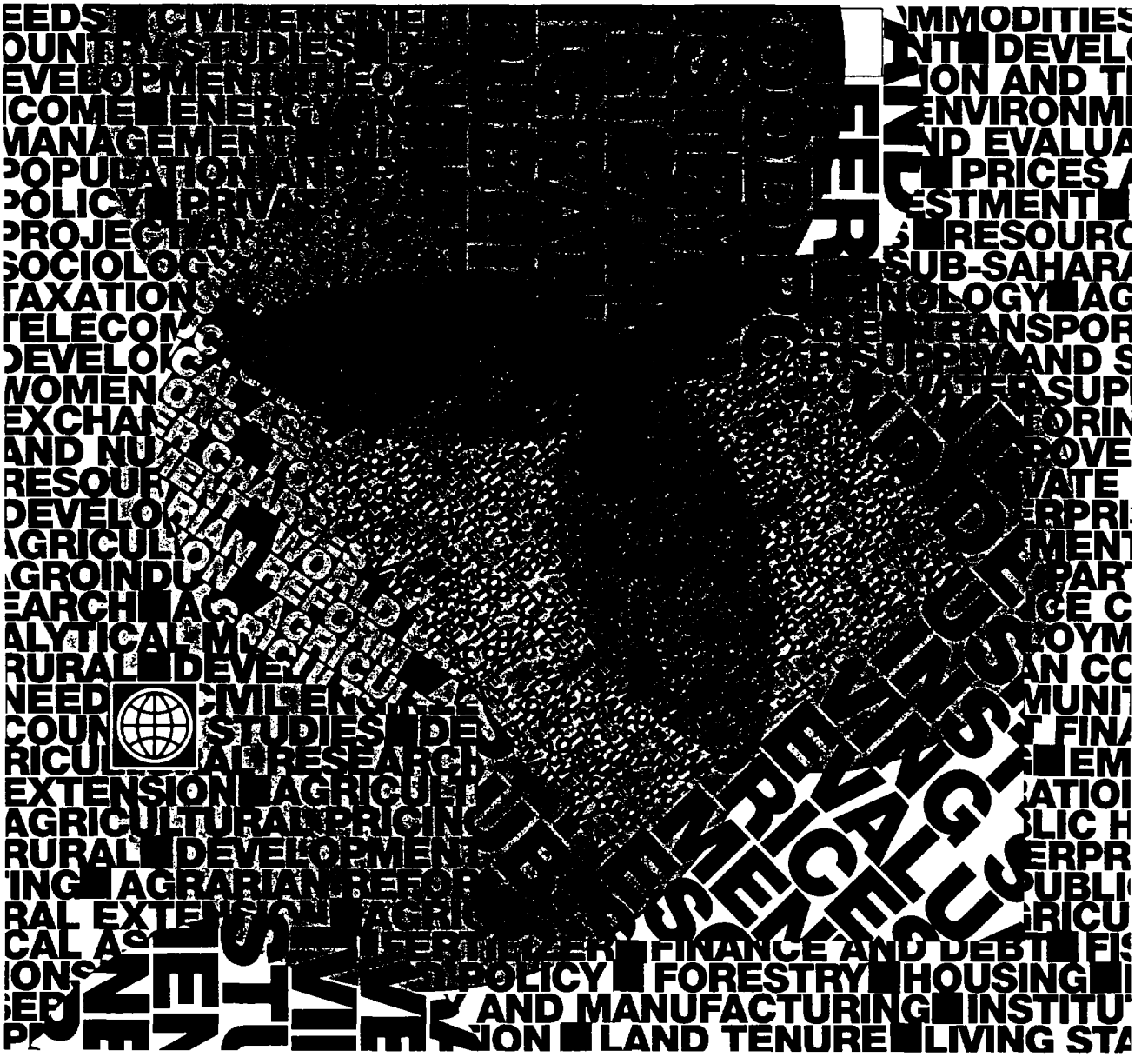
WORLD BANK TECHNICAL PAPER NUMBER 293

# Market Mechanisms and the Health Sector in Central and Eastern Europe

Alexander S. Preker and Richard G. A. Feachem



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The World Bank
Washington, D.C.

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ISSN: 0253-7494

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**Library of Congress Cataloging-in-Publication Data**

Preker, Alexander S.
Market mechanisms and the health sector in Central and Eastern Europe / Alexander S. Preker, Richard G. A. Feachem.
p. cm. — (World Bank technical paper, ISSN 0253-7494 ; no. 293)
Includes bibliographical references.
ISBN 0-8213-3331-3
1. Medical economics—Europe, Eastern. I. Feachem, Richard G., 1947– . II. Title. III. Series.
RA410.55.E852P74 1995
338.4'33621'0947—dc20 95-35190
CIP

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## FOREWORD

Trends in both health and the quality of health care in Central and Eastern Europe over the past five decades tell a disturbing story and pose difficult challenges for policymakers. The economic recessions, rising unemployment rates, and social adjustments of the 1990s have dealt a further blow to the health of the population in the region.

The resulting excess mortality is placing a heavy burden on the economies of the new democratic states. On top of the obvious economic and human costs of sick leave, disability pensions and medical expenditures, individuals who die in middle age, all of whom have received publicly funded education and other services, represent a loss of badly needed human capital.

The article which follows makes an important contribution to understanding the unprecedented wave of reforms which have swept across Central and Eastern Europe since 1990, as market forces have begun to replace state intervention and centralized planning in the health sector. Hopefully, these reforms will begin to repair the damage done to health during the socialist era, and allow the health sector to provide more efficient and effective health services in the future.

Rachel Lomax

Director
Country Department 1
Europe and Central Asia Region

## ABSTRACT

The early transformation of the former socialist states of Central and Eastern Europe to market economies has already led to significant changes in many aspects of life in those countries. Democracy and free enterprise have spread rapidly throughout the region. Shortages have disappeared, and the range and quality of goods in the shops has increased dramatically. Entrepreneurial talent has been liberated, particularly in the private sector, which by early 1994 produced more than a third of the total economic output. In a few countries growth has started to resume.

"Transformation, though necessary and desirable, [has however] not come without tears. In December 1989 the main unemployment office in Warsaw paid benefits to five people. A year later, twelve months into their 'big bang' reform, more than a million Poles were unemployed, and by mid-1993, 3 million. In Lithuania, output almost halved between 1990 and 1992. Poverty and infant mortality rose throughout the region, and death rates in Russia rose by nearly one-third. Everywhere crime increased sharply. The region's people need no reminder that the early stage of reform is uncertain and painful..." (Barr 1994).

The article which follows presents a conceptual framework for understanding the impact of the reform process on the health sector in Central and Eastern Europe. It first analyzes the positive and negative characteristics of the sector which were inherited from the past. It then examines the various forces of the reform process and the constraints being imposed by the transition. Finally, it presents the strategies for reform that are being adopted by many of the countries in the European and Central Asian Region during the early phases of the post-socialist era.

## ACKNOWLEDGMENTS

This article is based on a chapter by Alexander S. Preker and Richard G. A. Feachem in Nicholas Barr's book, Labor Markets and Social Policy in Central and Eastern Europe: The Transition and Beyond, New York: Oxford University Press, 1994, published by the World Bank in association with the London School of Economics and Political Science. The book, whose publication coincided with the 50th anniversary of the Bretton Woods institutions, suggests a coherent social policy strategy for post-communist Central and Eastern Europe, just as the Beveridge Report (by a former director of the London School of Economics) of 50 years ago set out a coherent social policy framework for the United Kingdom as part of postwar reconstruction in western Europe.

The authors extend their special thanks to Ralph W. Harbison, Division Chief EC1/2HR, for his continued enthusiasm and support during preparation of the Barr volume, which provided the driving force for the article.

# INTRODUCTION

To revitalize their health services, governments in the former socialist states of Central and Eastern Europe are experimenting with a new wonder drug called market mechanisms. This is rather like the doctor who gives penicillin to a patient who has a known allergy to it but will die without it. It is necessary to understand the associated dangers so that appropriate measures may be taken to prevent the treatment from killing the patient.

Market forces have of course existed in Central and Eastern Europe for a long time in the form of the underground economy, and they are a normal part of the health sector in most of the highly industrialized countries. So by themselves market forces in the health sector are nothing new. In most Western countries, however, the trend over the past century has been toward increasing the role of government because of known market failures in the health sector. In Central and Eastern Europe, by contrast, market forces are being introduced to deal with the systemic failure of excessive rather than insufficient government involvement.

This article presents a conceptual framework for understanding why the health sector performs poorly in Central and Eastern Europe (excessive state intervention), the prescribed treatment (market forces), the allergy (market imperfections), and the remedy (a new public/private partnership in the financing and provision of health care). The article looks at policies relating to health and, a closely related but distinct topic, at the organization of health care.

## THE INHERITANCE

It would be senseless for governments in Central and Eastern Europe to attempt to fix things which are not broken or to focus excessively on problems for which there are no known solutions (for studies of the different countries, see Preker 1990; Feachem and Preker 1991; World Bank 1991, 1992a and 1993b; World Health Organization 1991; and UNICEF/WHO 1992). They should, therefore, conduct a rapid assessment of the strengths, weaknesses, and perennial problems which their health sectors inherited, so that they can begin to redress the most urgent needs. Although each country has its own unique history, some of the common threads presented below are readily apparent.

### Strengths

The first major lesson to be learned from the socialist experience is that, under the right set of circumstances, state involvement in the health sector is desirable and may at times be essential. Rapid economic growth, expansion in the social sectors (health, education, and culture), and more readily available food, shelter, and employment led to significant improvements in living standards and health status in many of the socialist states during the early years of central planning.[1] In comparison with earlier periods of physical destruction, economic hardship, starvation, and homelessness in countries like the Baltic states, Poland, and the U.S.S.R., the 1950s were characterized by improvements in human well-being and health status despite the obvious price of political oppression and loss of personal freedom.

