

Health Care Modernization in CEE

Taking Stock: How Far Have We Come - And What Are Next Steps? (More Questions than Answers....)

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Accomplishments and lessons from
the past decade of modernization,
investment and reform....



Change During Last Decade

- Slowly improving health status, but low user satisfaction
- Separation of funding from provision, mostly Social Insurance (but rarely contractual relationship)
- High growth rates of (mostly private) providers and increase in providers revenue
- Devolution of ownership structure of hospitals, high debts to suppliers
- High pharma costs – high growth of brand penetration
- From budget to fee-for-Service to budget caps to DRG experimentation
- Where funding fragmentation - increasing administrative costs (>3%)
- Public Health modernization lagging



Structural Problems

- Long-term fiscal sustainability threatened at already high levels of expenditure and debts (Maastricht...!)
- Consumer demand will continue to rise... and new technologies are cost drivers:
 - Wages
 - Pharmaceuticals
 - Technology
- Excess capacity/uneven distribution of resources
- Over- consumption?
 - Drugs (much higher than OECD or EU average at 25-35%)
 - Cash benefits and sick leave
- Inefficiencies at the continuity of care-interface
- Aging (disability and social cases in acute care)



Cost-efficiency at Microeconomic Levels

- Demand Side

- Cost sharing
 - Austria: 70/30%
Public/Private
(20%=OOPP)
- Gate keeping GPs
 - Issue = Payment systems
- Limits on coverage of statutory package
 - Create competitive supplementary insurance market+regulation

- Supply Side

- Purchaser-Provider Split
 - (Selective) Contracting
- Payment systems
 - DRG, Capitation, etc.
- HTA
 - Public agency (NICE in UK; ANDEM in France)
- Provider Competition
 - Good attempts in CEE
- Management
 - Decentralization
 - HR policies



Lessons from Central Europe (1)

- **Balance public statutory and private financing**
 - Defined package of statutory insurance
 - co-payments for publicly paid services
 - supplementary/complementary private insurance
 - some risks to be shifted to private risk pools
 - Equity/access should be over-riding concern
- **Provide incentives for efficiency and quality**
 - pooling funds
 - Active + selective purchasing
 - performance based funding of health care providers
- **Strengthen Primary Health Care**
 - gate keeping – continuum of care
- **Modernize Public Health,**
 - Surveillance, DDM



Lessons from Central Europe (2)

