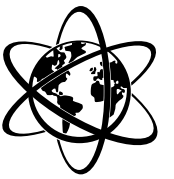
International Review of Administrative Sciences



Market-based health care reforms in Central and Eastern Europe: lessons after ten years of change

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Abstract

After 1989, all Central and Eastern European (CEE) countries implemented large-scale health care reforms. The changes differ among CEE countries, depending very much on the specific conditions present at the start of and during the processes. However, there are some common issues — most notably, the introduction of several market-based instruments, including introducing health insurance financing systems to replace general taxation-based models, privatization and the introduction of private payments and co-payments. Much was expected as the outcome of the changes. However, recent evidence indicates that many expectations from the 'marketization' of health care were not fulfilled. Such failures confirm that the transformation processes in CEE countries cannot be based just on the simple transfer of western good practice. The success of the implementation of new approaches has been a function of the effective combination of western and local expertise and the respecting of the specific local environment. One must be able to predict (as much as possible) the impact of new mechanisms in specific transitional conditions. The inability to do this has come at great cost to the citizens of the region.

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Vol 72(1):11–26 [DOI:10.1177/0020852306061611]

Introduction

After 1989, all Central and Eastern European (CEE) countries implemented large-scale health care reforms as they tried to convert a 'socialist' model of a health care system into a 'modern' one. The starting point was relatively similar, even though certain differences existed between countries. The aim of the 'old' systems was to provide a comprehensive system of health care for all members of society, free at the point of use. All decisions on health care were generally made on political or administrative grounds, and the only accountability was to the Communist Party.

The changes after 1989 differ among the CEE countries, depending very much on the specific conditions present at the start and during the processes. However, there are some common issues among the health reforms in CEE countries — most notably the introduction of several market-based instruments to reform 'socialist' systems of the delivery of health services. The most important 'market changes' were the introduction of health insurance financing systems to replace a general taxation-based model, privatization and the introduction of private payments/co-payments.

A lot was expected as the outcome of the changes. However, recent evidence assessing the outcomes of health reforms in CEE countries indicates that many expectations from the 'marketization' of health care were not fulfilled. This paper analyses certain selected aspects and outcomes of introducing market-based instruments into the health care systems in the CEE countries.

Health care reforms in CEE countries

In this mainly descriptive part, we want to present four brief case studies of the main steps and measures of health care reforms in selected CEE countries — Armenia, the Czech Republic, Russia and Ukraine. Actually, these case studies are drawn from a larger group of eight much longer and highly detailed case studies that also included Albania, Bulgaria, Georgia and Slovakia. Each case study was carried out by a country-based scholar or team. The selection of countries was done in a way to cover the region in the best possible comprehensive way; the main factors taken into the account were geographical location, size and level of economic development.[1]

Armenia[2]

Armenia inherited a highly centralized and bureaucratic health care system from the Soviet Union that was managed and financed solely by the state. The structure was vertical, strictly hierarchical and political party-influenced, and it provided little freedom of health care choice to the population. The centrally organized budget system prevented flexibility and adjustments to different local needs. The lack of reliable health care data on all major matters made it impossible to assess correctly the situation and to develop appropriate strategies to identify and solve problems in health care delivery. Moreover, much of the data that did exist were made to fit standards and expectations prescribed by the state. Despite the proclaimed guarantee of free medical assistance regardless of social status, the practice of unofficial extra payments to receive good medical treatment was common.

The Armenian reform, as described below, could be characterized by the following main dimensions:

- decentralization, privatization;
- change in the health finance system;
- attempts (limited) to maintain some access for the poor.

The sociopolitical and economic upheavals that followed the devastating 1988 earthquake, combined with the political collapse of the Soviet Union, created a catastrophic public health situation in Armenia. After gaining independence, Armenia did not have the finances required to sustain the existing health care system, which was expensive, unmanageable and inefficient. The government of Armenia identified the urgent need for a radical reform program in the health sector, and the National Health Policy Program was developed in 1996–98.