Entitlement by the entire regional population to a full range of health services was one of the remarkable achievements of the socialist regime and its health care system. No other region in the world, not even Europe or China, has ever succeeded in providing such extensive coverage of comprehensive health care to a population of similar size. Since equity in access to affordable health

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[1] Being interrelated, it is extremely difficult to attribute improvements in health status to any one of these factors.

services appears to be one of the most important determinants of health status at upper income levels, preserving this positive legacy should be a high priority.

By the early 1970s, countries such as Czechoslovakia and Hungary had very mature health systems. Compared with developing countries with similar per capita gross domestic product, or even compared with the highly industrialized countries, the health sectors of Central and Eastern Europe were well endowed in basic physical infrastructure, trained staff, and education programs. Structurally integrated networks of hospitals, clinics, and other clinical facilities, based on the Soviet health care model, secured universal access to curative health services throughout the region. Patients had their first point of contact with the lower tiers of the health system through individual outpatient departments of hospitals, polyclinics, diagnostic departments, emergency services, community health centers, rural health centers, and industrial health services. Doctors working in these settings acted as gatekeepers, treating what they could and referring more difficult cases to higher levels of care. University hospitals and national specialist institutes capable of providing advanced technological interventions formed the tip of this pyramid. A highly structured system of hygiene and epidemiology stations formed a similarly sophisticated and integrated network of public health services that concentrated on the control of infectious, occupational, and environmentally related diseases. These positive bequests from the former socialist regime are summarized in table 1.

Table 1. Positive Bequests from the Socialist Regimes

| Bequests | Characteristics |
|---|---|
| Entitlement | Entire regional population |
| Burden of financing | Evenly distributed |
| Access | Few financial barriers |
| Range of services | Comprehensive |
| Network of facilities | Structurally integrated |
| Resource base | Extensive infrastructure |

Because the previous system failed to produce many of its predicted economic and social benefits, radical reformers during the transition have been quick to condemn, and even been tempted to discard, almost everything that existed during the past. As a result, there is now a serious risk that, at least in the health sector, some of the countries in Central and Eastern Europe may throw out the baby with the bathwater. Not only would this waste valuable assets such as excellent vaccination programs and maternal and child health services, but it could also deprive a significant part of the population of basic health care at a time when unemployment and deteriorating standards of living are having a negative impact on health.

## Weaknesses

Unfortunately, despite these positive attributes, the national health services in Central and Eastern Europe were remarkably ineffective in promoting good health or preventing illness and disability from known and avoidable causes. The second major lesson to be learned from the socialist experience is, therefore, that relying too heavily on a state monopoly in a centrally planned and supply-driven health sector lowers the efficiency and quality of care. This must be quickly corrected if health services in the region are to be successfully integrated into the emerging market economies.

Interestingly, the health sectors in Western countries such as the United Kingdom, where governments have assumed a similar monopolistic and centralized dominance in the financing, ownership, and provision of health services, suffer from many of the same problems as those observed in Central and Eastern Europe. Thus, even though government involvement may be necessary to securing some positive attributes in the health sector, it is not in itself a sufficient ingredient in securing others, such as good health. There are two major sets of problems: poor health status and low-quality health services, as summarized in table 2.

Table 2. Legacies of Poor Health and Inefficient Health Services

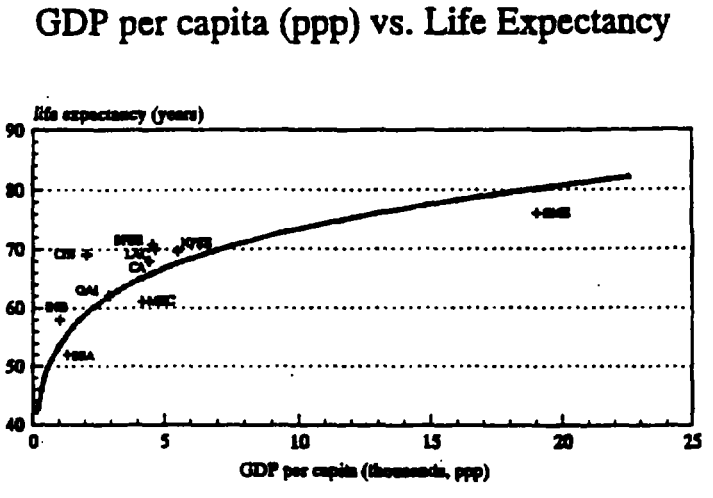
| Key Problem Areas | Issues |
|---|---|
| Health Status | High mortality, especially in adult men<br>High morbidity<br>Unhealthy lifestyles and environment |
| Policy-making/management | Ineffective intersectoral coordination<br>Low priority of health and good health care<br>Lack of responsiveness to local needs<br>Weak management, tracking and evaluation |
| Structure | Rigid over-centralized structure<br>Overemphasis on institutional care<br>Neglect of public health and primary care<br>Distortions in public/private mix |
| Function | Lack of functional integration<br>Ineffective, inefficient and low quality |
| Resources | Arbitrary statistical norms (physical and human)<br>Imbalances with surpluses and shortages<br>Over-utilization |
| Training and R&D | Narrow overspecialization and isolation<br>Graduate education isolated from universities<br>Research isolated from teaching<br>Non-competitive funding |
| Financing | Under-financing compared with capitalization<br>Adverse incentives |

Poor Health Status

The single strongest predictor of a nation's health status is not the character of its health services but its per capita GDP (Schieber 1989; World Bank 1993c). The relationship between GDP per capita and life expectancy at birth is strong, especially at lower levels of income (figure 1). Both the northern and southern countries of Central and Eastern Europe together with the Central Asian republics of the former U.S.S.R. occupy positions in figure 1 which suggest that overall, they are a little more healthy than their income level would predict. This is especially the case for the southern countries of Central and Eastern Europe. If, however, a measure of adult health is taken, such as risk of death between fifteen and sixty years for males, a different

picture emerges (see figure 2). The southern countries of Central and Eastern Europe and the Central Asian republics have male adult mortality risks close to those predicted by their GDP per capita. The northern countries of Central and Eastern Europe, by contrast, are more wealthy and less healthy. They have a male adult mortality risk of around 29 percent when, at their level of income, the predicted figure is 21 percent. In both figures 1 and 2, the national wealth and health status of Central and Eastern Europe is broadly similar to that of Latin America and the Caribbean.

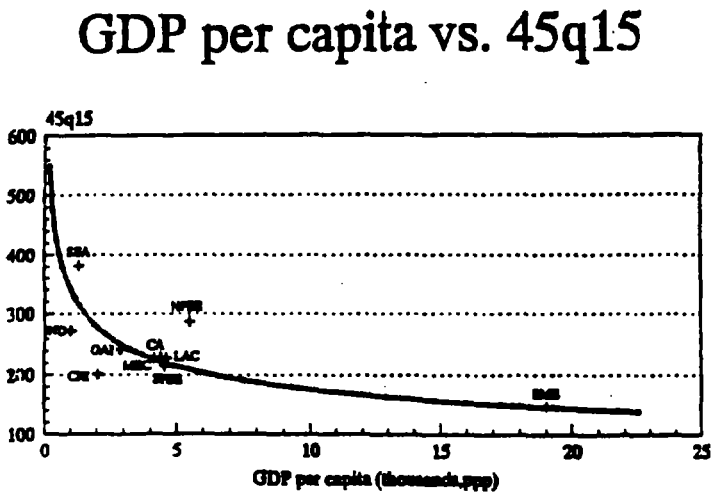
Figure 1: Life Expectancy by GDP per Capita and Region, 1990




*Note:* GDP per capita is in 1991 U.S. dollars converted from local currencies at purchasing power parity rather than the exchange rate. The line is drawn from the data points for every individual country; the regional pooled means are shown as a single point for each region.[2]

[2] The regions are defined as follows: CA, Central Asian republics of the former U.S.S.R. (Azerbaijan, Kyrgistan, Tajikistan, Turkmenistan, and Uzbekistan); CHI, China; EME, Established market economies (Australia, Canada, Japan, New Zealand, United States, and Western Europe); IND, India; LAC, Latin America and the Caribbean; MEC, Middle Eastern crescent (from Morocco in the west to Pakistan in the east, including

Figure 2: Risk of Death for Males between Fifteen and Fifty-nine Years of Age, by GDP per Capita and Region, 1990




*Note:* The risk of death measures, for every 100 males who are alive at fifteen years of age, the number who will be dead by sixty. The horizontal axis is in 1991 U.S. dollars converted from local currencies at purchasing power parity rather than the exchange rate. The line is drawn from the data points for every individual country. The regional pooled means are shown as a single point for each region.[3]

At the same time, the relationship between life expectancy and national wealth is weak at higher levels of income. Wilkinson (1992) suggests that among industrial countries income differentials, not the level of income, are a better predictor of health status, with more equitably distributed wealth being associated with greater longevity. In the light of this, the poor status of

North Africa and the Middle East); NCEE, Northern Central and Eastern Europe (Belarus, Czech Republic, Estonia, Hungary, Kazakhstan, Latvia, Lithuania, Moldova, Poland, Russian Federation, Slovak Republic, Ukraine); OAI, Other Asia and islands (all of Asia except for China, India, Japan, and Pakistan, plus the Pacific Islands); SCEE, Southern Central and Eastern Europe (Armenia, Bulgaria, Georgia, Romania, and Yugoslavia); and SSA, Sub-Saharan Africa.

adult health in the northern countries of Central and Eastern Europe is noteworthy in view of their history of a relatively compressed income distribution and supposed absence of poverty. There is, therefore, a real risk that the move to a market economy will make health status decline in some countries as poverty increases among some subgroups of the population.