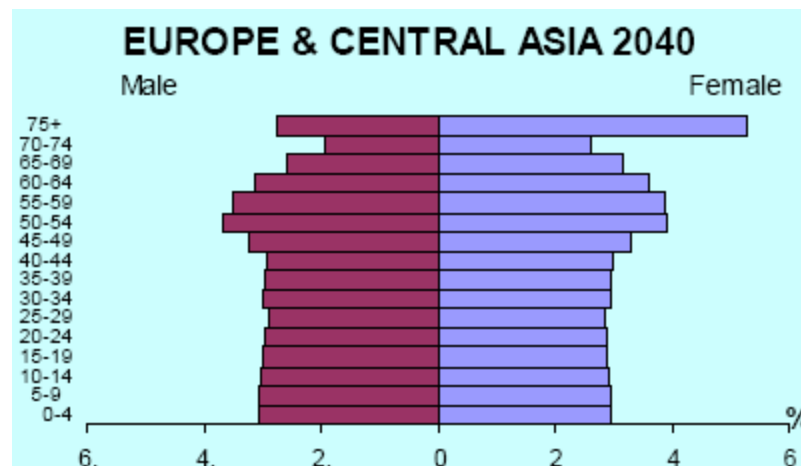
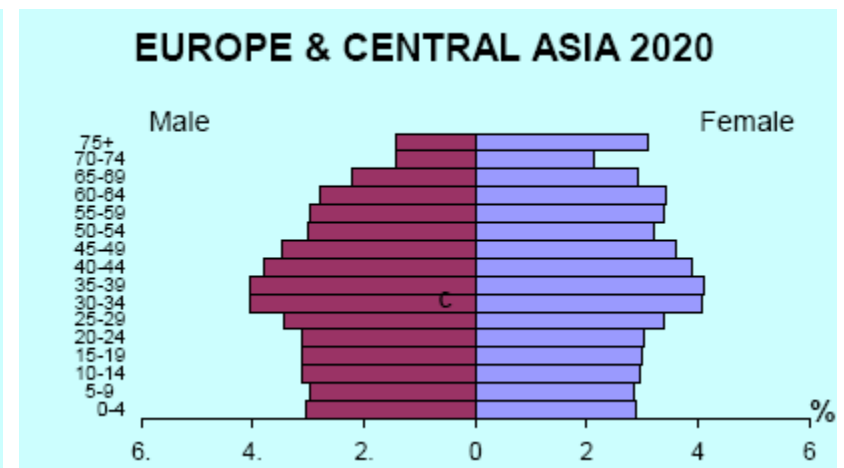
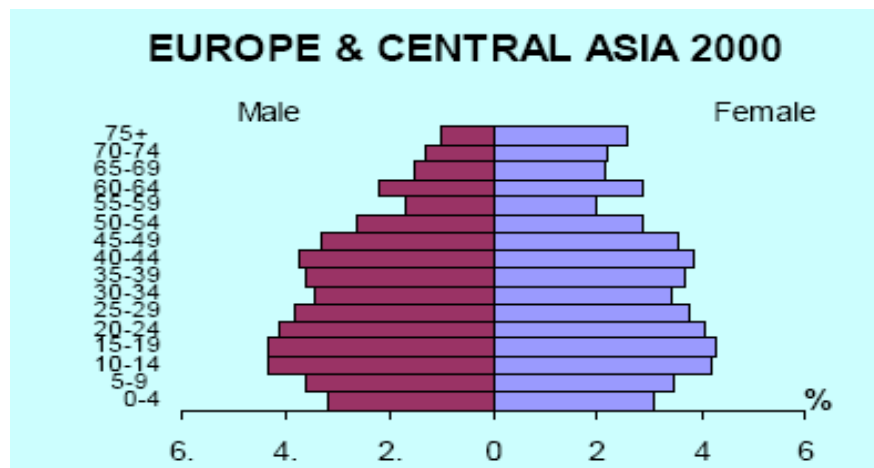
- **Contain pharma costs**
 - no single solution, all available instruments used
 - broad reference pricing, regulating wholesale-retail margins, substitution for generics, prescription guidelines and monitoring, feedback to physicians, drug budget holding for group GPs.....etc.
- **Optimize hospital capacity**
 - Address debts, autonomy, networking
- **Management and governance reforms of health care providers**
 - Decentralisation; autonomy; privatization, networking
- **Capacity building**
 - evidence based medicine, public health, health management, health economics, self-regulation



One of the most important new challenges which will require new thinking and preparedness across a number of sectors is the demographic change in Europe