The Armenian government has introduced radical health care system reforms that accept that health care cannot be provided free of charge. However, the government understood the need for a health care package for the most vulnerable populations, and the central feature of health care reform was the introduction of the Basic Benefits Package (BBP) in 1996. The BBP is 'a tool that has been widely used throughout the NIS as state health systems transform themselves from ones in which all expenses are covered by the state toward mixed systems in which state budget transfers are augmented by formal patient co-payments and, in the case of Armenia, subsidies to pay some of the transition costs from the World Bank' (PADCO, 2002).

The Ministry of Health has placed considerable importance on the optimization of the health care system, privatization and the introduction of medical insurance. Large institutional changes in the governance of the health care sector have been made. The Ministry of Health, previously overstaffed, was greatly reduced in size. It remained responsible for policy formulation, formulating reforms and overseeing their implementation. The responsibilities of the Ministry of Health also include monitoring the population's health status, determining the terms of medical education, licensing and regulation and setting standards.

There have been four major changes in the legal status of health care facilities during recent years as the facilities were transformed from organizations funded from the state budget to state non-commercial companies. In January 1995, all health care facilities were transformed into state enterprises. In 1997, another change was introduced as part of the decentralization of the health care system: all health care facilities were reconstituted as non-commercial state joint stock companies following the passage of the 1996 Law on Joint Stock Companies. After enactment of the Law on State Non-Commercial Organizations in November 2001, health care facilities were required to be reconstituted as state non-commercial organizations (SNCOs). By law, only the Republic of Armenia is allowed to create an SNCO.

In order to separate the provision of health care from the financing of health care, the State Health Agency was established. Although the Ministry of Health remained accountable for health care policy and provision, the responsibility for financing was transferred to the State Health Agency. The Agency acts as a third-party player that

distributes the state allocations to health care facilities and takes full responsibility for the management of state financial resources.

Czech Republic[3]

While the Czech (Czechoslovakia at that time) health system was operating relatively well, there was a need for significant changes even before 1989. Health professionals spoke openly about the rising crisis in the system. The fall of the former Communist regime opened the door for radical reform. The first reform proposal was published in 1990. The Working Group for Reform (SKUPR), representing a large part of the health professionals communities — mainly physicians, academics and economists — advocated the following reform principles, which were more or less realized in future reforms (SKUPR, 1990):

- transparency;
- economization;
- democratization;
- humanization; and
- a higher standard of quality of care.

The new system brought especially radical changes in organizational and institutional structures, funding and reimbursement methods. An important part of the reform was the separation of payers and providers of care. A new participant in the system was established — Health Insurance Companies (HICs). A contractual model replaced an integrated one. Existing institutions (so-called Institutes of National Health, or UNZs) were transformed into a network of independent, relatively autonomous health care facilities that became regular legal entities making decisions in their own name. While there were only about 430 health care facilities in 1991, by 1995 more than 22,000 existed. A physician's private practice was considered to be an independent health care facility, for example. New non-state and private facilities were founded. State institutions were transferred to municipalities, some hospitals were privatized, and most outpatient care also was privatized.

The transformation from a model funded through the government budget to a system of compulsory, universal public health insurance was possibly the most important element of the reform. There were several reasons for such a strategic decision:

- It was important to keep the current level of broad access to care for all citizens as a central pillar in the new system.
- Health insurance has had a long tradition in Czechoslovak history and also is quite common for the Czech Republic's neighboring countries in Central Europe.
- There was a widespread belief that it was necessary to introduce new methods of reimbursement for providing medical care — methods reflecting the quantity and quality of care.
- Insurance (and the contractual model) creates an environment that is friendlier for the privatization of medical services.
- Last, but not least, one objective was to make financial flows more transparent and to inform the public about the real costs of (i.e. the expenditures on) medical

care; the belief was that this approach would create an incentive for the general public to be more responsible and take better care of their own health.

The whole system was designed as a multiple payer system. HICs are not-for-profit, public-law, self-administered entities, although special legislation (adopted in 1991–92) strictly regulates their functioning. HICs are open; citizens may choose their insurers.

Health care is funded from several sources. The main source is public insurance premiums collected by HICs. Employees, employers and the government pay insurance premiums, with the amounts based on income. Out-of-pocket payments create less than 10 percent of total expenditures (mainly for drugs); public budgets have played a more important role here.