Although health status in Central and Eastern Europe today is reasonable in relation to the wealth of the region (except for that of adult males in the northern countries), an examination of trends over the last five decades tells a very different story and poses a considerable challenge for policymakers (Feachem 1994). After recovering from the war years, the region enjoyed a health status which overlapped that of the West. Life expectancy at birth was higher in Czechoslovakia than in Austria throughout the 1950s (Bobak and Feachem 1992). Furthermore, in the decade from the early 1950s, improvements in health status outpaced those in most Western countries except Japan. Infant mortality rates fell by nearly half in the communist countries, and life expectancy at birth increased by around five years. By contrast, life expectancy over this period increased by two and a half years in the Federal Republic of Germany and one year in the United States (Eberstadt 1993). By the mid-1960s, only one or two years separated average life expectancy in Central and Eastern Europe from that in the advanced capitalist countries, and the gap was closing.

From the mid-1960s, the relative trends changed dramatically. Health status in Central and Eastern Europe stagnated or deteriorated, while in the highly industrialized countries, it improved steadily. Between the mid-1960s and the late 1980s, life expectancy at age one fell for males throughout Central and Eastern Europe (the greatest fall---three and a half years---was in Hungary) and rose by less than one and a half years for females.[3] Over the same period, age-standardized male mortality rates in Bulgaria, Czechoslovakia, Hungary, and Poland rose 2--13 percent, while in the Netherlands, Sweden, Switzerland, and the

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[3] Life expectancy at age one rather than at birth is used because infant mortality (mortality before age one year) was not accurately measured in some countries in the region and because the relatively poor performance of the communist countries is particularly evident for mortality beyond one year of age.

United Kingdom, they fell 12--27 percent. The widening gap in life expectancy and mortality between East and West was particularly striking in middle-aged adults. In the communist countries, death rates for males aged forty-five to forty-nine years increased between 7 percent (German Democratic Republic) and 131 percent (Hungary) between 1965 and 1989, while they decreased in the highly industrialized countries (Eberstadt 1993). The risk of death between fifteen and fifty-nine years for men in the late 1980s was higher in Hungary than in Zimbabwe and higher in Czechoslovakia than in Viet Nam (Feachem et al. 1992). A substantial proportion of this divergence is attributable to an epidemic of cardiovascular disease and, particularly, of ischemic heart disease in middle-aged males (other leading causes of death and morbidity include cancer, respiratory disease, and accidents). By the mid-1980s, mortality rates from ischemic heart disease in men aged forty-five to fifty-four years were twice as high in Czechoslovakia as in Austria, while in the 1950s they had been the same (Bobak and Feachem 1992).

Superimposed on these longer-term trends of declining health are the effects of the transition. Although the data are somewhat fragmented and the precise causal relationships difficult to establish, the results in some countries are dramatic. The increase in crude death rates in the Russian Federation "assumes truly apocalyptic connotations. [It] increased by 33 percent . . . between 1989 and the first seven months of 1993" (UNICEF/ICDC 1993, p. 20, fig. 7).

It is no consolation to the countries in Central and Eastern Europe to know that their overall health status is similar to that in Malaysia, Sri Lanka, Uruguay, and Venezuela, since it is not with these countries that they must compete. They need human capital capable of competing effectively with the countries of the European Union. At present, the gap in health status between the former socialist economies and the highly industrialized countries is wide and growing, especially in the cohorts of working age. The gap in health status shown in table 3 is due only to differences in mortality. These mortality excesses place a burden on the economies of Central and Eastern Europe because of the lost investment in human capital (individuals who die in middle age have received publicly funded education and other services), medical expenditure made prior to their deaths, and the more general opportunity cost of lost lives. An

even greater burden is likely to be imposed by the huge morbidity differential that underlies the mortality differential. Lost productivity due to high rates of sickness in the labor force and lost investment due to the high costs of caring for the chronically ill and their families put the formerly socialist economies at a striking disadvantage when competing with their healthier rivals.

Repairing the damage caused by the last three decades of communist rule and closing the gap in health status must, therefore, be a central objective for human resources policy throughout the region. This will be neither easy nor quick. If they could achieve rates of overall decline in mortality similar to that of Chile over the past two decades (roughly 2 percent a year), it would take eastern Germany twelve years to catch up with western Germany, and Hungary would need twenty-three years to rejoin Austria (Eberstadt 1993).

Table 3. Health Status in Central and Eastern Europe and OECD Countries, 1990

| **Health measures** | | Central and Eastern Europe[a] | Established Market Economies[b] |
|---|---|---|---|
| *Life expectancy in years* | | | |
| At birth (years) | Average | 72 | 76 |
| | Range | 69--73 | 74--79 |
| At fifteen years | | 59 | 62 |
| *Risk of death (percent)* | | | |
| Between birth and five years | Average | 2.2 | 1.1 |
| | Range | 1.3--3.6 | 0.6--1.3 |
| Between fifteen and fifty-nine years | Males | 28 | 15 |
| | Females | 11 | 7 |

**Notes:**

[a] Albania, Belarus, Bulgaria, Czech Republic, Hungary, Lithuania, Moldova, Poland, Romania, Russian Federation, Slovak Republic, Ukraine, the former Yugoslavia.

[b] Australia, Austria, Belgium, Canada, Denmark, Finland, France, Federal Republic of Germany, Greece, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States.

*Source:* Calculated from World Bank 1993c, Table A4.

For many years, either these trends went undetected or information about them was suppressed for political reasons. The general philosophy ---that citizens are passive recipients of state-run health services rather than active participants in a process of improving life-styles and reducing environmental risks --- contributed to the problem.

Low-quality Health Services

During the early years of communism, the health sector (as part of the so-called non-productive sector) was accorded a lower priority than the industrial sectors. As a result, the enormous potential benefits of an intersectoral approach to health and health services planning under the former five-year plans were largely lost. These problems in policymaking at the central level were compounded by poor flows of information in the tracking and evaluation of health trends and lack of authority in decision making at local levels (a result of the inability to decentralize). The main resulting problems were poorly targeted investment, inadequate integration between the different parts of the system, excessive specialization, a narrow base for financing, and grossly deficient incentives to efficiency.

Poorly targeted investment had, by the early 1970s, led to a massive but lopsided buildup in acute care hospitals and excessive specialization at the expense of public health services and primary care. The rigid and over centralized Soviet-style national health services which evolved from this process contained both significant overlaps and significant gaps because different ministries all tried to provide services for their own enterprise-based workers. The private sector was excluded from nearly all activities.

The different components of a complex network of services were not functionally integrated. Standards were determined by arbitrary statistical norms, leading to many imbalances. Surpluses and shortages developed due both to variations in local patterns of use and to political patronage. The compulsory catchment areas and the role of primary care doctors as gatekeepers were unpopular with patients who rightfully felt that they were wasting their time waiting in line to be told that the services they needed were not available at that level of care. Not surprisingly, they were willing to pay substantial gratuities to be referred quickly up the line or to use services

outside their official catchment area. In the poorer countries, such as Romania and across the southern crescent of the former U.S.S.R., this shopping around was often unproductive because neighboring areas with higher levels of care, more often than not, had similar shortages. Instead of providing comprehensive and functionally integrated services, the system created many indirect barriers to access through corruption and adverse incentives.

Excessive specialization led to the absence of a broad education and to the development of narrow skills which are now difficult to adapt to the more complex demands of a market economy. For instance, girls would enter technical training in nursing at the age of fourteen, depriving them of a broader educational base. Since medicine was considered a technical skill, doctors and other health care providers received training provided by ministries of health. Medical education was, therefore, isolated from the education provided in general universities by ministries of education. Training of public health specialists, health economists, health service managers, general practitioners, nurses, and many other health care personnel was seriously neglected. Under the Ceaucescu regime in Romania, the nursing profession was virtually abolished, leaving the country with a serious deficit of trained nurses by Western European standards. Research was isolated from teaching and financed through noncompetitive grants. International isolation in training, research, and technology was pandemic throughout the region, especially in Albania, Bulgaria, and Romania. The problems of the health care system echo those of the rest of the education and training system, and the similarities are striking.

Health services were financed almost exclusively through general revenues. Although an equitable and possibly efficient source of financing, such dependence left the health sector vulnerable to political agenda. It also failed to send a clear signal to patients and health care providers that health care is not free even when provided without direct charge at the point of delivery. Under-the-table user fees in the form of gratuities or "black money" became widespread throughout the region. In countries like Hungary, up to 20 percent of health care expenditure is estimated to have taken the form of out-of-pocket payments. The recurrent budget required to operate the

resulting overcapitalized and underfunded health services outstripped the financial resources of most countries.

Incentives to efficiency were virtually nonexistent either to motivate patients to maintain good health and use scarce resources judiciously or to encourage health care workers and institutions to provide high-quality care. Doctors working on salaries had an incentive to minimize their work load by referring complex problems up the line. Directors of hospitals, similarly, had a strong incentive to avoid performing expensive diagnoses and treatments themselves and to refer difficult cases to higher levels of care. The less work, the less strain on their global budgets. As a result, queues and waiting lists were common even though the number of doctors and beds per capita was higher than in most Western countries.

### Perennial Problems

The third major lesson to be learned from the past is that some problems are an unavoidable part of the human predicament and may simply have to be accepted. No health sector reforms or expenditure will entirely eliminate the problems of aging, biological defects, poverty, and social misery. These existed both before and during the former socialist regimes, just as they do in market economies today. Universal entitlement and free access to health services may have alleviated some of the associated hardships, but they did not eliminate them altogether.