Anticipate Demographic Changes – Future Health and Long-Term Care Needs

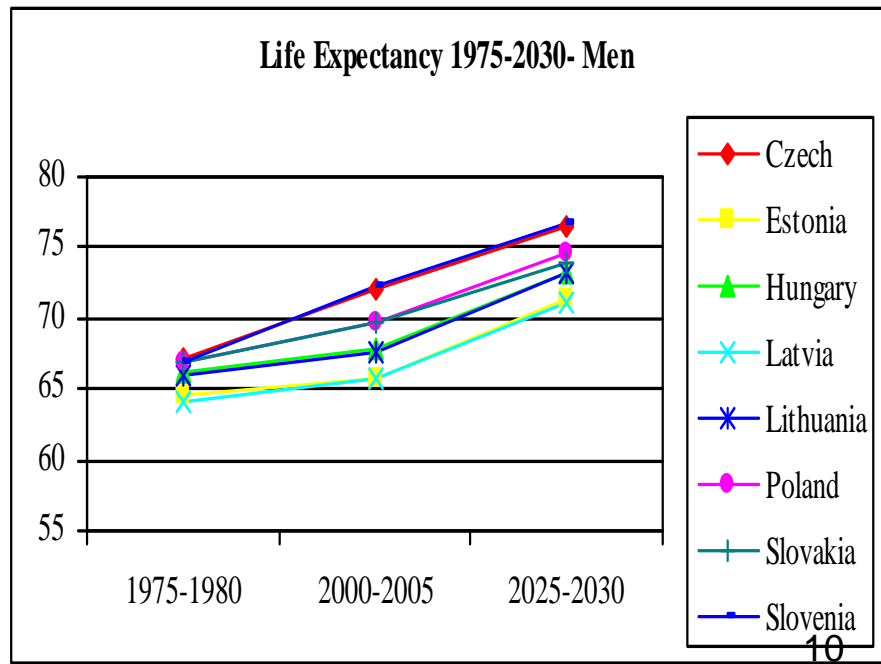
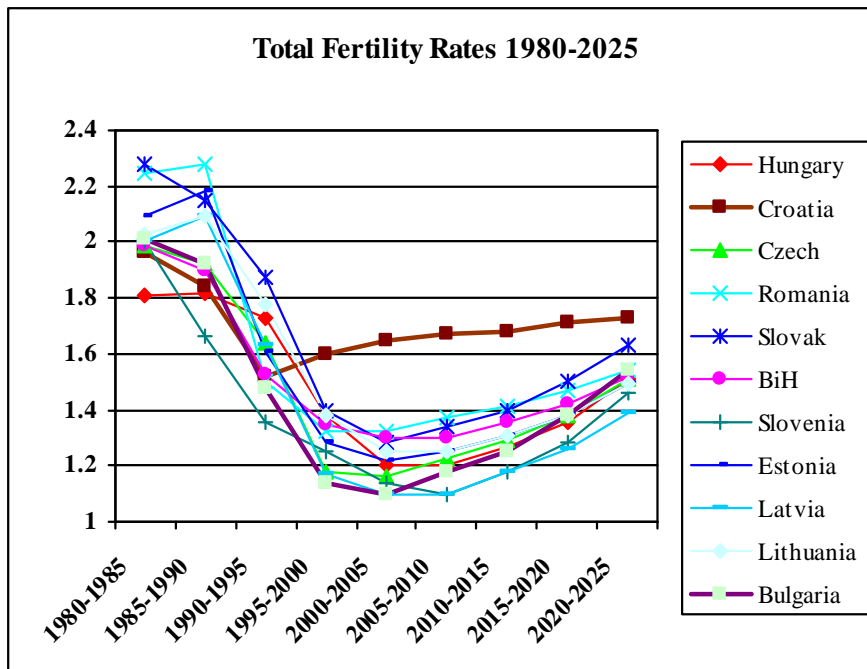
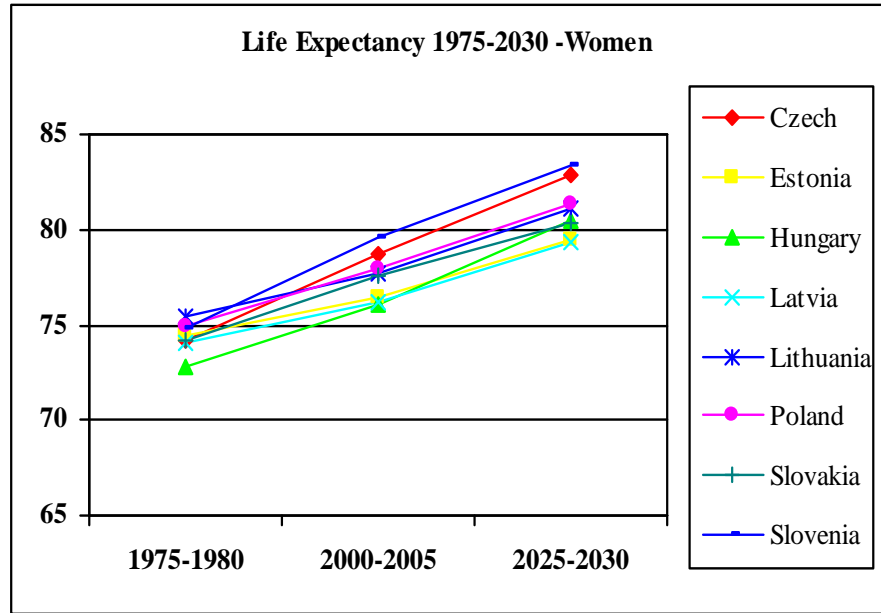