Russia[4]

When Russia was an integral part of the USSR, health care was financed and provided by the state, with the private practice of medicine a rare exception. While significant achievements of this earlier system are generally recognized, some major drawbacks are also well known. It is generally admitted, for example, that this system, which showed positive outcomes in times when the principal aim of health care was to fight infectious diseases, could not ensure the proper level of treatment of chronic illnesses (these illnesses constituted an increasing share in the morbidity structure). The health care system continued to expand and become broader (e.g. setting up new polyclinics and hospitals, training more professionals). However, Soviet leaders and researchers did not give adequate attention to the problems associated with increasing the health care system's efficiency when the resources allocated by society to health care decreased with the slowdown in economic growth.

The transition to a market economy and decentralization of decision-making inevitably led to reform in health care. This reform has been strategically carried out through the introduction of compulsory health insurance (CHI) and the decentralization of health care financing and management. The principles of CHI, and the mechanisms of its implementation, were articulated in judicial documents that include the 1991 Law on CHI. The following arrangements were introduced:

- CHI with universal coverage;
- health insurance contributions to be paid by employers for the employed, with local administrations paying for the unemployed;
- a basic CHI program of compulsory medical insurance (CMI), including a minimum set of medical services provided by the CMI system, had to be adopted at the federal level, and regional programs could not have a lesser scope than the federal one;
- individuals, as well as organizations, could participate in voluntary health insurance; and
- the system of CHI Funds — the federal fund of CHI and the regional funds of CHI — were to be set up as independent state non-commercial credit and monetary agencies to ensure the comprehensive character of CHI, the achievement of social justice (equality within the CHI system) and its financial stability.

The CHI funds were to accumulate with contributions to the CHI. These resources were then to be transferred to health services either directly or via special health insurance companies (HICs) created as independent non-profit organizations. The main functions of HICs were to conclude contracts with health services (e.g. hospitals, polyclinics); to reimburse them for medical services provided for the insured; to defend the interests of the insured; and to control the quality of health care.

By the year 2000, the federal fund of CHI, 90 regional funds of CHI (with 1129 branches) and 362 HICs had been set up in Russia. At present, CHI funds are regionally based in two respects: first, regional CHI funds are independent bodies, but not branches of the federal fund of CHI (as is the case, for example, with the national pension fund). Second, CHI funds collect contributions from employers, on the one hand, and from regional administrations, on the other hand. The employers' CHI contribution is fixed at 3.6 percent of payroll, divided between the federal CHI fund (0.2 percent) and a regional CHI fund (3.4 percent) covering only the employees and not including their dependents. The CHI contributions of regional authorities are to cover medical treatment for those not employed (e.g. children, pensioners).

Development of the CHI itself has also encountered serious problems. First, it is characterized by some extreme irregularities, in particular, a grave problem of the inability to use insurance policies issued by a regional fund to get medical treatment outside the fund's area. Moreover, by 2000, only about 30 percent, or 8210 health services that included 5649 hospitals, 1900 primary care/polyclinics and 661 dental clinics, had joined the CHI system.

As a result, three CHI models have emerged during the health care reforms. In some Russian regions, reforms have developed as planned by the legislation in force. Regional CHI funds accumulate the resources and conclude contracts with HICs, which act as insurers and deal directly with health services. Thus, CHI money is received by the latter through the HICs. In 15 regions, the only funds of CHI that function are those that collect money and act as insurers. HICs have not been set up there, and health services receive money from funds from CHI or their branches directly. In the rest of the regions, a combined system has been formed, with funds of CHI and their branches, as well as HICs acting as insurers. Their shares vary substantially, though, depending on the region.

A second serious problem encountered in the development of the CHI concerns the collection of payments to CHI. Enterprises, as well as regional administrations, often do not fulfil their commitments. In many regions, health authorities are unwilling to make contributions for the economically non-active population. According to the federal fund data, the share of payments by employers amounts to about 60 percent of expected CHI receipts, whereas contributions for the unemployed are about 26 percent.