## THE FORCES DRIVING CHANGE

The current reforms in Central and Eastern Europe fundamentally redefine the role of the state in the health sector, as elsewhere. This includes a call for more efficient allocation of resources through market mechanisms, greater individual freedom through democratic processes, and stronger institutional capacity of health systems through decentralized devolution of responsibility and management. The polar extremes of those driving forces which are most relevant to the health sector are summarized table 4. The

transition from a centrally planned command economy and socialist political system to a market-oriented economy and democratic political system are accompanied by a swing of the pendulum of policy choices.

Table 4: Driving Forces in Reform Process

| Driving Forces | Dichotomies in Policy Options | | |
|---|---|---|---|
| **Political Factors** | | | |
| Ideology | Collectivist | vs | Individualist |
| Political process | Autocratic | vs | Pluralist |
| Governance | Totalitarian | vs | Democratic |
| **Economic Factors** | | | |
| Economic model | Socialist | vs | Capitalist |
| | Command | vs | Market |
| | State | vs | Laissez-faire |
| Ownership/financing | Public | vs | Private |
| Prices/wages | Predetermined | vs | Competitive |
| Production | Supply driven | vs | Demand driven |
| Labor markets | Restricted | vs | Mobile |
| Incentive structures | Bureaucratic | vs | Meritocratic |
| | Normative | vs | Performance |
| Economic equilibrium | Static | vs | Cyclical |
| **Institutional Factors** | | | |
| Policy/legal | 5-year plans | vs | Incremental |
| Structure | Centralized | vs | Decentralized |
| Function | Simple/uniform | vs | Complex/diverse |
| Personnel | Superspecialized | vs | Broad skills |

Some countries, such as Poland and the Czech Republic, have opted for a "big bang" approach to restructuring, while others are following a more gradual path. In all instances, however, an elixir of rapid liberalization of demand, supply, prices, and wages, combined with the fiscal constraints of stabilization programs, provides a potent, and at times toxic, brew for ailing health services. In most countries, the health sector was not prepared for the resulting overshoot in economic liberalization nor for the sudden

rejection of the old political system and resulting institutional collapse. The mounting backlash against these negative effects of the transition is now threatening to destabilize the whole reform process. This presents a particularly difficult short-term problem for policymakers in the region, who have to address the strengths, weaknesses, and perennial problems of the past as well as those of the transition.

The first major driving force is the tendency for economic liberalization in the health sector to go too far too fast. The removal of centralized state control over the health sector and the rapid introduction of unregulated competitive markets have already led to the emergence of significant market failure. In the Czech Republic, ownership of most health care facilities was quickly transferred to local communities. Substantial parts of the former national health service have been privatized, especially in the case of pharmaceutical products, medical equipment, supplies, ancillary services, and ambulatory health services (private offices, clinics, pharmacies, and diagnostic centers). Many health care providers, such as general practitioners, consultant specialists, dentists, and pharmacists, working outside the hospital subsector no longer see themselves as public employees but rather as entrepreneurs in private practice. Patients see themselves as consumers of health care, demanding services in return for their taxes or social insurance contributions. Unfortunately, instead of engendering a constructive partnership between the public and new private sector, unrestrained privatization within an excessively relaxed regulatory framework has led to unscrupulous profiteering and pillaging by health care providers and unchecked use by patients (both problems are caused in part, though not wholly, by the third-party payment incentives).

With the sudden liberalization of prices and wages, the cost of critical supplies and pharmaceuticals has exploded. In Poland, for example, public expenditure on pharmaceuticals increased from 12 percent of health care expenditure to more than 30 percent almost overnight. The unbalanced shift in incentives from a normative-based system to a performance-based system has

exacerbated the problem of cost containment.[4] In the Czech Republic, the original annual budget of the newly created health insurance fund was more or less exhausted within six months of its inception at the beginning of 1992 and had to be replenished; expenditure in the first six months of 1993 was almost as much as in the whole of 1992. In Hungary, the proposed replacement of global hospital budgets with performance-related diagnostic related groups (see the glossary) is likely to have the same effect if not accompanied by strict mechanisms to cap the budget.

In countries like Albania, large-scale layoffs in the industrial sectors have led to significant dislocations, housing shortages, family disruption, and unemployment as firms begin to shed labor to become more efficient and try to avoid bankruptcy during the recession. These social disruptions have increased the demand for health care at a time when resources are extremely limited.

A second driving force, the sudden rejection of constraints on freedom of choice, has led patients and health care providers throughout the region to shop around indiscriminately, wasting valuable resources and increasing the pressure on an already over used health service. In Poland, the obsession with steering committees and popular consultation has led to ineffective policymaking and management. Critical pieces of legislation remain deadlocked in Parliament for months, even though many of the proposed reforms could easily have been introduced through regulation. In Hungary and surrounding countries, rejection of past socialist ideals and excessive confidence in individual autonomy and self-sufficiency have almost completely replaced all concern for collective protection and equity. Gypsies, migrant populations such as immigrant workers, and minority groups such as AIDS patients are now

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[4] A normative-based system would finance hospitals on the basis, for instance, of the number of beds; a performance-based system of reimbursement would pay hospitals in a way related to the number of patients treated. The incentives given by the two methods are clearly different: the former encourages hospitals to have lots of beds, but to keep them empty; the latter encourages hospitals to give large amounts of treatment, whether or not it improves health.

threatened with loss of entitlement and of access to adequate health care.

Third, the rejection of the communist model has led to a massive collapse in the prevailing centrally planned institutional framework for health services which had previously been provided through the public sector and which has not been replaced by private or nongovernmental sectors. The abolition of five-year plans has left many ministries without a clear strategy for the future and without an institutional capacity to develop new policies.

Purges of the nomenclature and a witch hunt for previous card-carrying communists have decapitated the ministries of health and many health care institutions in the Czech Republic, Poland, and the Slovak Republic, leaving a dearth of experienced senior staff. Medical doctors with little training or experience in management have assumed key administrative posts in health ministries, hospitals, and other institutions, creating a policy vacuum in which poorly prepared and contradictory reform proposals are often presented to Parliament at the same time. Important decisions about the budget allocation process and major capital investments are now heavily influenced by vested interests such as the medical profession, pharmaceutical companies, and equipment manufacturers and importers. As a result, the investment needs of hospitals and clinics may be increasing unnecessarily, not least because maintenance and repairs are neglected.

Excessive decentralization and a breakdown in referral networks in countries such as Bulgaria, the Czech Republic, Hungary, and the Slovak Republic have led to potentially expensive overlaps, as every community hospital wants its own neurosurgical unit and the latest technological equipment. A splintering of the former centrally organized wholesale and retail distribution systems has added to the crisis caused by rapidly rising prices. The result has been serious shortages of pharmaceuticals and critical supplies in much of the former U.S.S.R., where many of the distributional links which formerly led to Moscow have now been cut. Severe supply shortages are of course experienced also in countries ravaged by war.

## REFORM STRATEGIES

### Objectives

Governments in Central and Eastern Europe are finding that reforming their health sectors during a period of major socioeconomic adjustment is vastly different from reforming them in a more stable environment. Frequent changes in leadership in Poland during the early years of the reforms, hyperinflation in Latvia, and purges in the civil service in the Slovak Republic make it difficult for government to introduce sustainable health care reforms. Reforming the health sector is also different from reforming other parts of the economy because health services cannot shut their doors while they are undergoing significant restructuring and reform. As a result, the massive layoffs and liquidation of assets in eastern Germany following reunification did not extend to the health sector.

Health sector reforms, therefore, carry with them special opportunities and risks. Policymakers in Central and Eastern Europe have an opportunity to redesign their health services and health financing systems, while drawing on the best of Western experience and avoiding known pitfalls such as the escalation of costs in the United States, waiting lists in the United Kingdom, and excessive prescription of drugs in Germany. Yet, they run the risk that lower standards of living, weaker commitment by governments to maintaining essential services, and restrictions in public expenditure on health care will weaken the health sector's role as a critical link in the social safety net. For instance, the privatization of family doctors' offices in Russia, under consideration in 1993, could worsen the shortage of doctors in regions outside Moscow. Continued underfunding of immunization programs or maternal and child clinics could worsen the already high infant and maternal mortality rates.

### Policies

In an effort to be consistent with the underlying thrust of the transformation process, many governments in Central and Eastern Europe are trying to introduce health and social policies which simultaneously support

the broader aims of associated political, economic, and institutional reforms as well as objectives which are specific to the health sector itself. The underlying thrust of the transformation is to increase the overall well-being of the population by restoring individual freedom, increasing living standards, and creating a strong safety net for those persons unable to take advantage of these benefits without additional assistance. In the case of health and health care, as elsewhere, this includes incentives for individuals to become more self-sufficient, competitive markets to improve efficiency, and decentralization of management to improve the responsiveness of institutions to local needs.

Illness limits people's autonomy, reduces their participation in employment, and increases their dependence on health services. Thus poor health has a direct negative impact on labor mobility, productivity, and public expenditure. Unrestrained demand for health services and explosive increases in prices, if left unchecked, could trigger a vicious cycle of poor economic performance and deteriorating standards of living which would jeopardize other measures taken to improve health. The current sense of urgency, therefore, stems not only from ethical motives to improve health and the quality of human capital but also from a desire to underpin the emerging market economies with sound fiscal policies and institutional reforms.

Most countries in Central and Eastern Europe have begun to formulate policies which address these broad objectives. They can be grouped under three major categories:

- The first set of policies is directed at improving health, without which self-sufficiency and individual freedom cannot be restored. This includes measures to raise standards of living, to promote healthier life-styles, to protect the environment, and to improve the effectiveness of preventive and curative health services.

