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Health Care Reforms in Central and Eastern Europe

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1. *Legacy of Socialist Health Care Provision*

Under the socialist system most if not all health care was provided by state institutions on the guiding principle of free universal entitlement at the time and point of service. The system was financed by payroll taxes (usually split between employees and employers) while the central budget offered significant additional funds on behalf of those who did not have income from a permanent job (children, elderly, conscripted soldiers, students, citizens on maternity leave, etc.) Health care was considered to be based on the concept of social insurance (wrongly translated as social security) which, in turn, was claimed to represent societal solidarity.

There were several inherent shortcomings in this arrangement:

- **Constant and serious imbalance between demand and supply**

As entitlement was notionally universal and free at the point and time of providing the service, most people visited doctors and requested treatment as many times as they felt necessary. Demand for ever more complex and expensive services grew constantly while capacity and financial resources were always limited. It clearly resulted in the formation of long lines with ever growing waiting times for complex and costly operations. At the same time the quality of services deteriorated markedly almost across the board.

- **Social solidarity collapsed with uneven access and quality**

People with money and/or connections and/or privilege and/or influence were able to jump the queue by using and abusing their power. While doing so, they demanded better service which, given the limited amount of overall financial and human resources in health care, led to a further deterioration of access and quality for ordinary people.

- **No link between contributions and benefits**

When people felt obliged to pay for better quality and faster service at the point and time of getting it they questioned the logic of paying their payroll taxes in the first place. In a system of universal social insurance there was no individual record keeping on who

had actually paid and who did not. Evading payments of social security contributions was easy and justifiable for those without connection and money to jump the queue, either. It then further undermined the financial equilibrium of the health care system and its ability to provide impetus to much needed social cohesion. Its legitimacy came in jeopardy.

2. *Early reforms of health care in the Visegrad countries (V4)*

When the first democratically elected governments took power privatization was put high on the political agenda. However, privatizing social services, including health care was considered a controversial issue. Physicians themselves were very much divided as to what part of their profession should be subjected to market forces.

- **Privatizing general practitioners' business**

Reforms started with the privatization of the business of general practitioners, so-called "house doctors" practices which are usually the first point of entry for patients into the health care system. In most cases privatization did not require any physical sale of large equipment but only a new licensing system for the practice. This first tier of health care was also regarded as best provided by doctors licensed by local authorities at the lowest level of self-government; so the lowest level local governments acquired the right to issue licenses and auction off practices wherever there were potentially more than one takers.

Financing of general practitioners changed for the better. While doctors were obliged to collect patients' insurance cards with a predetermined minimum and maximum limit, they were remunerated by the local governments on a capitation basis. Patients now have the right to choose among a good number of certified doctors which has given rise to a certain level of competition, thus reinforcing incentives for quality improvements.

- **Free entry of private capital to health care provision**

Other important aspect of early reforms was the possibility to establish new institutions for any level of health care, either sole proprietorships, partnerships or limited liability companies for general practitioners or private clinics for outpatient (ambulatory) and inpatient (in hospitals) care. However, these new establishments remained on the fringes of health care provision because people did not have much funds to pay for all costs and most of those who actually had could still use their connections and influence to get reasonably acceptable quality in state owned health care establishments at the expense of the social insurance fund. But private capital still found valuable market niches especially in high tech intensive areas of in- and outpatient care. Moreover, the state managed social insurance funds started to pay partially for a number of services offered by the private clinics since it helped to alleviate the burden of state providers with highly overstretched capacity.

- **Rationalization of fund management in state insurance**

While rationalization in slack capacity (e.g. the reduction of hospital beds, the eventual transformation of hospitals into sanatoria and/or old age asylum, etc.) did not yield too many tangible results (because of heated political opposition and professional resistance) and most physicians fiercely resisted losing their legal status as civil servants with all prerogatives and privileges attached to that, governments were successful in rationalizing the management and administration of the health insurance funds, typically the largest extrabudgetary funds (after pension) in the fiscal sector with or without self-government.

3. *Co-payments as a measure to limit excess demand*

It is actually only in Slovakia where the government was able to introduce a much debated co-payment system for both visits to general practitioners and outpatient care establishments and a daily fee for staying in hospitals (invariably a flat fee for basic services). That seems to be quite important for limiting unnecessary visits, superfluous checkups and prescriptions, in itself leading to a marked reduction of drug overuse, which is quite rampant in V4. The amount of funds in concept of co-payment flowing into the health care system is limited because the individual amount to be paid is only symbolic and there are many exemptions, especially for poor people and the elderly. But the purpose of the system is not to cover any significant fraction of the costs but rather to make the population sensitive to costs at all. The Slovak system has already proved its merit in that regard. Other countries, like Poland and Hungary introduced user fees for higher quality and more comfortable hotel services in hospitals (such as single bed rooms with TV and telephone, etc.). Although the role of these fees in overall financing is limited, it might be important for some hospitals and it certainly has led to improved capacity utilization at a good number of individual establishments.

4. *Identifying basic and supplementary services*

The Slovak Parliament approved six fundamental pieces of legislation two weeks ago. These laws for the first time in the history of transition try to identify separately so-called basic and supplementary health care services and render their provision to tax-based state financing and individual mandatory health care insurance, respectively. While this has been and still remains an arduous process and not without much political interference, the concept of separating these two sets of health care services cannot be overemphasized. This is the first time the general public is obliged to accept that the scope of state funded health care is not unlimited and universal entitlement does not imply inalienable citizens' right to get all types of health care services without any consideration to costs. This part of the new set of legislation also has important constitutional implications as the Slovak constitution guarantees the rights of every citizen to health care very broadly.