At present, on average, more than 65 percent of the resources to cover health care needs come from the budgets of different levels of government, including 80 percent from local budgets, with the remaining resources (close to 35 percent) being CHI's share. There are substantial regional variations in CHI's share of total health care expenditures; percentages fluctuate from 2 percent in the Saratov region to nearly 78 percent in the Samara region.

Ukraine[5]

The Ukrainian health care sector had a long-established tradition of good medical provision and was among the best in the USSR. However, during the communist era in Ukraine there was a centralized health protection system, which possessed the characteristics of a totalitarian regime of state authority, had a highly developed administrative and bureaucratic nature and was not receptive to change. Non-governmental structures of preventive and general health protection services did not function and the financing of the health system was provided overwhelmingly through the state budget. Such important mechanisms as medical insurance and private medical practice were not used. These historic conditions have created the gradual alienation of the health protection systems from the basic tasks of health services for citizens and have become obstacles for reforming the existing conditions of the current transitional period in Ukraine.

The Ukrainian reform focused on similar aspects as in other CEE countries — decentralization, privatization and the introduction of health insurance. The basic focus of this reform has been the change of the health protection financing system by dint of a gradual transition from a one-source budgetary system to a multi-channel financing one. Formally the public health policy strategy of reform in Ukraine has focused also on achieving the aim of providing economic effectiveness and quality medical care, with the preservation of its accessibility for the whole population.

In the sphere of health, in line with reforms elsewhere in CEE, the Government program proposed to strengthen primary health care on the basis of family medical practice, develop a system of health insurance and create the conditions for private medical practice. A key feature of the current situation in Ukraine is the low level of remuneration for doctors and other health care staff. In regions outside the capital, nonpayment of wages remains a huge problem. In many cases, trade unions work closely with hospital management but many problems remain: low morale and poor working conditions, lack of equipment, unsatisfactory health and safety for employees, and irregular pay and imposed administrative leave for personnel.

Concerning decentralization, currently there are three basic hierarchical levels of health management in Ukraine: base (community), regional (oblast) and national, which are closely associated with one another. The base level covers rural and urban administrative regions. In the rural administrative regions (rayons) a chief doctor of general practice leads the territorial unit. At the same time, he/she is the chief doctor of the central rayon hospital. He/she leads the functions in the health care system performed by the rayon administration and works within the administrative sub-system of the rayon central hospital.

At the regional (oblast) level, the management of health care is somewhat different. Here, health agencies exist within the system of town or city authorities and they are led by a department head. Under the department head is a group of administrators composed of the main specialists (such as physicians, surgeons, pediatrists, etc.). This management system exists within the administrative structures of town or city hospitals.

The national ministry performs many regulatory (often controlling) functions in health care including managing the development of health establishment networks;

supervising the regional organization of medical care; control of regulations for sanitary protection; realization of arrangements for the prevention of infectious diseases; control over the regional health expenditures and labor protection regulations.

Concerning finance, the national budget for health care is directed toward the financing of socially important medical, sanitary and health programs, including immunization, grants for medicines to preferential population categories, extraordinary arrangements regarding epidemics, subsidizing of certain territories with the aim of making health care conditions of the population equal and to stabilize financial possibilities, etc. However, none of the national programs in the field of health care are being implemented in full. The rest of the costs should be provided by private funds, including the system of health insurance.

By the share of GDP channeled for health care, Ukraine lags behind not only developed countries (where expenditures on public health are close to 8 percent of the GDP), but also countries with average and even low incomes, where the indicator is equal to 4 percent of the GDP. In 2000, Ukraine spent only 2.7 percent of GDP for this purpose. According to the WHO standards, expenditures on public health should be not less than 5 percent of the GDP; otherwise the health system becomes not only ineffective but unmanageable. As a result, in Ukraine, experts estimate that the need of the population for medical services is satisfied at the level of a mere 30 percent of minimal requirements.

Outcomes of the health reforms

Massive changes of health systems have been realized in all CEE countries, with common reform measures focusing on introducing market-based tools into the system — especially privatization and health insurance-based systems of financing care. It was expected that such reforms would increase the quality, efficiency and effectiveness of the health system and would not negatively influence dimensions of access and equality.