Source: World Bank,
HNP Stats, 2004



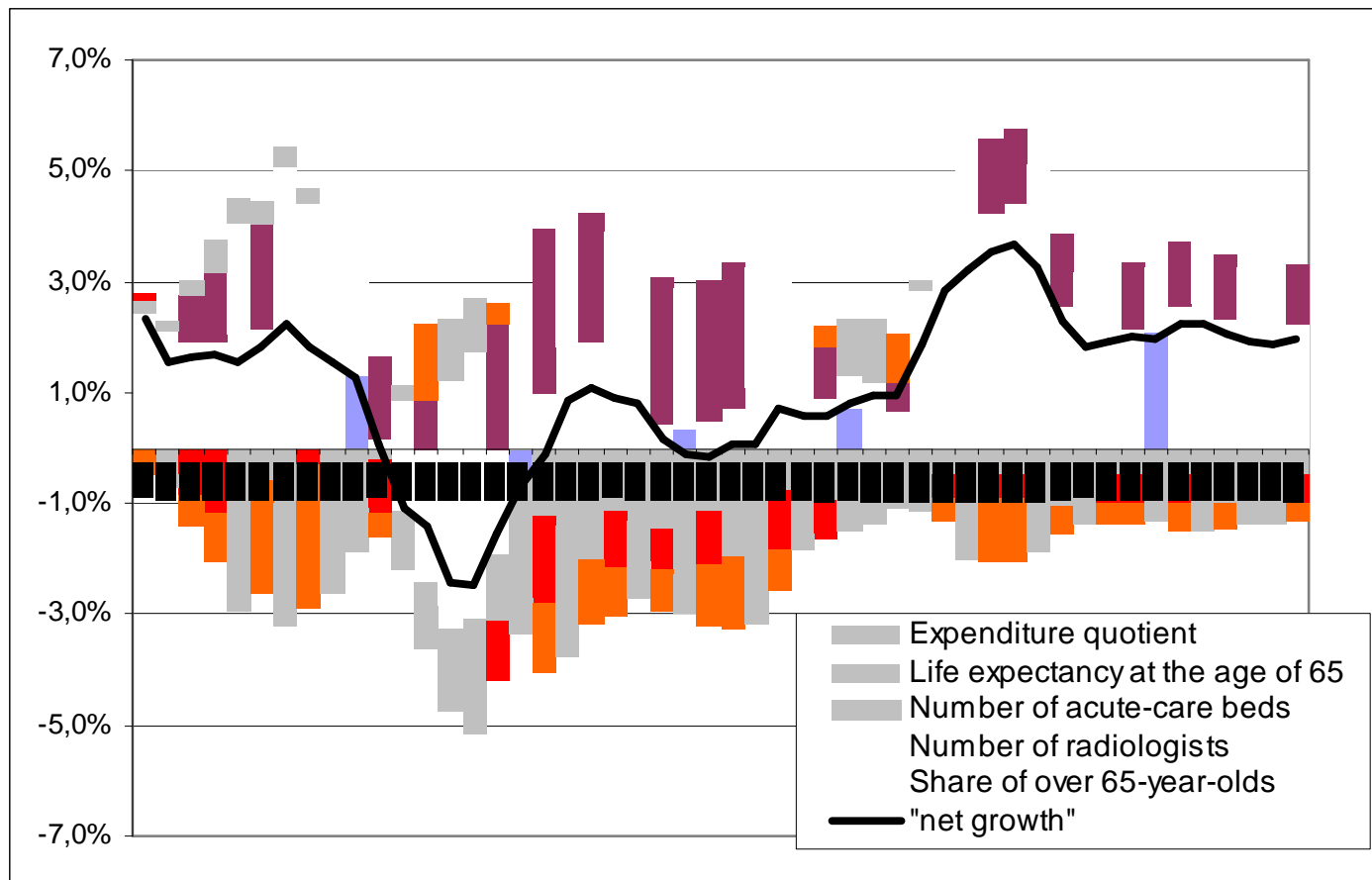


Demographic shift caused by falling fertility rates and increasing longevity



Austrian Model: Supply and Demand Factors and Expenditure Growth

Scenario „neutral“, growth rates in percent

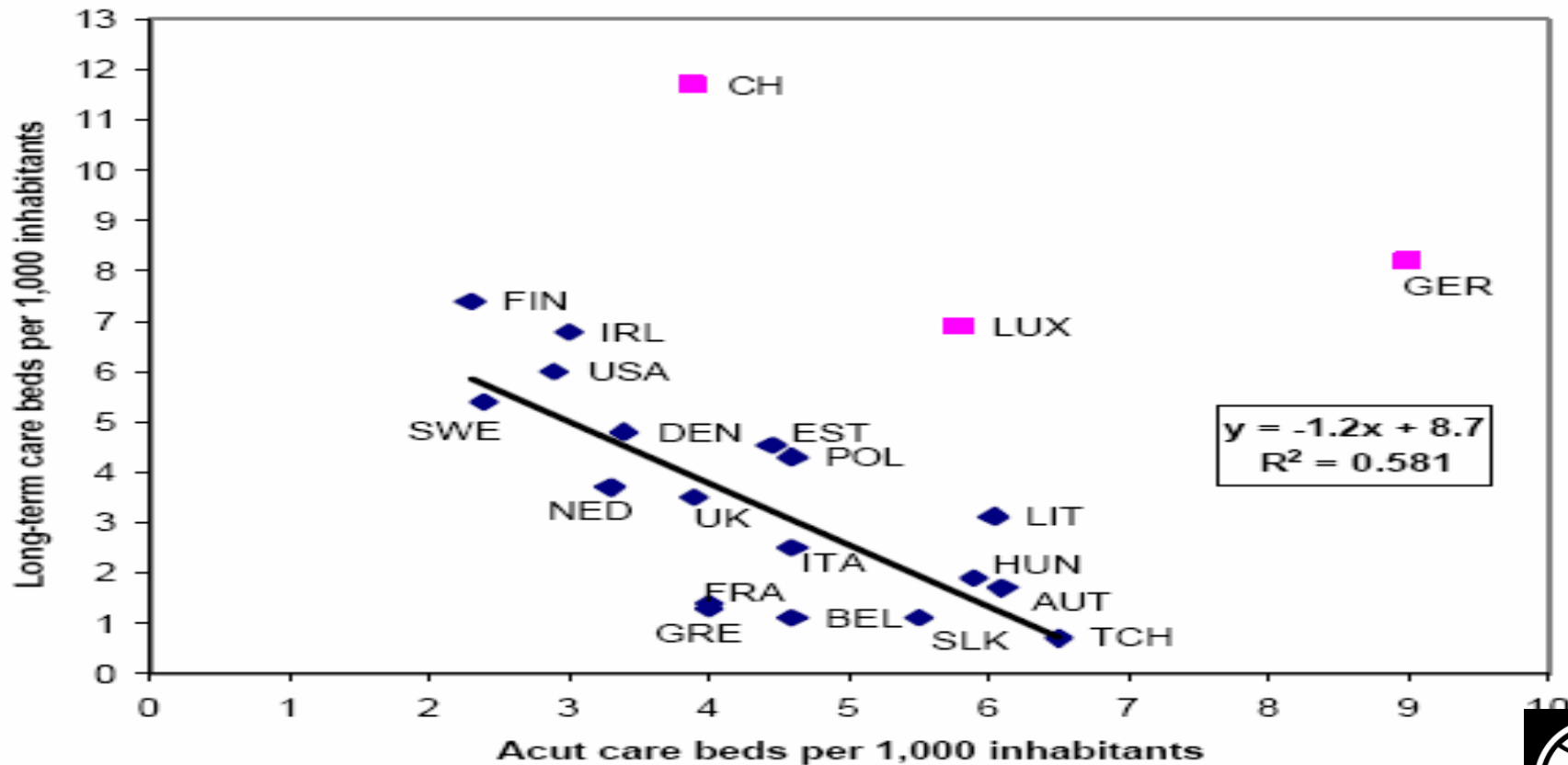


Long-Term Care Funding/Coverage

Country	Service	Funding	Coverage
A	Nursing Home Personal Home care	General Taxation	Universal
D	Nursing Home Personal Home care	Contributions	Universal
IRL	Nursing Home Personal Home care	General Taxation	Means-tested
L	Nursing Home Personal Home care	General Taxation Contributions	Universal
NL	Nursing Home Personal Home care	Contributions	Universal
E	Nursing Home Personal Home care	General Taxation	Means-tested
S	Nursing Home Personal Home care	General Taxation	Universal
UK	Nursing Home Personal Home care	General Taxation	Means-tested



LTC versus Acute Care Beds



Source: OECD Health Data, WHO Health for all, 2004; IHS HealthEcon calculations 2004.

In the end, one of the most important factors will be finding a formula for sustainable financing of the sector.

