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Choice and Solidarity: The Health Sector in Eastern Europe and Proposals for Reform

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The citizens of Eastern Europe have witnessed an unprecedented social and economic transformation during the past decade of transition from socialism to market-based economies. We describe the legacy of socialism and summarize the current state of the health sector in ten Eastern European countries, including financing, delivery, purchasing, physician incomes and the widespread phenomenon of under-the-table payments. The proposals for reform, derived from explicit guiding principles, are based on organized public financing for basic care, private financing for supplementary care, pluralistic delivery of services, and managed competition, with attention to incentives and regulation to impose a constraint on overall health spending.

Keywords: health systems, Eastern Europe, transition economics, health care reform

JEL classification: I10, I18, P20, P30

Introduction

The citizens of Eastern Europe have witnessed an unprecedented social and economic transformation during the past decade of transition from socialism to market-based economies. Health sectors have been swept up in the dramatic changes, which reflect a starting point of ownership, financing, organization and ideology almost the opposite of that of the US and quite different from many other established market economies.

This article describes the current state of the health sector in ten countries of Eastern Europe: Albania, Bulgaria, Croatia, the Czech Republic, Hungary, Macedonia, Poland, Romania, Slovakia and Slovenia.[1] We focus on similarities, although the health sectors—just as the political and economic systems—differ in many aspects not highlighted here.

Several studies have described the health sectors of Eastern Europe and/or advocated reforms.[2] We seek to contribute to the literature by synthesizing information from many sources to present a concise, up-to-date summary of the current situation, and by offering proposals for reform tailored to the unique challenges of the region, based on explicit ethical and institutional guiding principles.

The paper is organized as follows. Section I describes the legacy of socialism and presents available data on the health sectors in Eastern Europe, including current financing, delivery, purchasing, physician incomes and the widespread phenomenon of under-the-table payments. Section II presents guiding principles for reform and recommendations regarding scope of social insurance benefits, financing, organization of insurance, delivery system ownership, contracting, payment, and regulation.

I. The Current State of the Health Sector in Eastern Europe

More than a decade ago, dramatic political events in Eastern Europe captured world attention, as the Berlin Wall fell and nations began the transition from socialism to democratic, market-based economies. How have these changes affected the health sector? The massive fall in production in Eastern Europe in the 1990s was the deepest recession so far in the economic history in these countries. However, spending on social services, including health

Exhibit 1. GDP and health spending in Eastern Europe.

	GDP per capita, USD 1990, PPP				
Country	1990	1991	1992	1993	1994
Bulgaria	5296	4157	3764	3812	3914
Czech Republic	9754	8363	7970	7623	8058
Hungary	6514	5657	5535	5605	5756
Poland	4504	4234	4206	4260	4605
Romania	4433	3706	3321	3363	3454
Slovakia	7315	6273	5977	5829	5986
Slovenia	...	8920	8191	8520	8979
	Health spending per capita, USD 1990, PPP (% of GDP)				
Bulgaria	275	226	256	196	185
	(5.2%)	(5.4%)	(6.8%)	(5.2%)	(4.7%)
Czech Republic	527	443	430	556	612
	(5.4%)	(5.3%)	(5.4%)	(7.3%)	(7.6%)
Hungary	436	385	398	415	455
	(6.7%)	(6.8%)	(7.2%)	(7.4%)	(7.9%)
Poland	230	246	265	...	309
	(5.1%)	(5.8%)	(6.3%)		(6.7%)
Romania	124	122	116	101	114
	(2.8%)	(3.3%)	(3.5%)	(3.0%)	(3.3%)
Slovakia	393	310	304	371	422
	(5.4%)	(5.0%)	(5.1%)	(6.4%)	(7.1%)
Slovenia	...	461	608	653	700
		(5.2%)	(7.4%)	(7.7%)	(7.8%)

PPP = purchasing power parity.

Source: J. Kornai and J. McHale, "Is Post-communist Health Spending Unusual? A Comparison with Established Market Economies." *Economics of Transition* 8(2) (2000): 369–399.

Exhibit 2. Population, disability-adjusted life expectancy, and WHO rankings of health system performance for Eastern Europe.

Country	Total Population in 1999 (in thousands)	Disability-adjusted Life Expectancy (years)	Health System Performance WHO Ranking (1-191)
Albania	3113	60.0	55
Bulgaria	8279	64.4	102
Croatia	4477	67.0	43
Czech Republic	10262	68.0	48
Hungary	10076	64.1	66
Macedonia	2011	63.7	89
Poland	38740	66.2	50
Romania	22402	62.3	99
Slovakia	5382	66.6	62
Slovenia	1989	68.4	38

Sources: World Health Organization, *World Health Report 2000 Health Systems: Improving Performance.*
Note: Disability-adjusted life expectancy is a summary measure of the burden of disability from all causes in the population, and can be understood as the expectation of life lived in equivalent full health. The WHO's health system performance assessment system is based on five indicators: overall level of population health; health inequalities (or disparities) within the population; overall level of health system responsiveness (including patient satisfaction); distribution of responsiveness within the population (how well people of varying economic status find that they are served by the health system); and the distribution of the health system's financial burden within the population.

spending, generally decreased less than GDP. This was one of the attempts made by all governments in the region to alleviate somewhat the severe decline in living standards caused by the transformational recession.