Experience shows that most such expectations were not fulfilled, but there are major differences between countries, depending very much on the economic situation of the country. Recent European Union members (Czech Republic, Slovakia) are much better off compared to former Soviet Union members, where the health systems almost collapsed. In the comparative analysis that follows, we briefly show what happened with regard to the most important dimensions of health care system performance — life expectancy, access and finance.

Life expectancy Although a country's health care financing system has only a limited impact on the health status of its inhabitants (the potential of health care financing to influence health status is estimated to be between 10 and 20 percent), some links do exist. The life expectancy data in Table 1 show distinctly different patterns with respect to the health status of inhabitants in CEE countries — in some CEE countries, the health status is improving, but in other countries, it is significantly declining. A lack of financial resources, including financial resources for health, and citizens' lifestyle (with no resources to change or influence it), are likely to be among the most important factors underlying these life expectancy differences.

Table 1 Changes in life expectancy in selected CEE countries: 1970–75 to 1995–2000

Country	Life expectancy: 1970–75	Life expectancy: 1995–2000	Change (%)
Slovenia	69.8	75.0	+ 7.4
Czech Republic	70.1	74.3	+ 6.0
Slovakia	70.0	72.8	+ 4.0
Poland	70.4	72.8	+ 3.4
Hungary	69.3	70.7	+ 2.0
Romania	69.2	69.8	+ 0.9
Lithuania	71.3	71.4	+ 0.1
Bulgaria	71.0	70.8	– 0.3
Latvia	70.1	69.6	– 0.7
Ukraine	70.1	68.1	– 2.9
Russia	69.7	66.1	– 5.2

Source: UNDP (2003).

Second only to problems of finance, the nature of the reforms may represent the most significant problem. All of the delivery system reforms have been 'clinical' type reforms, and prevention has been almost totally neglected. Even comparatively well-developed Bulgaria currently devotes only 1 percent of national health expenditures to health promotion and disease prevention.

The problem of the worsening health status is highlighted by the case of Georgia. Reliable conclusions about the dynamics of mortality and morbidity in Georgia cannot be drawn from the country's inefficient data collection system. According to official statistics, mortality has declined; however, experts estimate that the mortality rate has increased steadily from 6.4 in 1996 to 8.2 in 2000 (Tsuladze and Maglaperidze, 2000). The difference may be explained by the fact that a considerable number of deaths are not registered. In rural areas, for example, there is no real need to register deaths, which are associated with expenses.

The numbers reflecting cases of diseases per 100,000 inhabitants are also not absolutely reliable due to inefficient registration and the unreliability of data on population size. Prior to the 2002 census, the last census was conducted in 1989. After 1989, considerable migration occurred, which was largely unregistered. This, together with the low rate of attendance at health care facilities, points to morbidity rates higher than those reported through registration and presented in statistical compendia. Data from the Center on Health Statistics and Information (Healthcare, 2002) demonstrate the steady deterioration of the health of the population, beginning from the onset of reform (see Table 2).

The reasons for the deterioration of the health of the Georgian population do not lie entirely in ineffective health policy and improper management; the health of the population has deteriorated also due to the wider spectrum of problems which the country now faces. The budget of the country is meager. Poverty, which is spread among more than half of Georgia's population, has a manifold and complex impact on health. It does not allow a person to seek professional assistance in case of illness,

Table 2 Number of cases of diseases by nosology in Georgia per 100,000 inhabitants

No.	Disease	1996	1997	1998	1999	2000	2001
1	Infectious and parasitological diseases	671.3	738.2	729.1	715.9	659.3	945.3
2	Tuberculosis	*	*	*	*	133.4	128.8
3	Sexually transmitted illnesses	37.2	66.2	77.6	45.6	33.5	50.3
4	AIDS and HIV	0.2	0.4	0.5	0.7	1.8	2.1
5	Neoplasms	482.5	475.1	501.9	539.9	557.4	586.6
6	Diseases of endocrine system	320.2	329.7	246.8	313.2	333	306.5
7	Mental disorders	1554.9	1689	1850.9	2193.2	2192.6	2338.5
8	Diseases of circulatory system	3124.1	3221.3	3527.1	4524.7	4257.4	4838.1
9	Diseases of respiratory system	*	*	*	*	3382.8	3532.7
10	Diseases of urinal system	296.8	304.7	351.2	529.5	476.9	569.2
11	Diseases of digestion system	1555.7	1021	863	899.4	628.9	902.7
12	Diseases of nervous system and sense organs	363.7	459.9	644.9	781.9	718.6	800

* Data are not available.

and it also causes illness or contributes to its development due to malnutrition, low education, lack of exercise, bad sanitation conditions, air pollution and water and soil contamination.