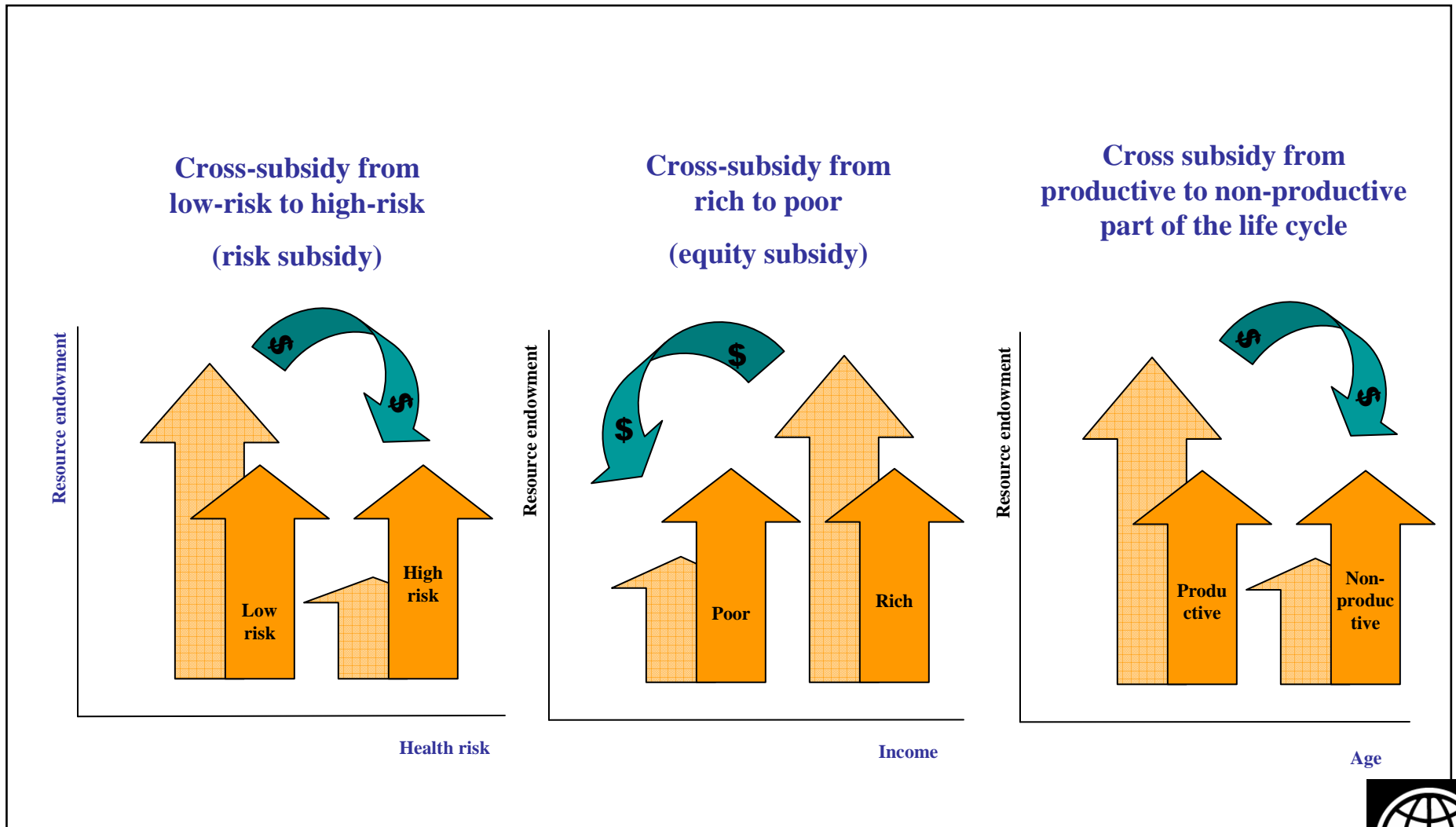


Tax System Criteria

- Revenue adequacy and stability: the tax should raise a significant amount of revenue, be relatively stable, and be likely to grow over time
- Efficiency: minimizes economic distortions
- Equity: should be fair in terms of the treatment of different income groups
- Ease of collection: should be simple to administer
- Political acceptability: transparency, broad diffusion, and clarity about the uses of the tax promote acceptability



What do We Mean by Risk Pooling?



Voluntary Health Insurance

(Financed through private voluntary contributions to for- and non-profit insurance organizations, care provided in private and public facilities)

Strengths

- As a prepayment and risk pooling mechanism is generally preferable to out of pocket expenditure
- May increase financial protection and access to health services for those able to pay
- When an “active purchasing” function is present it may also encourage better quality and cost-efficiency of health care providers

Weaknesses

- Associated with high administrative costs
- Not effective in reducing cost pressures on public health financing systems
- May be inequitable without public intervention either to subsidize premiums or regulate insurance content and price
- Has the potential to divert resources and support from mandated health financing mechanisms
- Requires well developed financial markets and strong regulatory capacity



Efficient Purchasing is Essential

- What care will be produced?
- How will care be produced?
- How much care will be produced?
- What level of 'quality' will be produced?
- To whom will care be offered?
- What kinds of care and how much will consumers 'demand'/access?