Exhibit 1 shows per capita health spending in selected countries of Eastern Europe, using prices that adjust for cost-of-living differences and therefore are comparable across countries. Only in the Czech Republic and Slovenia did per capita health spending in 1994 exceed the OECD average in 1970. Nevertheless, compared to per capita income, Eastern European health expenditures in the mid-1990s were in many cases sizable—close to or exceeding 7 percent of GDP in the Czech Republic, Hungary, Poland, Slovakia, and Slovenia.[3] Other countries such as Bulgaria and Romania spent considerably less. Although more recent, comprehensive and reliable data is not available for all countries, the World Health Organization estimates that the majority of Eastern European countries spent less than 6.5 percent of GDP on health in 1997 (Albania 3.5%, Bulgaria 4.8%, Hungary 5.3%, Macedonia 6.1%, Poland 6.2%, and Romania 3.8%).[4]

What did these countries buy with their health expenditures? Exhibits 2 and 3 reveal that only in a few countries (e.g., the Czech Republic and Slovenia) do health indicators come close to those of the European Union. (Indeed, according to the World Health Organization's health system performance rankings, Slovenia ranks neck-and-neck with the US). The situation in other Eastern European countries is worse to an alarming degree. Although population health depends on the combined effects of several factors, certainly if health sector performance improved, it would help to improve population health, ideally in conjunction with other favorable changes.

Exhibit 3. Infant mortality, life expectancy at birth, and crude death rate in Eastern Europe.

	Infant Mortality Rate (Deaths Per 1000 Live Births)			Life Expectancy at Birth, in Years			Crude Death Rate[1] Per 1000 Population		
Country	1990	1994	1997	1990	1994	1997	1990	1994	1997
Albania	30.9[2]	32.9	..	72.6	73.0	..	5.5[2]	5.3[4]	..
Bulgaria	14.8	16.3	14.4[6]	71.5	70.8	72.8[6]	12.1	13.2	14.7
Croatia	10.7	10.2	8.2	72.6	73.2	72.6	10.9	10.4	11.4
Czech Republic	10.8	8.0	6.1	71.5	73.2	74.1	12.5	11.4	10.9
Hungary	14.8	11.6	9.9	69.4	69.5	70.8	14.1	14.3	13.7
Macedonia	31.6	22.5	15.7[5]	71.8[3]	71.9	72.5	7.7[2]	8.1	8.3
Poland	16.0	15.1	12.2[5]	71.0	71.8	72.4	10.2	10.0	10.0[5]
Romania	26.9	23.9	22.0	69.8	69.4	69.1	10.7	11.7	12.4
Slovakia	12.0	11.2	8.8[6]	71.1	72.5	..	10.2	9.6	9.8[5]
Slovenia	8.3	6.5	5.2	74.1	74.2	75.3	9.4	9.7	9.6

[1]Crude death rate is the death rate not adjusted for differences in the composition of the population that would explain differences in death rates, such as gender and age.
[2]1989; [3]1991; [4]1993; [5]1996; [6]1998.
Sources: World Health Organization, *Health for All Database* (Copenhagen: WHO Regional Office for Europe, 1998 and 1999); OECD, *OECD Health Data 98: A Comparative Analysis of Twenty Nine Countries* (Paris 1998); National Statistical Institute, *Statistical Yearbook of Bulgaria* 1998 (Sofia 1999); National Statistical Institute, *Statistical Reference Book of the Republic of Bulgaria 1999* (Sofia 1999); Central Bureau of Statistics, *Statistical Yearbook of the Republic of Croatia 1998* (Zagreb 1999); Central Statistical Office, *Statistical Yearbook of the Republic of Poland 1998* (Warsaw 1998); Statistical Office of the Republic of Slovenia, *Statistical Yearbook of the Republic of Slovenia 1998* (Ljubljana 1998); Statistical Office of the Slovak Republic and VEDA, *Slovak Republic in Figures* (Bratislava 1999).

The Legacy of Socialism

The primary feature that Eastern Europe inherited from "classical socialism"[5] was the Soviet model of public provision of medical care. The health sector was an integral part of the command economy. A strict bureaucratic hierarchy controlled the activities of doctors, nurses and other medical personnel, who were all government employees working in state-owned hospitals, outpatient clinics, and district doctors' offices. Distribution of resources occurred mainly in a direct, physical form, allocated by bureaucratic decisions regarding input quotas, material allocations, and staffing quotas. Decision-making regarding personnel and resources devoted to health was centralized at the highest political levels. Ordinary citizens had no say at all: no choice of provider, no room for appeal. The classical socialist system was the ultimate manifestation of paternalism.