- The second set of policies focuses on health care and is directed at restoring macroeconomic balance, building new and more efficient markets, and controlling for market failure, without which economic

growth and productivity will not be restored. In the health sector, this includes measures (a) to control public expenditure through cost-containment policies and the introduction of non-budgetary sources of health care financing, (b) to increase consumer choice, diversify supply, and improve labor productivity, (c) to improve risk pooling, and (d) to ensure quality control.

- The third set of policies is directed at improving the political and institutional capacity of the health sector to implement relevant reforms. This includes measures to introduce new legislation, to strengthen the physical and administrative infrastructure of institutions, and to reorient the training of personnel.

Variations in the evolving health systems which are observed throughout the region can be explained largely on the basis of differences in how policymakers combine these options (World Bank 1993c).

Improving Health

The first and most important reforms being introduced in the health sector in Central and Eastern Europe, like the Close the Gap Program in Hungary, aim to reduce the difference in health status between the countries in the region and the highly industrialized countries with which they will compete in the future.

The determinants of the health gap between Central and Eastern Europe and Western Europe are not well understood. A plausible breakdown would attribute 30 percent of the gap to differences in wealth and associated socioeconomic factors, 50 percent to known life-style risk factors, 10 percent to environmental pollution and occupational risks, and 10 percent to deficiencies in the preventive and curative health care services.

Although policies to increase standards of living and economic growth are extremely important, they lie, for the most part, outside the health sector. Policymakers in Central and Eastern Europe are, nevertheless, trying to avoid any actions in the health sector which would contribute unnecessarily

to the fiscal deficit or to inflationary pressures during the transition, since this would indirectly hurt health by retarding economic recovery and improvements in the standard of living. At the same time, they are concentrating their attention on those categories which have a more direct impact on health: life-styles, pollution and occupational risks, and preventive health care.

Good health depends not only on income per head but also on the distribution of that income. The risk factors causing disease are experienced particularly by the poor and less educated, and it is they who must be reached by incentives and educational programs. Unhealthy jobs are taken by workers with no other options, typically the least skilled and least educated. It is the poorest who live in the shadows of belching chimneys. Closing the gap in health status, therefore, requires a concern for equity and an emphasis on reaching the most disadvantaged sections of the population. Fortunately, so far, no country in Central and Eastern Europe has withdrawn universal entitlement or equity in access to services, although the health insurance programs recently introduced in the Czech Republic, Hungary, Russia, and the Slovak Republic could alter this situation.

***Changing Life-styles.*** The largest single contribution to the health gap is the high and rising rate of cardiovascular disease among adults, especially adult men. Risk factors for cardiovascular disease include excess consumption of alcohol, smoking, obesity, lack of physical exercise, and poor diet (high in animal fat, salt, and cholesterol; low in fruits and fresh vegetables). All these factors are more prevalent in Central and Eastern Europe than in the highly industrialized countries, and the most important factor, smoking, is much more prevalent. Surprisingly, no country in the region has introduced effective policies to reduce these risk factors. Such policies would include:

- Taxation-based disincentives to consumption of alcohol, tobacco, and unhealthy foods;
- Legislation on alcohol, tobacco advertising, and food labeling;
- Public education programs to inform and sensitize the population about diet, physical exercise, and dangerous behavior.

***Reducing Pollution and Occupational Risks.*** Environmental pollution is widespread in Central and Eastern Europe, and bringing it down to an efficient level, which takes account of both the costs of pollution and the benefits of the polluting activity, is a priority for government action. This is so for more reasons than the negative impact on health. The most serious problems are dust and gases in the air, lead in the water and soil, and nitrates and heavy metals in the water. Air pollution is particularly damaging. Black spots are prevalent throughout the region, and at the junction of the Czech Republic, Germany, and Poland is the so-called Black Triangle, where about 6.5 million people are exposed to extremely polluted air. In the Czech Republic, air pollution may explain about 9 percent of the gap in health status with Austria (World Bank 1993c). Occupational risks are widespread and varied. Under the communist regime, worker organizations, management, and the state conspired to allow appallingly unsafe and unhealthy working conditions to be maintained. This conspiracy was shrouded in an elaborate system of inspection, certification, and regulation which was corrupt and ineffective.[5]

Most governments in Central and Eastern Europe realize that rectifying this legacy will not be cheap or easy. As a result, effective inspection and regulation, and incentives for investing in anti-pollution technology and occupational safety have not yet been introduced. In the future, such measures must be applied evenly, and preferably throughout the region, to prevent compliant industries from being disadvantaged in the marketplace. Worker organizations, such as Solidarity in Poland, could play a central role in forging a wider public consensus.

***Supporting Preventive Health Services.*** In some respect, preventive health services were performing well under the previous regimes. In particular, most countries offered good services for pregnant women and babies, high rates of immunization among children, and effective programs for controlling infectious diseases, such as typhoid and tuberculosis. Immunization coverage rates in countries such as the Baltic states, Bulgaria,

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[5] For example, an adverse report by a safety inspector could be interpreted as sabotage of the plan.

Czechoslovakia, Hungary, and Poland were among the highest in the world, and diseases such as poliomyelitis and measles were reduced to very low levels.

Maintaining these achievements, and building upon them by adding new vaccines such as hepatitis B, has not yet become a high enough priority for many countries. Control of some communicable diseases is now threatened in the former U.S.S.R. by problems in the production, purchase, and delivery of vaccines. Without more effective action, illnesses such as tuberculosis, which is on the rise in Western Europe, will pose a great threat to the poorer countries in Central and Eastern Europe.

Improving education and services for women and their babies is an effective way to increase health status and avoid unnecessary medical expenditure. In contrast with past achievements in providing effective immunization services, family planning under the communist regime was grossly inadequate throughout Central and Eastern Europe, leading to many unwanted pregnancies, frequent and expensive hospital abortions, and dangerous back-street terminations of pregnancies (Johnson, Horga, and Andronache 1993).

***Improving the Quality of Curative Health Services.*** Although the direct impact of curative health services on life expectancy and morbidity may be much less than the effects of public health measures such as those described above, policies in this area are nevertheless important for several reasons. Well-being can be measured in terms of quality as well as length of life. Since modern medicine is constantly finding new ways to relieve suffering, the curative services cannot be ignored simply because they do relatively little to increase life expectancy. For instance, victims of accidents may suffer permanent disabilities and loss of productive employment when their fractures are not set properly.

Furthermore, the way curative health services are financed has an important effect on the financial resources available to other areas of the health sector, such as preventive services, and to income support programs. This, in turn, indirectly affects standards of living and health. Although international guidelines exist for the cost-effectiveness of some basic

interventions, such as the treatment of diarrhea or various forms of immunization (World Bank 1993c), policymakers in Central and Eastern Europe are finding that they must often develop solutions specifically for their own country. Hungary and Poland are already reviewing the costs and outcomes of such policies. Based on these reviews, they are drawing up "baskets" of affordable health care which match the financial resources available to the health sector.

Maintaining Macroeconomic Balance

Given that perhaps one-third of the health gap between Central and Eastern Europe and Western Europe is due to differences in wealth and associated socioeconomic factors, many governments are according very high priority to policies in the health sector which support measures to restore macroeconomic balance. These policies are of two broad forms: (1) policies to contain public expenditure on health care in an effort to relieve the fiscal imbalance and avoid crowding out the newly growing, but fragile, private sector and (2) policies to mobilize non-budgetary resources for health care financing to rejuvenate the sector. In both cases, various techniques are being used successfully.

***Containing Costs.*** In the past, it was relatively easy for governments to maintain tight control over health care expenditure. Since the sector was financed exclusively through the state budget, expenditure caps could be enforced by indexing budgets at or below the rate of inflation (global budgets in the case of hospitals and clinics; salaries or capitation fees in the case of doctors and other health care workers). Hard budget caps, such as global budgets for hospitals and budget envelopes for doctor services, continue to be used throughout most of the region as well as in many Western European countries (Culyer 1989). This has markedly reduced health care expenditure both in real terms and relative to GDP in many countries. For example, in Poland caps led to an annual drop in health care expenditure of approximately 10 percent in real terms between 1990 and 1992.

As countries begin to introduce diversified sources of health financing and more complex performance-based reimbursement for health care providers,

controlling health care expenditure through budget caps is becoming more and more difficult. For instance, different variants of the decentralized German health insurance model (sickness funds), under which doctors and institutions are paid according to the number of examinations and procedures they perform, are becoming extremely popular throughout the region. German policymakers control health care expenditure under this model through a complex process of managed price fixing. Negotiated agreements among the government, the sickness funds, and the medical profession, rather than market forces, determine prices. Undesired increases in the number of examinations or procedures are, in this way, offset by downward adjustments in prices. Even using such complex methods, many Western European countries have difficulty controlling health care expenditure (Abel Smith 1992). The Czech Republic introduced a similar model in 1992, which replaced salaries by carte blanche fee-for-service payments, before having adequate information systems to track costs or establishing a process for negotiating prices. The entirely predictable result was that within a few months, the authorities had completely lost control of health expenditure.

***Mobilizing Resources***. During the early stages of the transition, the health sector in most countries had enough internal reserves to withstand significant budget cuts without seriously compromising the quality of care provided. In the face of continued budgetary restraint and explosive increases in prices, especially in the case of imported pharmaceuticals and equipment, this is no longer true. Countries like Bulgaria, the Czech Republic, Hungary, the Slovak Republic, and several countries of the former U.S.S.R. have, therefore, turned to public---and to a small extent private---health insurance and direct charges to shore up the dwindling state budget.