High medical costs relative to income do not allow much of the population to seek professional help. According to a United Nations Development Program survey, only 27.5 percent of those who said they needed medical help visited the doctor (UNDP, 2002). In 1991, 179,377 people underwent surgery; while in 2000 the number was only 69,360. In 1991, 1,164,685 people used emergency services; while in 2000 only 150,645 did. People now go to medical institutions only in extreme cases, when effective help is often already impossible. Rather, people seek informal advice from friends about how to treat the symptoms, and then they take medication on the basis of such advice. This pattern often leads to further aggravation of patients' health conditions. The purchase of drugs without prescriptions and without consultation with doctors is a common practice in Georgia.

The situation in Ukraine is very similar. Every year, up to 70 million cases of illness are registered in the country, every second Ukrainian may be considered seriously ill. Diseases of social origin, such as tuberculosis and HIV/AIDS, are especially widespread. According to the Ukrainian Institute of Public Health, only 4.4 percent of Ukrainian males and 2.9 percent of females are in good health and are in the so-called safe zone; the health of 22.1 percent of males and 19.4 percent of females may be called average; while 73.5 percent of males and 77.7 percent of females have one or another degree of a disease.

Access to care The trends concerning access to health care services are relatively similar in all CEE countries. Accessibility to services and equality of access are decreasing, but in different degrees. As noted earlier, access and equality are still the primary formal features of health systems in Central and Eastern Europe (even though they have not been fully achieved — and are not achievable). However, they have largely disappeared from the health systems in less developed countries.

The focus on access is well illustrated by the case of Slovakia. The 1998 Slovak government's Programmatic Statement (see www.government.gov.sk), prepared at the time of an increasing financial crisis in the system, is representative of this view:

> The government will guarantee generally accessible and high quality health care for all citizens. Within the frames of the basic health insurance is assured to any citizen equal access to and equal quality of basic health services.

In reality, inequality in access is increasing everywhere. To a large extent, it is the result of the deepening financial crisis and the unofficial shifting of the financial burden to citizens. These inequalities are aggravated by the existence of an informal health economy.

Again, a typical example might be Ukraine. Formally, according to the contents of its health reform strategy, Ukraine has focused on achieving economic effectiveness and providing quality medical care, while at the same time preserving accessibility for its entire population. However, the government has been unable to maintain access by all citizens to medical care and treatment. Access is increasingly limited because of insufficient public financing of the health care system and the transition to a system of 'paid medicine' in the country. These factors have reduced the network of medical institutions available to citizens and led to a shortage of (free) medicines for the sick, as well as a constant fear of ill health, inadequate treatment and even total impoverishment.

A similar case is Albania. Because of the lack of access to health care and poor conditions in hospital and health centers, the health care system has the problem of 'under-the-table' payments to doctors (a growing problem in many of the CEE countries). More than three-quarters of the population (80 percent) have admitted paying an illegal fee to doctors, and it is the people in the rural areas and those who are less educated and poor that cannot afford these payments.

Even in Slovakia, where waiting lists exist for specialists, unequal treatment occurs, because there are no formal and effective rules for deciding which patients receive precedence in treatment. Also, in the case of hospital care, it is common to make additional illegal or non-legal payments for extra services, e.g. a separate room. It is

likely that a systematization of these practices will be introduced through additional co-insurance. Access is not always equal because of corruption and other factors. There are no Patients' Charters, and complaints generally find no responsive addressee. This is important, because more than two-thirds of Slovaks claim that they have had to pay bribes to ensure good health care (Miller et al., 1998); the likelihood that Slovaks must offer bribes to medical doctors is estimated to be about 89 percent. A recent unpublished study financed by the World Bank estimates that bribes amount to 10 percent of health costs (1 billion USD).