As in other branches of the classical socialist economy, chronic shortage reigned: crowding in clinics and hospitals, long queues in waiting rooms, and waiting lists for hospital beds, examinations, and long-postponed surgery. Forced substitution was common: the specialist or medicine required was in short supply, so that lower-quality substitutes were consulted or prescribed instead.

The health sector was always among the lowest priorities in the economy. The lack of resources and faulty incentives contributed heavily to the system's generally poor quality of care and technical backwardness.

On the other hand, the population benefited from a relatively comprehensive and effective system of basic public health services, and became accustomed to the government serving as a comprehensive, general insurance institution. The expectation of such a role is one of the underlying legacies of the classical socialist system, although corruption and privilege (e.g., through special attention and facilities for those with political connections[6]) marred the image of paternalist security and equal access.

In sum, state monopoly and bureaucratic centralization, coupled with the shortage economy, lead to lack of patient rights, low quality of care, and sluggish technological development. On the other hand, citizens enjoyed security, solidarity, and (at least declared) equality, albeit at an extremely low level. This system has not survived unchanged in any Eastern European country, but all confront challenges stemming from its legacy.

Redefining the Right to Provision

In some parts of the region, such as former Yugoslavia, Hungary and Poland, health sector reforms—such as quasi-market reforms in the public delivery system—took place during the market socialist period[7] preceding the political turning point of 1989–1990. For most of Eastern Europe, however, significant health sector reforms began only recently. In the initial transition from plan to market, health policy took a back seat to broader pressing issues of macroeconomic stabilization, liberalization, privatization and enterprise reform. Health reforms accelerated in the mid-1990s in several countries, but in general the transformation remains far less dramatic than in other sectors of the economy.

No country retained the unlimited, universal entitlement to health care under the socialist system, although coverage for basic medical services remains close to universal (see Exhibit 4). Most countries introduced a Bismarkian social insurance system (see Exhibit 5), restricting entitlement to those paying social-insurance contributions,[8] introducing co-payments for some services (see Exhibit 6), and excluding other services (such as dental care) from the basic benefit package of social insurance. With the sole exception of Bulgaria, Eastern European patients now have a choice of primary-care physicians (PCPs) who act as gatekeepers.[9]

Financing

Compulsory social-insurance contributions finance the majority of health services in Eastern Europe (see Exhibit 7). The contribution rates as a percentage of earnings vary significantly across countries, from the modest 3.4% in Albania to the alarming 23.5% in Hungary (see Exhibit 8). The central state budget continues to play a large role, however, through financing public health, specialized research and clinical institutions, medical education, and financing deficits of the social insurance fund. In fact, in several cases (e.g., Hungary and Croatia), the state is legally obliged to cover any fund deficit. Not surprisingly, this *soft*

Exhibit 4. The right to health care in Eastern Europe.

Country	Basis of Entitlement[1]	Basic Coverage[2]
Bulgaria	Citizenship until June 1999, since then contributions	Almost universal
Croatia	Contributions	Copayments for house calls by a doctor or nurse, all visits to a doctor's office, and certain preventive examinations/tests
Czech Republic	Contributions	Universal except for dental care and cosmetic surgery
Hungary	Contributions	Universal except for dental care and cosmetic surgery
Poland	Citizenship until 1998, since then contributions	Almost universal
Romania	Citizenship until 1998, since then contributions	Almost universal
Slovakia	Contributions	Universal except for dental care and cosmetic surgery
Slovenia	Contributions	Almost universal, with universal copayment

[1]Wherever the German model was introduced, it was stipulated in principle who pays contributions for whom. Countries differ as to whether children are insured through their parents' contributions (as, for instance, in Hungary and Bulgaria) or through contributions paid by the government (for instance, in the Czech Republic and Slovakia). The contributions covering the health care of old-age pensioners are generally paid by the government or by the pension fund. In practice, the government in several countries (in the Czech Republic, Hungary and Slovakia) has pruned its contribution payments, thereby reducing the central budget deficit and raising the deficit of the social insurance organization.

[2]Pharmaceuticals have ceased to be prescribed free of charge throughout the region (see Table 6).

Sources: WHO, *Health Care Systems in Transition. Czech Republic* (Copenhagen: WHO Regional Office for Europe 1996); WHO, *Health Care Systems in Transition. Slovakia* (Copenhagen: WHO Regional Office for Europe 1996); WHO, *Health Care Systems in Transition. Bulgaria* (Copenhagen: WHO Regional Office for Europe 1999); WHO, *Health Care Systems in Transition. Croatia* (Copenhagen: WHO Regional Office for Europe 1999); WHO, *Health Care Systems in Transition. Poland* (Copenhagen: WHO Regional Office for Europe 1999); OECD, *Economic Survey, 1999. Hungary* (Paris 1999); NERA, *The Health Care System in Romania* (London: PPBH 1999); M. Toth, "Health reform in Slovenia" (Manuscript 1997).

budget constraint has lead to sustained and sizable social insurance fund deficits in those countries, in contrast to nations without such a guarantee (e.g., Slovenia; see Exhibit 9).