This silver bullet solution of health insurance did not mobilize financial resources for the health sector for two reasons: (1) the health insurance contributions in countries like Hungary usually replaced rather than supplemented budgetary sources of health finance, and (2) rising unemployment and a growing informal sector in countries like the Slovak Republic reduced compliance and eroded the original contributions base. As a substitute for the state budget, social insurance for health care is, therefore, no panacea

as an additional source of finance. When the government is forced to bail out an insolvent health insurance fund, as in the Czech Republic, shifting health care financing from the state budget to national health insurance may even damage other efforts to contain public expenditure.

Medical doctors in countries which have not introduced health insurance are looking with envy at the incomes of their Western European neighbors, while ignoring the negative experiences of other countries in Central and Eastern Europe. They continue to lobby their Parliaments for German-style health insurance. In the poorer countries of the region, such as Bulgaria, the Slovak Republic, and the southern crescent of the former U.S.S.R., a rapid collapse in the collection of contributions would have a devastating effect on equity and the quality of care provided. In many of these countries, governments are realizing that state budget support for the health sector is unavoidable and that giving up cost controls under the assumption that health insurance will regulate itself is courting disaster.

Building Markets

Governments in Central and Eastern Europe are finding that it is neither desirable nor possible to insulate the health sector from the market forces sweeping the region. Many are turning to radically new health policy paradigms which can be grouped under three headings: (1) policies to liberalize demand by increasing consumer choice and redefining the role of governments, patients, health care providers, and enterprises as active partners in the health sector; (2) policies to diversify supply by establishing a new enabling environment for nongovernmental and private sector activities in the ownership, production, and financing of health care; and (3) policies to improve incentives in a new competitive market for health care. The individual elements of these policies are summarized in table 5 and described in greater detail in the following sections.

Table 5: Policy Options to Improve Market Forces in Health Sector

| Policy Area | Extreme Policy Options | | | Health Paradigms |
|---|---|---|---|---|
| **Consumer Choice** | State | vs | Individual | Partnership |
| Governments | Monopolist | vs | Minimalist | Stewardship |
| Patients | Recipients | vs | Consumers | Active Participants |
| Providers | Employees | vs | Vested Interests | Preferred Providers |
| Enterprises | Mini-states | vs | Capitalists | Responsible Agents |
| **Diverse Supply** | Planning | vs | Market Place | Managed Competition |
| Type of Good | Public | vs | Private | Mixed and Merit Goods |
| Ownership | State | vs | Providers ----┐ | |
| Production | Planned | vs | Supply/Demand ├- | Public/Private Mix |
| Financing | Taxation | vs | Insurance ----┘ | |
| **Productivity** | Normative | vs | Input/Output | Outcome Based |
| Incentives | Bureaucratic | vs | Personal Gain | Efficiency<br>Cost-Effectiveness<br>Quality/Satisfaction |

The strategy to use market forces in the health sector is double edged: on the one hand, it offers a chance for new approaches to improving health and the performance of health services; on the other, it carries an immense risk of reopening the Pandora's box of well-known market imperfections. The budgetary crisis which occurred in Poland in 1992 because of a sudden increase in the price of pharmaceuticals and the recent breakdown in the supply network in Russia are only the tip of the iceberg.

Because of such market failures, many Western countries have recently begun to use managed competition, or managed care, to create a restrained, but competitive, environment in which the advantages of market forces can be exploited, while the undesirable effects are controlled (Enthoven 1988). Governments in Central and Eastern Europe are discovering that market forces are an excellent way to improve efficiency, but only if accompanied by regulation, some public production, and targeted subsidies to minimize the associated abuses and deficiencies (Evans 1984).

***Increasing Consumer Choice.*** As a first step, many countries are improving consumer choice by redefining the role of governments, patients, health care providers, and enterprises in the health sector. In the past, both state and individualist extremes led to many unsatisfactory outcomes. The communist era provides ample evidence that well-being and health are poorly served when consumer choice is totally suppressed. At the same time, experience from Western countries over the past century provides equally good evidence that excessive reliance on consumer sovereignty has its own shortcomings. The changes require redefinition of the role of government, of patients, of health care professionals, and of enterprises.

The central government in the Czech Republic, Hungary, and Poland has already relinquished much of its previous monopoly by transferring the ownership of most health care facilities and the responsibility for providing services to local authorities and the private sector. Likewise, responsibility for financing health care is being transferred from the state budget of the central government to decentralized and semi-autonomous health insurance funds. Instead of withdrawing completely from the health sector, however, governments in these countries are assuming a new and important role as regulators or stewards of the emerging nongovernmental and private sector activities. Whatever the policy developments in a particular country, governments in all cases remain responsible for putting policies and programs into place to protect equity and the quality of care as patients are becoming more active participants in securing health. This is especially true since patients are not well informed about the cost-effectiveness of most treatments, and supply shortages would cause severe distortions in the market value of treatment without such intervention.

All the key players are adapting quickly to the new context by responding to price signals in a competitive environment. Patients are becoming active consumers of health care, in contrast with their passive role under the old system. In the Czech Republic, patients have gained increased freedom to choose their doctor and mode of treatment. The remaining barriers are created by geographical and resource constraints.

Health professionals, too, are responding to price signals. In Hungary, health care providers are negotiating the place of work or mode of practice with local governments and the health insurance fund. In most countries, enterprises and governments are choosing the extent to which they participate in health care activities. Although many doctors sit in Parliament and on influential legislative committees, there has been little self-regulation of the health care professions. Even in Poland, where syndicate activities started early under Solidarity during the 1980s, self-regulation is not effective because responsibility for conducting professional activities and enforcing professional standards is vested in single professional organizations such as the Physicians Chamber, Nurses Chamber, or Pharmacists Chamber. The strict internal controls necessary to prevent abuses such as supplier-induced demand, especially where payment is on a fee-for-service basis, are often missing.[6]

During the socialist years, the boundaries between the enterprise and the state were blurred: both were responsible for the welfare of workers, and both provided extensive and elaborate networks of health services, social programs, and education. In some countries, such as the Soviet republics, industrial subsectors like mines, railways, police, and military provided health services for up to 10--15 percent of the population, financed largely through direct or indirect public subsidies. As enterprises become preoccupied with making a profit and avoiding bankruptcy, they are seeking to withdraw from their position as mini-states within states. The potential, sudden collapse in health services of these sectors would require massive and expensive restructuring; this is a time bomb which few governments have taken adequate steps to defuse. Nor have they sought to ensure that enterprises assume a new role as responsible employers who provide safe workplaces and protect the environment in line with international standards.

***Diversifying Supply.*** Governments are finding that diversification of

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[6] Retrospective reimbursement for medical providers who operate on a fee-for-service basis creates incentives to oversupply; if uncontrolled they can easily lead to exploding medical costs.

supply requires major changes in the way they treat health care as an economic good. It also requires major changes in ownership and financing.

***Health care as an economic good.*** Private goods exhibit excludability (an individual can be prevented from consuming a good until he or she has paid for it), rivalness (consumption by one individual prevents consumption by another), and rejectability (one individual can choose to forgo consumption). True public goods have significant elements of non-excludability, non-rivalness, and non-rejectability. Mixed goods have some but not all of the characteristics of private goods. The diverse possibilities for health care goods and services is demonstrated in figure 3 below. A breakdown occurs in efficiency, equity, and sustainability when public goods or goods with significant externalities are allocated through competitive markets. The reverse problem---when private goods are allocated by centralized planning---is one of which Central and Eastern Europe needs little reminding: all have experienced low-quality health care, black money, queues, and the like.

Figure 3: Economic Nature of Health Care Goods and Services

| | Nature of Economic Good | | |
|---|---|---|---|
| Intrinsic Properties | Public Good | Mixed Good | Private Good |
| Excludability | - | ± | + |
| Rivalry | - | ± | + |
| Rejectability | - | ± | + |

Governments in Central and Eastern Europe are finding that health care is not a homogenous private good which can be uniformly submitted to market forces. Policymakers have to answer a number of major questions:

- Which sector, public or private, should produce the service in question?
- Which sector should finance the service, in particular what charges, if

any, should be made to patients?

- Should patient choice be constrained, for example, by requiring family doctors to act as gatekeepers for treatment by specialists or by restricting drug subsidies to a range of basic drugs?

Different types of health activity involve different packages of these elements. Public health services, such as sanitation services, control and prevention of communicable diseases, and health promotion, and other activities, such as research and development and professional education, have significant public goods characteristics. Yet some of the elements which make up these services---such as clean water, collection of refuse, immunizations, public health campaigns, individual research projects, and postgraduate training---may have sufficient characteristics of private or mixed goods to be subjected to market forces. Some of these elements are, therefore, usually sold as public utilities rather than given away as public goods. Hungary, for example, has recently introduced a controlled internal market by establishing a competitive process for funding research. Nongovernmental organizations are being contracted to conduct public health campaigns in Poland. And private pharmaceutical companies are being provided with incentives to produce desired vaccines in Russia. In the case of such public or near-public goods, production can thus be public or private, consumers typically do not pay charges, and consumption is relatively unconstrained.

Hospital care, including expensive diagnostic and therapeutic care, although in principle a private good and hence marketable, has not been privatized anywhere in the region. Such action would lead to politically unacceptable inequity and allocative inefficiency if left to market forces alone. In this case, production was historically mainly public, although that is changing; consumer charges historically were mainly unofficial, though again that is changing; and consumer choice was constrained by ambulatory clinics acting as gatekeepers.

Ambulatory care and long-term residential care were generally treated as private goods even under communism because it was difficult, if not impossible, to prevent their sale in the informal economy. Following the collapse of the socialist regimes in the Czech Republic, Hungary, and Poland, the new democratic governments were quick to introduce legislation which allowed the private production of medical drugs and supplies and the services of general practitioners and pharmacists. In such cases, supply is becoming increasingly private, and the role of consumer charges is growing.

