees for the citizens in their zones, and have to provide health care free of charge, either themselves or by purchasing it from hospitals. The hospitals receive advances, not budget allocations, and sell their services at fixed prices. The average length of stay in St Petersburg’s hospitals decreased from 17 to 12 days within a year. The polyclinics are taking more responsibility and are becoming equipped to perform minor surgery. The Fiodorov Centres, which perform eye surgery, pay their surgeons according to the number of patients whose vision is restored. Surgeons are penalized for operation failures and cases of infection.

The other central and eastern European countries are rejecting their national systems in favour of health insurance and the fee-for-service approach. The people behind this change are often physicians, who hope to gain high incomes from it, but they are confusing the effects of free-market mechanisms with those of patients’ standards of living. In central and eastern Europe there is a clear danger of throwing out the baby (universal access to health care and control over expenditure) with the bath water (mediocrity and bureaucracy). There can be no financial reform in the health sector unless there is fiscal and wage reform. Wages are at present paid net of taxes and social contributions, which are recovered from the employer. Should this continue, with the attendant risk of bolstering an arbitrary bureaucracy? Or should wages be increased and health insurance funds be established in order that people may have responsibility, individual choice and democratic control over health expenditure? How can illegal payments be transformed into legal ones, and how can physicians be persuaded that new forms of payment would be more in keeping with their civic responsibilities?

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The economic climate in eastern Europe today is quite different from that in which the health systems of western Europe were set up at the end of the nineteenth century or after the Second World War. Perhaps the

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countries of eastern Europe will reject unbalanced systems, such as company health insurance schemes in which the ratio between the number of contributors and the number of beneficiaries may be disastrous, and allow people to have freedom of choice.
Perhaps they will avoid the old disputes as to whether the public or private sector is preferable, and steer clear of inflationary mechanisms that lead to blind rationing. On the other hand they may prefer western European approaches to those of the USA.

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They may experiment with capitation fees for family doctors; provide their health insurance funds and their physicians with more responsible representatives, along the lines of the Royal Colleges in the United Kingdom or the medical associations in Germany; and adopt methods of remuneration compatible with the objectives of equity, employment and social status for physicians. The new approach of informed buying adopted by public and private insurance companies should be of great interest in eastern Europe.

Whatever happens, recent experience in Europe and the USA has confirmed that the way physicians behave can be shaped by financial incentives, and it is therefore important to choose these wisely.

References


New foods, new tests

New techniques of molecular biology open up great possibilities for important developments in the global food supply. At the same time, these techniques provide sound scientific methods for addressing questions of the safety of the foods and food ingredients produced by their use. In many applications of the new biotechnology in which improved microorganisms are used in food processing, a careful, rigorous analysis of the microbiological, molecular, chemical and toxicological parameters will provide a sound basis of safety when the food substance is produced in accordance with current good manufacturing practice.