Provincial and local governments also have important responsibilities for health care financing, although the resources available are not always commensurate with new mandates. The health sector is far from immune to the strong tensions between central and local government that are commonplace in other sectors.

Private financing, through voluntary insurance and out-of-pocket (both legal and illegal or semi-legal) payments, plays a role in almost all countries in the region (see Exhibit 10). Voluntary private medical insurance is most common in Slovenia. In 1998, almost 70 percent of Slovenians purchased supplementary insurance from the National Health Insurance Institute, either as individuals, or through trade union or special pensioner contracts. These

Exhibit 5. Shift toward the German model of social insurance in Eastern Europe.

Country	Year of Introduction	Autonomy	Controlled by the Government	Notes
Bulgaria	1999–		Yes up to 2000	
Romania	1999–	Yes		Since 1999, geographically decentralized SIFs[1]
Poland	1999–	Yes		Since 1999, geographically decentralized SIFs
Albania	1994–		Yes	Restricted SIF finances only drug reimbursement and PCPs
Czech Republic	1992–	Yes		Since 1993, decentralized, competing, nonprofit health-insurance funds
Slovakia	1994–	Yes		Since 1993, decentralized, competing, nonprofit health-insurance funds
Hungary	1991–	Yes up to July 1998	Yes from August 1998	
Croatia[2]	1945– (1993)	Yes		
Macedonia[2]	1945– (1991)		Yes	
Slovenia[2]	1945– (1992)	Yes		

[1]SIF stands for social insurance fund.
[2]For an explanation of the two dates see main text.
Sources: WHO, *Health Care Systems in Transition. Czech Republic;* WHO, *Health Care Systems in Transition. Slovakia;* WHO, *Health Care Systems in Transition. Bulgaria;* WHO, *Health Care Systems in Transition. Croatia;* WHO, *Health Care Systems in Transition. Poland;* OECD, *Economic Survey, 1999. Hungary;* personal communication by the Romanian Ministry of Health; Toth, "Health reform in Slovenia".

policies, which mostly cover patient co-payments, account for about 12 percent of Slovenian health care expenditure. Private medical insurance in Hungary, Poland, and other countries is increasing, but from a very small base. If proper account could be made of the extent of semi-legal "gratuity" payments to providers, however, the scope of private financing would appear much larger than the official figures reveal, as we discuss further below.

Delivery

The legacy of socialistic planning is clearly evident in the region's health-care delivery system. One of the well-known symptoms of the chronic shortage economy was that shortage and surplus existed side by side throughout the economy. Relatively poor countries such as Bulgaria have more doctors and hospital beds per capita than the OECD average (see Exhibit 11). At the same time, doctors' waiting rooms are overcrowded, and patients must wait a long time for certain kinds of tests and procedures.

Delivery: Public Institutions

The vast majority of the institutions providing health care have remained in public ownership, although rights of control have actually shifted considerably since the classical period.

Exhibit 6. Presence, absence, size, and sphere of copayments in Eastern Europe at the end of the 1990s.

Country	Pharmaceuticals	Outpatient Care	Inpatient Care
Albania	Yes, different reimbursement categories[1] On average 25%	No	No
Bulgaria	Yes, for all outpatient care, and in practice in hospitals as well	Appreciable except in cases of referral. Planned: 1% of minimum wage/visit	Appreciable except in cases of referral. Planned: 2% of the the minimum wage/day, for max. 20 days annually
Czech Republic	Yes, different reimbursement categories[1] On average 10%	No, except for the material costs of one or two dental treatments	Yes, in institutions for chronic bed-ridden patients and for extra hotel services
Croatia	Yes, appreciable	10%	Yes, appreciable
Hungary	Yes, different reimbursement categories[1] On average 30%	Appreciable except in cases of referral	Yes, in institutions for chronic bed-ridden patients and for extra hotel services
Macedonia	20%	20%	10%
Poland	Yes, different reimbursement categories[1]	No	No
Romania	Yes, appreciable	No	No
Slovakia	Yes, different reimbursement categories[1]	No	No
Slovenia	Yes, different reimbursement categories[1]	Family doctor, 0–25% Dental care, 0–85% Other outpatient care, 0–85%	5–15%