One of the great challenges facing governments in Central and Eastern Europe is to decide where to draw the boundary between different types of health care goods and services, especially in the case of mixed goods, which are open to a fair amount of interpretation. The choice made in the Czech Republic, which now charges fees for access to private clinics and hospitals, is quite different from that of the Slovak Republic, which still provides free access to public clinics and hospitals. A second challenge is to develop effective policies for dealing with the various types of abuse as they arise. Governments throughout the region have so far been unsuccessful in introducing effective policies to deal with gratuities, bribes, and the emerging informal health sector economy.

***Ownership and finance.*** Many countries in Central and Eastern Europe are also introducing major changes in the ownership and sources of financing for health care. In fact, much of the striking variability in the health systems in both Western countries and Central and Eastern Europe can be explained by the mix of public and private production of health care. Figure 4 presents this mix: the columns show different types of financing of health care, and the rows show the different types of ownership.

Figure 4: Topology of Ownership and Source of Financing of Health Care

| | Public Financing | | Private Financing | |
|---|---|---|---|---|
| Production | Prepayment of Health Care | | | Direct Charge |
| Ownership / Delivery | Government / General Revenue | Statutory / Social Insurance | Regulated / Private Insurance | Competitive / Out-of-pocket User fees |
| Purely Public | A | D | G | J |
| Private Non-profit | B | E | H | K |
| Private For-profit | C | F | I | L |

Interestingly, none of the health systems in the highly industrialized countries or in Central and Eastern Europe falls wholly into a single cell. For example, the systems in the United Kingdom and the Nordic countries are primarily in cell A, but also have components of B and C, and J to L, in their public sectors. Their private sectors include a range from D to L. Canada and Australia are mainly in B and C, but likewise include D to L in their private sectors. In Canada, J to L are prohibited by law for standard services in the public sector, but direct charges are levied for above-standard services, pharmaceuticals, and many other goods and services provided through ambulatory care. The systems in some continental European countries are mainly in cells D to F, but include A to C through the public sector for targeted services and populations. Australia, Canada, France, Germany, and the United States are similar in their use of health insurance but very different in the ownership of health care services. Although health care in most of Central and Eastern Europe is currently concentrated in cell A, about 10 to 15 percent of the private sector and black market activity takes place in cells J, K, and L. As the countries move toward health care systems with a more diverse public/private mix, they are already beginning to occupy other

cells in this schema, especially cells D, E, and F, given the tendency to move from general revenue financing to that of national social insurance.

The source of financing for the health sector in the highly industrialized countries and Central and Eastern Europe falls simultaneously into two broad categories: direct charges and third-party prepayments. Direct charges are made in the form of official user fees or unofficial gratuities paid directly to health care providers when services are rendered.[7] Third-party prepayments are made through taxes, social insurance payroll levies, and earmarked health insurance contributions paid by individuals, families, and employers to intermediaries (the state budget, social insurance funds, or private health insurance companies) before services are rendered by health care providers (hospitals, clinics, doctors, and pharmacies). In the West, most prepayment schemes are subsidized either directly through deemed contributions covering the non-contributing population (the poor, unemployed, and elderly) or indirectly through tax credits. Likewise, the new health insurance schemes in the Czech Republic, Hungary, and Russia also rely on direct subsidies to cover the non-active parts of their population.

***Improving Incentives.*** Governments are quickly discovering how to let the genie out of the bottle in a market economy by improving the structure of incentives. Incentive structures in the health sector are, of course, nothing new in Western countries. Positive incentives include profits, subsidies, professional recognition, and special status. Negative incentives include losses, fines, professional disapproval, and exclusion. As parts of the health sector are being privatized, and wage differentials are increasing, such incentives are beginning to have an effect.

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[7] User fees are also referred to loosely and inconsistently as tariffs, copayments, deductibles, ticket moderateur (France), and cost recovery. They are usually legal charges used to supplement income from third-party prepayment schemes in both industrial and developing countries. Gratuities are also referred to as black money, under-the-table bribes, tips, and tokens. They are often illegal charges used to supplement doctors' salaries.

The incentive effects of third-party reimbursement of services supplied on a fee-for-service basis are highly conducive to exploding costs. Western countries such as the United States, where similar problems are observed, have tried to deal with the problem through regulation and countervailing incentives, for instance, by encouraging health care providers to join together in preferred provider organizations, which offer a predetermined basket of care for a fixed price (see Sandier 1989 and Barr 1994 for general discussion of the underlying principles).

In Hungary, recent changes in the mechanism used to pay health care providers (capitation payments for family doctors, fee-for-service payments for specialists, and diagnosis-related groups for hospitals; see the glossary) have had a much greater impact on the character of service delivery than earlier changes in ownership and the introduction of contributory health insurance. A well-run prepayment scheme can offer good coverage and comprehensive care as well as low administrative costs and good control of expenditure. A poorly run scheme can be expensive to manage while providing poor coverage and incomplete care. There is, therefore, no ideal model for the countries in Central and Eastern Europe to follow.

The underlying principle for governments which want to introduce such incentives is, therefore, simple: use them carefully because they will almost certainly be more powerful than expected. Governments which use incentives skillfully as thermostats to turn desired behavior on and off can greatly improve both efficiency and equity. For instance, outcome-based incentives reward providers who improve the health of their patients, not just those who see more patients each hour. The idea is that the reimbursement regime should be based on outcomes not on inputs, giving doctors an incentive to improve the health of their patients instead of merely rewarding them for the amount of treatment provided irrespective of its cost-effectiveness.[8]

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[8] Many Western countries are experimenting with funding regimes which give providers the incentive to keep patients healthy. Health maintenance organizations (see the glossary) are one example. Along similar lines, reforms in the United Kingdom in the early 1990s allowed some family doctors to act as the funding agency for certain types of hospital

Governments which use incentives poorly quickly find themselves facing escalating costs due to supplier-induced demand and reduced efficiency as resources are moved into narrowly defined areas of low priority. The cost explosion in the Czech Republic was entirely predictable and could have been prevented though the introduction of appropriate incentives such as preferred provider organizations or of adequate mechanisms to cap the budget. The incentive structure certainly increased the productivity and income of doctors but led to few gains in the quality and cost-effectiveness of their interventions.

Regulating Market Forces

Market imperfections in health care are pervasive:

- Consumer information is highly imperfect, creating serious problems of quality control.
- Workers have only limited power to insist on safe working conditions, and, without appropriate sanctions or regulations, employers have little incentive to improve safety.
- Major problems with externalities mean that, although environmental cleanup is in the interests of society as a whole, individual firms have no incentive to produce in a less polluting way.
- Private insurance is unable to cover some important medical risks.
- Third-party reimbursement, particularly in a fee-for-service environment, creates incentives which can lead to uncontrolled escalation of costs.

In addition, and separately, in a market system the poor are likely to be excluded from medical care because of its cost.

Examples of the ill effects when these problems are ignored are legion. At least 35 million Americans have inadequate medical insurance coverage; costs are difficult to contain; and the massive dumping of low-quality drugs

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treatment, again giving them incentives to keep their patients healthy.

and the importing of defective medical equipment have already occurred in Poland and other countries in Central and Eastern Europe because the government does not---or cannot---enforce adequate standards for quality control.

***Introducing a Regulatory Structure.*** Because the problems are so pervasive, policies to regulate market forces have to be an integral part of measures used to harness market forces. Thus they emerged repeatedly in the discussion of the previous sections and are recapitulated here only briefly. State intervention, apart from income transfers, is of three types: regulation, finance, and public production.

Regulation is necessary in a variety of forms:

- Quality control is made necessary by imperfect information. The government has a stewardship role which includes controlling the quality of medical services generally, ensuring that professional standards are upheld, and maintaining regulatory regimes for the testing, production, and sale of drugs.
- Containing medical expenditure in the ways described is necessary because of the third-party payment problem. Regulation of medical spending can be imposed at the level of the total system, as in the United Kingdom, or at the level of the hospital, as in Canada, or at the level of the individual provider, as in Canada or Germany.
- Environmental action is needed because of the externality problem; such policies need to be stimulated either by appropriate incentives or by appropriate regulatory structures.
- Safety at work requires regulation and enforcement to ensure minimum standards.

Public funding of medical care is necessary for two very different sets of reasons: to ensure the provision of public goods and to ensure wide-ranging access:

- Public health activities such as vaccination programs and public health

education are generally largely, if not wholly, publicly funded.

- The non-active populations with low income require subsidies, particularly the elderly.
- The poor also require subsidies.
- Drugs, particularly limited drug formularies, are generally subsidized.
- Health finance, more generally, is frequently government run (tax funding) or government mandated (social insurance), to address failures in the private health insurance market and to ensure adequate access for the poor.

Public production has various aspects:

- Public education is needed to counter imperfect information. Examples include programs to inform the population about diet, physical exercise, and the ill effects of alcohol, narcotic drugs, smoking, and the like.
- Other public health activities, such as maintaining clean water, need to be sponsored by the government, even if some or all of the production is in the private sector.
- Medical education and medical research, having significant public good attributes, also involve some government activity.
- Public clinics may be necessary to ensure that health care is available in rural areas and slums.

***Experience Elsewhere***. Three additional observations from the highly industrialized countries may be of critical importance to future health policies in Central and Eastern Europe.