Health finance The development of insurance systems might be expected (at a minimum) to bring important positive changes to health care finance, especially as concerns increased efficiency in the delivery of services. Because of its controversial character and the reform implementation failures, such expectations have not been fulfilled in any of the CEE countries.

The short-term outcome resulting from the introduction of health insurance (and other market mechanisms) in health care has been increased costs (relative to the resources available) — and especially increased costs for drugs and hospital services. It might be argued that such rising costs were necessary due to prior underfinancing of the health care system and the opening of the system to the importation of expensive foreign drugs and equipment. Nevertheless, the growth was too fast, clearly showing that insurance systems did not serve to contain costs.

The cost-containment problem is highlighted by developments in the most progressive countries, where economic performance has not constrained the financial situation of the health care system so dramatically. The data from the first reform phases in the Czech Republic and Slovakia (Tables 3 and 4) highlight the problem of growing costs very well (health insurance was introduced in 1992 in the Czech Republic and in 1993 in Slovakia).

Data confirm that the limited resources available cannot be viewed as the primary cause of the poor financial performance of the health care systems in countries like Slovakia or the Czech Republic. Since there is limited opportunity to increase revenues, the focus should be on cost containment measures to improve the efficiency and economy of the system in order to balance demand, supply and resources available. However, very little has been done in this regard during the entire period since 1989. The most important inefficiencies could be defined as excessive employment, low economic performance of hospitals and ineffective drug regulation policies.

The core of the problem can be highlighted by the example of Slovakia. The analysis of the economic performance of the system shows that health care reform measures did not have a significant positive impact on the economy of the health care system and the main problems causing inefficiencies, mainly:

- oversupply of medical personnel, especially doctors;
- oversupply of facilities, mainly hospital beds;
- lack of capacities to manage demand (rationing);
- ineffective management of hospitals;
- ineffective drug management; and

Table 3 Total health expenditure in Czech Republic and Slovakia

	Country	1991	1992	1993	1994	1995	1996
Total health expenditure (bill. CZ/SK crowns, current prices)	CZ	39.5	45.7	73.0	88.9	100.9	115.8
	SK	17.5	19.1	17.8	21.6	31.8	38.2
Health expenditure as % of GDP (bill. CZ/SK crowns, current prices)	CZ	5.3	5.4	7.3	7.8	7.6	7.8
	SK	5.9	6.4	5.3	5.7	6.2	6.6

Source: Radičová, I. and M. Potůček (1997).

Table 4 Expenditure for drugs in Czech Republic and Slovakia

	Country	1991	1992	1993	1994	1995	1996
Total drug expenditure (bill. CZ/SK crowns, current prices)	CZ	7.7	12.3	14.2	21.3	25.7	28.3
	SK	3.3	4.5	6.3	6.3	8.6	10.0
Drug expenditure as % of GDP (bill. CZ/SK crowns, current prices)	CZ	1.03	1.45	1.42	1.86	1.95	1.90
	SK	1.17	1.35	1.71	1.43	1.67	1.72
Expenditure for drugs per capita (CZ/SK crowns, current prices)	CZ	747	1192	1375	2061	2488	2744
	SK	618	853	1189	1174	1603	1861

Source: Potůček and Radičová (1998).

- limited prevention and lack of incentives to protect the health status of the patient.

The data on hospital performance presented in Table 5 serves to illustrate this point.

These problems persist and are solved largely by imposing new costs on the private sector and the consumers of health care. Instead of stimulating stronger pressures for higher efficiency within the system, the system created debts and penalizes private sector suppliers for problems caused primarily within the system by government health professionals and health establishments. This solution of shifting the debt burden out of the public health care sector clearly shows that the development of relations between the state and other sectors is still far from international

Table 5 Individual performance of staff in hospitals in Slovakia

	1996	1997	1998	1999	2000	2001
Number of diagnoses per employee	1064	862	844	839	823	835
Number of diagnoses per doctor	8311	6729	6462	6278	6041	6110
Revenues per doctor (SK)	2,478,107	2,473,468	2,366,756	2,166,794	2,309,061	2,541,271
Revenues per nurse (SK)	807,704	795,539	772,538	734,652	803,901	889,445
Revenues per employee (SK)	317,186	316,748	309,053	289,451	314,767	347,342
Costs per employee (SK)	342,973	332,994	355,175	358,614	363,248	392,534

Source: Zajac and Pažitný (2002).

standards, leaving too much space for the state to manage its own problems (e.g. an imbalance between resources available and the scale of 'free' services promised to citizens) by using the resources of others, in this case mainly the private sector and patients, who are pushed to pay bribes to get appropriate services.