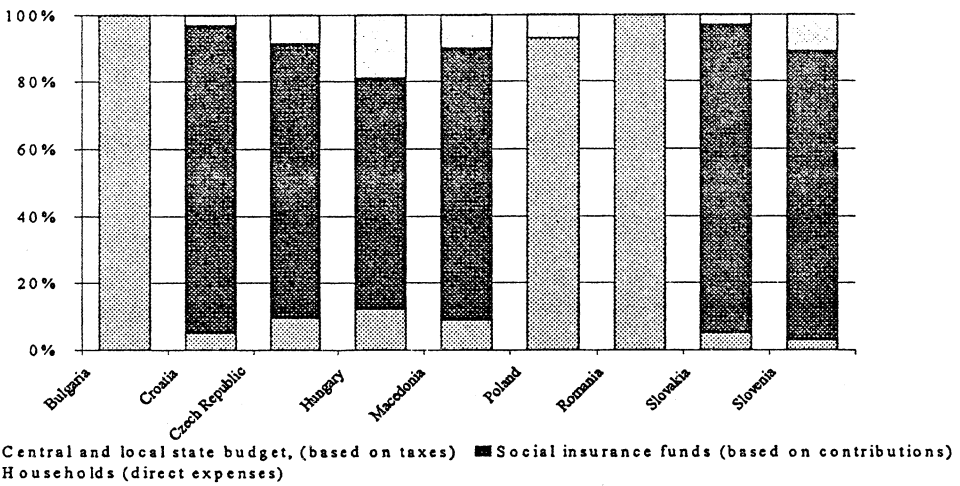
[1]Most countries have introduced a differentiated system of subsidies for pharmaceuticals. The copayments may vary according to the type of drug and according to the patients' social situation. Some must be paid for by the patient entirely and some receive government subsidies according to a set amount.

Sources: M. Chen, and M. Mastilica, "Health care reform in Croatia: For better or worse?" *American Journal of Public Health* 88, (1998): 1156–60; PHARE, *Recent Reforms in Organization, Financing and Delivery of Health Care in Central and Eastern Europe in Light of Accession to the European Union,* (Brussels: PHARE Conference, 24–26 May 1998); NERA, *The Health Care System in Hungary* (London: PPBH 1998); personal communication by Ventsislav Voikov (Bulgaria).

Here too the collapse of the command economy has made itself felt, although the curious combination of independence and dependency of public health-care institutions is reminiscent of the role and situation of industrial state-owned enterprises during the market-socialist period.

- In most countries, doctors working in hospitals and other public institutions qualify as civil servants, ranked in the bureaucratic hierarchy according to their position and seniority. Although a manager in principle enjoys independence in operative decision making, intervention from superiors is ubiquitous.
- Even though in principle hospitals must cover their expenditures out of their revenues, in practice, they repeatedly exceed their budgets. The outcome is usually a bailout by the central or local state budget. Attempts to deny such assistance result in enormous

Exhibit 7. Sources of health care financing in Eastern Europe, 1997



Sources: OECD, *Czech Health Care System. Delivery and Financing,* (Prague: Czech Association for Health Services Research 1998); M. Bútora and T. W. Skladony (eds.), Slovakia 1996–1997. *A Global Report on the State of Society* (Bratislava: Institute for Public Affairs 1998); WHO, *Health Care Systems in Transition. Bulgaria;* WHO, *Health Care Systems in Transition. Croatia;* WHO, *Health Care Systems in Transition. Poland;* OECD, *Czech Health Care System. Delivery and Financing* (Prague: Czech Association for Health Services Research 1998); PHARE, *Recent Reforms* (Appendix); personal communication by the Romanian Ministry of Health; Toth, "Health reform in Slovenia".

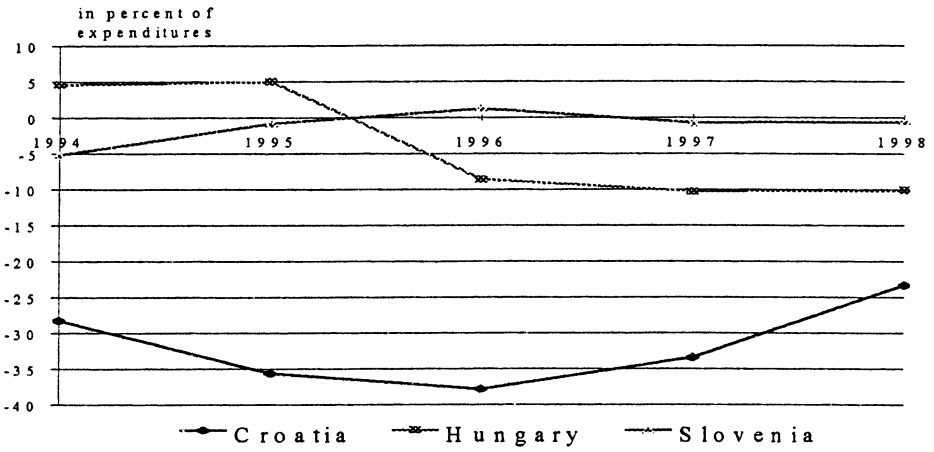
Exhibit 8. Size of the health-care social insurance contribution and the nominal distribution of the contribution between employers and employees in Eastern Europe.