First, public funding, whether through taxation or social insurance, is the major source of health financing in the OECD nations. Countries like the United States which rely to any great extent on private risk-rated health insurance (cells G, H, and I in figure 4) appear to have much greater problems (a) with ensuring equality of access---because of uninsurable risks and the poor---and (b) with containing costs---because of the third-party payment problem---than countries which rely on other sources of health finance. At the same time, countries like Sweden and the United Kingdom which rely heavily

on public ownership (cells A, D, G, and J) appear to have much greater problems with efficiency and productivity than countries which rely more heavily on nonprofit and private ownership. Health care financing mechanisms which rely on general revenues or national health insurance, combined with some direct charges and nonprofit or private ownership, would appear to be a much better choice for Central and Eastern Europe than private health insurance and public ownership.

Second, direct charges on their own are not effective as a major source of finance. Providing financial protection against the unpredictable risk of illness and the high cost of modern health is the main reason why pooling risk through third-party prepayment schemes has become the cornerstone of health finance over the course of the twentieth century. Direct charges, although they may play an important role in financing less expensive care and discretionary services, provide neither adequate protection against the risk of catastrophic illness nor a sufficient source of financing for expensive health care, typical of modern health systems. As a result of these factors, direct charges contribute less than 20 percent of the financial resources available to the health sector in most Western countries. Governments in Central and Eastern Europe must balance the expected benefits of introducing copayments as a disincentive against excessive use and as a source of additional revenue against their negative impact on vulnerable populations during the transition. So far, none have formalized the gratuities or black payments which are characteristic throughout the region.

Finally, no system is perfect. Significant tradeoffs between efficiency and equity are associated with each of these mechanisms. Greater equity at the macroeconomic level may be achieved through the risk-pooling characteristic of prepayment schemes. Greater efficiency at the microeconomic level may be achieved through the market forces associated with direct charges. Governments in Central and Eastern Europe, like those in the OECD countries, are finding that neither model by itself is ideal.

The main message is that in the case of medical care, a carefully designed blend of market forces and government intervention is needed. As

market forces are introduced in Central and Eastern Europe, problems with cost containment, quality assurance, and equity are beginning to appear. To counter these effects, many governments are now rewriting the social contract for the health sector based on policies which (a) protect highly vulnerable populations, such as mothers, children, and the elderly, through targeted entitlement to specially designed services, (b) secure affordable access to a basic basket of cost-effective health services for the whole population, and (c) distribute the financial burden of illness across the population as a whole.

## Implementing the Reforms

Alongside policies to improve health and those to increase the cost-effectiveness and equitable distribution of health care, a third set of policies is seeking to improve the political and institutional capacity of the health sector to implement relevant reforms. This effort includes introducing new legislation, strengthening the physical and administrative infrastructure of institutions, and reorienting the training of personnel.

Most governments have introduced a new legal framework for the legitimate entry of the private sector (private ownership and provision of health services), syndicate activities by the medical profession and other professional groups, and decentralized decision making. Poland has passed the Health Care Institutions Bill legalizing private practice, Hungary and the Czech Republic have transferred ownership from the central government to local communities, and Russia has vested Oblasts with almost autonomous power over their health services, similar to the Canadian provinces or the states in Australia.[9] The Physicians Chambers in Poland was the first professional body to gain the status of a self-regulating medical syndicate, with responsibility for setting professional standards and negotiating collectively. Many countries are passing new regulations to control the quality of pharmaceuticals and medical equipment.

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[9] Russia is divided into eighty-four Oblasts.

Although countries such as Russia and other former Soviet republics are still struggling with critical imports of pharmaceutical products and other nondurable goods, the Czech Republic, Hungary, and Poland are concentrating on building an infrastructure for the health sector. This includes new diagnostic and therapeutic equipment to improve clinical interventions, computer systems to improve cost control and management, and limited public works to consolidate outmoded and inefficient physical facilities. Since catching up with standards in Western Europe would cost billions of dollars, governments are finding that it is critical to establish clear priorities. Without such priorities, every community hospital will attract gifts of CAT scanners or other expensive high-technology equipment from bilateral lenders without having the recurrent budget to operate them effectively.

As many countries in Central and Eastern Europe are decentralizing and privatizing their health services, they are finding that clinical and nonclinical personnel need much broader training in such fields as health policy, management, health economics, chronic disease epidemiology, computer science, and medical sociology than was either necessary or possible in the past. Modern management skills and data analysis are required to cope with the complexity of many of the new health insurance systems. The success of many of these reforms will lie in a fundamental new orientation in the education system and applied research in the health sector.

## Conclusions: Priorities and Sequencing

In most of Central and Eastern Europe, a collapse in the public enterprise sector, inflation, and unemployment have reduced the real income of large segments of the population and created a fiscal crisis. The resulting poverty deprives the population of exactly the healthy living arrangements, diets, and life-styles which are necessary for good health. At the same time, reduced tax revenues make it impossible for governments to maintain their historical commitment to public expenditure programs like health care, just at the time when they are most needed. Of necessity, therefore, most governments are cautiously introducing reform in the health sector in two phases.

Short-term Policies

The first phase (up to two years) concentrates on urgent measures which need to be taken or avoided to survive the early transition. The following actions are not intended to be exhaustive but rather to focus on critical measures which must be taken by government to avoid a collapse of the health sector and to strengthen its role as part of the social safety net.

First, policy should ensure continuing delivery of basic health services and cost-effective acute critical care. This includes:

- Ensuring that the share of GDP devoted to the health sector is maintained during the transition, either through the state budget or through some form of national health insurance.
- Providing immediate relief of critical shortages in areas where the health system is collapsing. Of particular importance is action to guarantee the continuing availability of essential drugs and supplies.
- Allocating an adequate budget for services designed to protect vulnerable populations. These include maternal and child clinics, immunization programs, and social services for the elderly.
- Selecting and implementing cost-effective corrective interventions, especially for cardio/cerebrovascular and related diseases, accidents, and pulmonary diseases. This includes maintaining properly equipped and staffed ambulance services, emergency rooms, and intensive care units.

Second, measures to contain costs should focus particularly on avoiding actions likely to lead to a cost explosion. This entails:

- Introducing hard budget caps, such as global budgets for hospitals and salaries, or capitation payments, for doctors and other health care workers. Such action is vital to contain costs during the transition. Other forms of reimbursement, such as fee-for-service payments and itemized retrospective payments, would be difficult to control and, unless accompanied by wide-ranging and sophisticated regulation, would lead to exploding costs.

- Avoiding the fool's gold of using health insurance as a way to mobilize additional financial resources for the health sector. The introduction of such a mechanism would be premature. During the early transition, the potential contributions base was shrinking because of rising unemployment and a growing informal sector; in addition, an adequate mechanism for collecting contributions suitable for a system of health care finance based on social insurance has yet to be put in place in most countries.

Medium-term Policies

Policies with a medium-term dimension could be started immediately, or in the near future, if the short-term issues just described are addressed at the same time. Since their impact will be mainly in the medium term, policymakers must ensure that measures taken to restructure health services do not destabilize and lead to a collapse of the sector during the transition. Excessively rapid decentralization and changes in the financing mechanisms could have just such an effect, particularly if they are introduced before the institutional capacity necessary to implement such changes has been built up. Many of these, therefore, are being left for a second phase of the reform process. The actions listed below are of four broad sorts: those which relate mainly to improving the quality and mix of actions to improve health, those aimed at improving the efficiency with which those services are delivered, those which relate mainly to health finance, and those intended to improve institutional capacity.

First, new and more effective approaches to public health and disease prevention should be introduced. Actions include:

- Mobilizing greater community participation in health promotion and prevention programs
- Launching national campaigns to promote healthier eating habits, to reduce alcohol and substance abuse, to discourage smoking, and to encourage greater physical activity
- Providing safe alternatives to abortion through extended family planning programs

- Coordinating an intersectoral approach to occupational and behavior-related illness and accidents.

Second, imbalances between public health, primary care, institutional care, and community services require correction. The emphasis should be on:

- Setting up or improving training programs in primary care, public health, and community services
- Increasing the intake of students into these programs and restricting the intake into specialist training
- Raising the income of primary care, public health, and community service workers relative to other clinical specialties
- Increasing the relative weight of investment in primary care, public health, and community service facilities and programs relative to hospital-based care
- Setting up professional bodies to improve the status of individuals who choose a career path in these areas.

Third, efficiency should be improved with particular focus on:

- Containing costs through regulatory mechanisms and hard budget caps
- Stimulating productivity through performance-based reimbursement for the health sector, such as capitation payments for general practitioners, case-mix adjusted budgets for hospitals, outcome-based reimbursement for specialist services, and changes in ownership (transfers to local government or privatization)
- Encouraging competition among providers.

Fourth, a new public/private mix should be established in the provision of health services. This would involve:

- Creating a legal framework which facilitates appropriate private sector activities in the health sector
- Setting up accessible loan facilities for doctors, dentists, laboratory technicians, and other health workers who want to set up private

practice or private clinics

- Removing subsidies from the public production of pharmaceutical products, medical equipment, and supplies
- Introducing publicly mandated financing of privately owned health care facilities.

Fifth, the sources of health care financing should be diversified by:

- Introducing national or government-mandated contributory health insurance
- Adding copayments to some goods and services
- Excluding above-standard services from publicly financed programs
- Eliminating public subsidies such as tax credits from nonessential services and private health insurance.

Finally, institutional capacity should be strengthened through legislative reform; consolidation, rehabilitation, and renewal of basic infrastructure; modernization of equipment; upgrading the training of personnel; and improved quality control systems.

Again, this list is not intended to be exhaustive but rather to focus on early action which can be taken to strengthen and reconstruct the health sector. Even in the medium term, few governments are planning to expand dramatically the physical infrastructure of their health sectors. Such investment is being postponed until there are signs of significant economic recovery, which, in some countries, may be many years away.

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Cover design by Walton Rosenquist


ISBN 0-8213-3331-3





Preker/Feachem
**Market Mechanisms and the Health Sector in Central and Eastern Europe**
The World Bank