- By what method, how much, and by whom will providers be paid and/or consumers reimbursed?



Case Studies (1)

- From SHI to tax financing: **Iceland and Spain**
 - **Iceland**
 - Transition period – 1972 to 1989
 - Sickness funds retained but financed by tax payments from the state and local governments
 - **Spain**
 - NHS introduction in 1986 marked shift to tax funding
 - SHI contributions slowly decreasing over time



Case Studies (2)

- Tax subsidization of duplicate private health insurance plans: **Australia**
 - Incentives to join private/voluntary health insurance plan before age 30
 - Coverage through VHI increased by 14.3% to 45.3% between 1996 and 2001
 - Questionable success
 - Health expenditures increased from 8.5 to 9 percent of GDP between 1995 and 2000



Case Studies (3)

- Medical savings accounts: **Singapore**
 - Medisave: 6-8% of income paid into a MSA
 - Funds invested in capital market by govt.
 - Used to pay for hospital costs and select out-patient costs
 - Medishield: Supplemental catastrophic health coverage
 - Medifund: for low-income individuals, financed by state from general taxes



Summary and Outlook:

Reform will never end –

constant recalibration necessary....

- MoH stewardship – intergovernmental action
 - Health outcomes!
- Insurance and payment reform
 - Public vs. private
- Restructure providers networks - Continuum of care
 - Shrink to fit – but improve quality
- Public health reform:
 - DDM
- Medical Education
 - (+ management + economics)
- Information Technologies
 - Most critical, but most difficult to procure and run effectively
- Fiduciary/corruption
 - Regulation, self regulation, consumer protection, consumer information, role of press