Conclusions: reassessment of the 'marketization' of health care

The decisions for 'marketization' were heavily influenced by foreign advisors, like the World Bank and the International Monetary Fund, and by their politico-ideological orientation. Often, specific local conditions (objective and subjective) were not taken into the account. A key issue is the specific character of health and health care. There is more or less common agreement among all economic theories that health and health care cannot only be the individual responsibility of citizens and that it is inevitable that the state should have a specific role. Basic economic and socio-economic arguments support such state interventions, based on the allocative and redistributive roles of government (Stiglitz, 1989). 'Social economy' and the social sciences go beyond this, and suggest that there is a need for a generally accessible health service delivery and public health system. And experiences from developed countries (like UK 'quasi-market' reforms) confirm that the market alone cannot answer most of problems of health care delivery. Taking this into account, the heavy focus on marketization during the CEE reforms represented a very risky approach.

Apart from specific regional problems, probably the crucial objective issue in all countries was finance, which was tied to the level of economic performance of the country. Health reforms started to be realized in the period of more or less massive decline of GDP per capita in most CEE countries.

The second issue was introducing 'marketization' of health care in the period when many potentially competitive markets in the CEE transitional countries were still not well developed. Even in the most developed countries, like Slovakia and the Czech Republic, the financial markets did not function in the first half of the 1990s; banks and insurance companies (most of them state owned) were not stable. The creation of a functional health insurance 'market' in such an environment was very difficult.

Health reform 'actors' also did not perform as in the 'standard conditions' of developed countries. Health reforms were not well thought through conceptually, and there was inadequate preparation for their implementation. Many controversies have arisen as a consequence. For example, in Russia regional administrators are entitled to define the amount of their contributions to health insurance systems, taking into account the structure of the regional population and its health status; at the same time, contributions by enterprises and organizations are fixed by federal legislation, and a fine is imposed for non-payment. As a consequence, the state often intervenes when the market is working, and does not intervene in cases where the market fails.

Almost everywhere the state formally accepted 'marketization', but in reality tried not to give up control over the health care system, allowing politicians and bureaucrats to 'benefit'. Thus, often, the state was acting in contradictory ways:

- On the one hand, introducing health insurance and certain other market-type mechanisms into the health care system, and it was willing to use the potential benefits of market-based regulation in the area.
- On the other hand, the state limited the scope for competition and independency by permanently intervening in the health insurance system, by frequently changing the rules and by many indirect mechanisms.

The outcomes of such an approach are straightforward: the blocking of most potentially positive impacts of the insurance-based system of financing, and monopolizing the system by direct and indirect mechanisms. A lot of resources were devoted to introducing a health insurance system, but these resources often have been spent just to replace one type of state monopoly in the financing of the health care by another type of state-controlled system.

There are other factors, but even this short list of reform barriers clearly indicates the major sources of failures connected with health reforms in the CEE countries. The transformation processes in CEE countries cannot be based just on the simple transfer of western good practice. The success of the implementation of new approaches is based on an effective combination of western and local expertise, and on respecting the specific local environment. One must be able to predict (as much as possible) the impact of new mechanisms in specific transitional conditions. This has been confirmed at great cost to the citizens of the region.

Notes

1 This research has been supported by the Open Society Institute, New York and also by the grant agency of the Czech Republic (Reg. No. 402/02/P124). The overall project was directed by Allan Rosenbaum, Juraj Nemec and Kenneth Tolo and administered through the Network of Institutes and Schools of Public Administration in Central and Eastern Europe (NISPAcee).

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