Country	Size of Contribution (Percentage of Earnings)	Nominal Distribution of the Contributions Between Employers and Employees, Percent
Albania	3.4	50:50
Bulgaria[1]	6.0	50:50
Croatia	16.0	50:50
Czech Republic	13.5	66:33
Hungary	23.5	75:25
Macedonia	3.6	100:0
Poland[1]	7.5	0:100
Romania[1]	14.0	50:50
Slovakia	13.7	66:33
Slovenia[2]	12.8	50:50

[1]From 1999. [2] The size of the contribution has steadily fallen from 18 percent in 1992.

Sources: R. B. Saltman and J. Figueras (eds.), *European Health Care Reform: Analysis of Current Strategies* (Copenhagen: WHO Regional Office for Europe 1997); NERA, *The Health Care System in Romania;* WHO, *Health Care Systems in Transition. Bulgaria;* WHO, *Health Care Systems in Transition. Croatia;* WHO 1999c, *Health Care Systems in Transition. Poland.*

Exhibit 9. Deficits of the social health insurance funds in Croatia, Hungary and Slovenia.



Sources: Central Bureau of Statistics, *Statistical Yearbook of the Republic of Croatia 1998* (Zagreb 1999); OECD, *Economic Survey;* Statistical Office of the Republic of Slovenia, *Rapid Reports: Labour Market;* Banka Slovenje, *Monthly Bulletin, April 1999* (Ljubljana 1999); PHARE, *Recent Reforms.*

Exhibit 10. Share of private insurance in Eastern Europe.

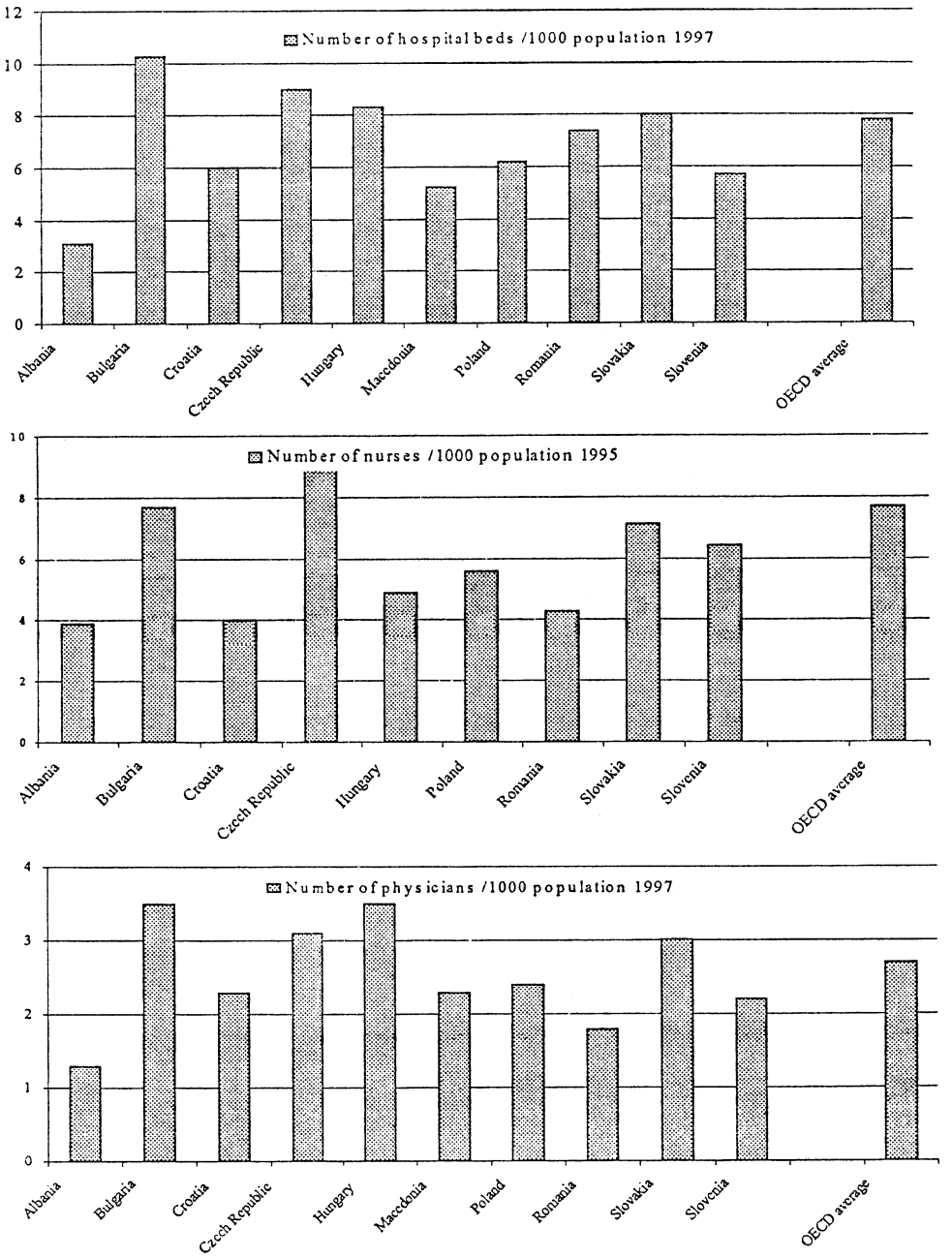
[-2pt] Country	Provided by	For What	Expenditure for Private Health Insurance
Bulgaria	Commercial insurers	Amenities	Minimal
Croatia	Commercial insurers Nonprofit insurers	Amenities excluded from basic package, copayments	Minimal
Czech Republic	Nonprofit insurers Commercial insurers Foreign managed-care companies	Amenities excluded from basic package, care in private hospitals	Minimal
Hungary	Commercial insurers Voluntary health funds Foreign managed-care companies	Amenities, care in private hospitals, loss of salary during sickness, gratuities[1]	Minimal
Macedonia	Commercial insurers Voluntary health funds		Minimal
Poland	Commercial insurers Foreign managed-care companies	Amenities excluded from basic package, care in private hospitals	Minimal
Romania	Commercial insurers		Minimal
Slovakia	Commercial insurers Foreign managed-care companies		1% of THE (1995)
Slovenia	Slovenian Health Insurance Fund Commercial insurers on voluntary basis	Copayments, drugs, emergency care abroad	12% of THE[2] (1997)