5. *Catalogizing and categorizing health care services*

The new Slovak legislation mandates the government to set up a commission to describe all illnesses and define diagnosis and therapy very precisely in each and every case (the process called catalogizing in Slovak). This is indispensable for the insurance system (both public and private) to assess its eventual financial obligation but also for the physician to calculate what amount of insurance income he or she is entitled to get in each individual of exam and cure. Categorization of health care services, in turn, is vital for the patients; that will define the share of payment (both insurance and co-payment) required from them. In most cases therapeutic services are going to be financed in a multi channeled manner, i.e. part of the costs will be covered by the state, another part by mandatory insurance and the remainder by co-payment, i.e. private payment at the time and point of sale. The art of this categorization exercise is to find a dynamic equilibrium not only in financial flows but, more importantly, between self-care and social solidarity.

6. *Multipillar system of financing with mandatory private health insurance*

Although the Slovak reform is stopping short of establishing a substantive mandatory private insurance system, it is indispensable that governments tailoring long-term reforms should contemplate such a move. The arrangement could be similar to what is already a widespread practice in reformed pension provision; a multipillar financing offered by strong private institutions defending the interest of patients while competing for their money. As time goes by and the newly created health insurance supervisory system acquires teeth and valuable experience, more and more of what is now covered by state owned insurers could be ceded to competing private health insurance companies. That would also reinforce the effectiveness and efficiency of state health insurance funds because management and surveillance practices prevalent in the private sector could spill over to the public sector as well. This is true even though the accelerated pace of innovation in the health care business makes categorization of services a moving target and, hence, the definition of justifiable costs will always remain somewhat arbitrary.

7. *Competition among in- and outpatient care establishments*

There is still heated ongoing debate on the issue of privatizing hospitals and outpatient clinics. Unfortunately that was at the center of government proposals in Hungary and the new law based on that was quickly killed by the constitutional court. It is important to emphasize that the ownership of secondary (specialists) and tertiary (intensive hospital care) health care providers is much less important than the issue of their financing. Without fostering fierce competition among hospitals and clinics it is impossible to improve the quality of their services, they will not be interested in cost control at all. Competition can be created by free entry and exit and full liberalization of ownership without necessarily obligating existing providers to privatize. Patients should have the freedom to choose among secondary and tertiary providers while these latter should have the obligation to accept all people certifiably insured and the right to refuse all who do not have proper insurance. (The state health insurance fund will cover all expenses of

medical services in life threatening situations, like accidents, catastrophic events, epidemics, terrorist attacks, etc.)

8. *Decentralization of secondary and tertiary care*

Most of hospitals and outpatient clinics will most likely remain in the hands of either local or regional governments because the provision of health care services is always one of the most important pillars of self-government (the other being primary and secondary education). That outcome can only be reinforced by reforms of subsovereign government if the direction of these reforms will be the creation of larger units at the lowest level of self-government. In V4 countries, most notably in Poland, where the government decided to decentralize the management of the state health insurance fund, hospitals and larger units of outpatient care are now managed at regional level of subsovereign government. In smaller countries, like the Czech Republic, Hungary and Slovakia there is no obvious anchor level for managing larger health care providers in the hierarchy of public administration, but decentralization is still possible and desirable (subsidiarity in the EU).

9. *Preliminary thoughts on reforming health care in Ukraine*

Ukraine is a large country, similar to Poland in size of its population and economic potential but with no perspective to join the EU in the near future. This makes health care reform probably easier and more difficult at the same time.

Recently Ukraine has been quite successful in recharging the batteries of its economy. Real growth has reached unprecedented high levels, fiscal equilibrium has largely been restored. Now it is time to address structural issues in public finance which can also make the fiscal stance sustainable in the long run.

Ukraine can now afford spending substantially more on maintaining and improving general public health standards, including prevention of epidemics, such as HIV/AIDS, tuberculosis, discouraging smoking and drinking, etc. This is indispensable for fighting demographic decline and lengthen life expectancy for new generations, too. Primary care should be better equipped to discover serious illnesses and determine more precisely the correct path for patients in secondary and tertiary establishments.

It is highly advisable to consider the introduction of co-payments for doctor visits no matter how symbolic that might be. This is important to prevent overuse of primary care and reduce the pace of growth for the use and abuse of prescription drugs. In addition, further decentralization of financing in- and outpatient care establishments is necessary in order to improve the management and control of these institutions. After careful planning and analysis the introduction of mandatory private health insurance is to be considered. That will improve substantially the awareness of the population of the costs of health care and provide sufficient incentive for self care. Privately funded and managed insurance companies should compete for the money of the patients while secondary and tertiary health care providers should compete for contracts with the insurers. When supported by powerful professionals the position of patients vis-à-vis physicians can be strengthened considerably and, therefore, the quality of services is expected to substantially improve.

The financing of health care should also change over time. Health care contributions paid by the employers need to be reduced and the overall amount of such contributions should be in line with the costs of providing basic services for all people employed. A low and single rate health care tax should be levied on all personal income to underpin social solidarity in the system. In addition, all individuals should be obliged to choose among competing health care insurers and buy various levels of coverage for themselves and their families. The central budget will obviously remain responsible to provide funds to both the state health care fund and private insurers on behalf of all people without regular income, such as citizens on maternity leave, etc.