[1]The unofficial term "gratuity insurance" is common for some of the health insurance policies available on the market.

Sources: PHARE, *Recent Reforms* (Appendix); WHO, *Health Care Systems in Transition. Croatia.*

[2]Total Health Expenditures

Exhibit 11. Resources in health-care provision in Eastern Europe.



Sources: WHO, Health for All Database (Copenhagen: WHO Regional Office for Europe 1999).

pressure on the superior organizations, which eventually relent. For example, the Polish health sector had amassed debts equivalent to several billion dollars by the end of 1998, when the Finance Ministry carried out an extensive bailout. This is just one illustration of how public health-care providers in Eastern Europe continue to enjoy soft budget constraints.

Delivery: Legal Private Activity

The largest change has occurred among doctors practicing individually, in primary care and dental care. All the Eastern European countries legalized private practice in the early 1990s, and some undertook "privatization campaigns" (the Czech Republic in 1993, Slovakia in 1995 and Croatia in 1996). Several—the Czech Republic, Hungary, Romania, and Slovakia—"privatized" primary care, by converting doctors from state employees to self-employed professionals, working under contract with the insurer and the local (or regional) government, which provides the premises and equipment. Privatization of dental care is even more extensive, and pharmacies are now overwhelmingly private (see Exhibit 12).

In contrast, the proportion of specialist care delivered through legal private practice is low in most countries, with some exceptions (see Exhibit 13) and a growing prevalence of dual practice. For example, Chawla and co-authors[10] found that 1096 publicly employed specialists in Krakow spent an average of 10.8 hours a week in private practice.

Exhibit 12. Share of private health-care providers in Eastern Europe, 1997.

Country	Inpatient Beds	Primary-Care Physicians	Dentists	Pharmacies
Bulgaria	~0	Minor	82	70
Croatia	~0	Minor	96	~100
Czech Republic	9.4	95	~100	~100
Hungary	~0	76	40[1]	~100[1]
Poland	~0	Minor	~100[1]	93
Romania	~0	Minor	~100	75
Slovakia	~0	98	~100	100
Slovenia[2]	~0	14	37	68

[1] 1998.

Sources: National Statistical Institute, *Statistical Yearbook of Bulgaria 1998;* WHO, *Health Care Systems in Transition. Croatia;* Institute of Health Information and Statistics of the Czech Republic, *Czech Health Statistics Yearbook 1997* (Prague 1998); M. Gyenes and F. Kastaly, Kérdőíves felmérések eredményei, elemzései (Results and analysis of questionnaire surveys), in Gyenes, Monika (ed.), *A fogászati privatizáció kézikönyve* (Handbook of Privatizing Dentistry), (Budapest: Péztár 2000 Kft. 1998); WHO, *Health Care Systems in Transition. Poland;* Romanian National Commission for Statistics, *Romanian Statistical Yearbook 1998* (Bucharest 1999); Bútora and Skladony, *Slovakia 1996–1997. A Global Report on the State of Society;* Health Insurance Institute of Slovenia, *Annual Report of the Health Insurance Institute of Slovenia for 1998* (Ljubljana 1999).

Exhibit 13. Share of private specialist providers in Hungary and in the Czech Republic.

	Budapest[1]			Czech Republic
	Number of Specialist Licenses Issued in 1999[2]		Private Licences/all Licences[3] (%)	Specialists[4] in Nonstate Sector/Specialists in Both State and Nonstate Sector in 1997(%)
Specialty	Total	Private		
Internal medicine	1892	1217	64	48
Surgery	726	166	23	42
Obstetrics/gynecology	485	289	60	62
Pediatrics	478	324	68	76
Lung	155	38	25	..
Ear, nose, and throat	188	107	57	56
Ophthalmology	228	131	57	59
Dermatology and venereology[5]	176	132	75	64
Psychiatry[6]	278	69	15	64
Urology	131	59	45	33
Primary-care dentistry and special dentistry	1974	1877	95	...
Remedial gymnastics and massage	129	82	64	...

[1]National data were not available. [2]Licenses were issued under several categories: physician in private practice, health-care entrepreneur, private clinic, unit of a public or private, nonprofit, or private forprofit hospital. [3]Following from the licensing mechanism, this ratio does not reflect the number of patients treated in the private sector, nor the number of doctors working there. [4]Including specialists working in both outpatient and inpatient units. [5]In the Czech Republic, only dermatologists. [6]Neurology excluded.

Sources: Institute of Health Information and Statistics of the Czech Republic, *Yearbook 1997;* personal communication by István Felmérai of the National Public Health and Medical Officers' Service of Hungary (2000).

The first nonpublic hospitals, clinics and other health-care providers have also appeared in some countries, such as the Czech Republic, Hungary, Poland, Slovakia and Slovenia. Some are nonprofit, owned and operated by churches and private foundations. Others are for-profit institutions.[11] In the Eastern European region as a whole, the nonpublic share in total service volume remains very small. The one exception is the Czech Republic, where 9.4 percent of hospital beds were private in 1997. Hungary also has a high private-sector proportion for certain special diagnostic and therapeutic treatments. By 1996, 80 percent of the budget earmarked for kidney dialysis was paid to the private sector, and 75 percent of CT scanners and 57 percent of MRIs were privately owned.

Purchasing and Payment

Eastern European countries generally have separated financing from provision, with a social insurance fund serving as a purchaser, institutionally distinct from providers (see Exhibit 5).[12] Hungary (1991) and the Czech Republic (1992) were among the early converts. Croatia, Macedonia and Slovenia replaced occupation-based social-insurance funds (which

had continued in Tito's Yugoslavia from before 1945) with a national social insurance fund in the early 1990s. Poland introduced social insurance reforms in 1999, and such reforms are planned in Romania and Bulgaria.

Slovenia is the only Eastern European country to apply a transparent procedure that establishes purchasing priorities. Annual negotiations between the Health Ministry, the providers, and the medical insurance company, using previous year utilization data and current waiting lists, results in an agreement on the quantity and payment to be made for each service. Providers apply for funds from the aggregate budget. The budget constraint is hard, since the insurer seems able to commit credibly to lack of reimbursement for utilization in excess of the agreement. In 1998, the aggregate service volume was 95.3 percent of the plan, although the number of inpatient admissions exceeded the forecast by 8 percent.[13]

By the end of the 1990s, most countries had moved away from historical-cost budgeting—with its lack of incentives for efficiency, similar to unquestioned reimbursement of costs—towards alternative payment methods (see Exhibit 14). Fee-for-service predominated in some countries, such as the Czech Republic. In that case, real health care spending increased by almost 40 percent in two years, with health expenditures jumping from 5.4 to 7.3 percent of GDP between 1992 and 1993. Private practice physicians paid on a FFS basis billed

Exhibit 14. Payment systems in Eastern Europe, 1997.

Country	Primary Care	Outpatient Care	Inpatient Care
Albania	Capitation	Global budget and salary Planned: FFS	Global budget and salary
Bulgaria	Global budget and salary	Global budget and salary	Global budget and salary
Czech Republic	FFS Planned: capitation	FFS with national cap and full cost reimbursement for certain inputs	FFS with national cap, full cost reimbursement for certain inputs and per diem fee. Since June 1997, global budget
Croatia	Capitation and FFS	FFS and salary	FFS
Hungary	Capitation	FFS with national cap	Case-based payment (DRG)
Macedonia	Capitation	Global budget and salary Planned: FFS	Global budget and salary Planned: Case-based payment
Poland	Global budget and salary Since 1999, capitation and FFS	Global budget and salary Since 1999, capitation and FFS (according to the choice of the territorial fund)	Global budget and salary Since 1999, case-based payment (according to the choice of the territorial fund)
Romania	Global budget and salary Since 1999, capitation and FFS	Global budget and salary Since 1999, capitation and FFS	Global budget and salary Since 1999, case-based payment
Slovakia	FFS Experimentally: combined with capitation	FFS	Per diem fee paid prospectively Experimentally: case-based payment
Slovenia	Capitation and FFS with a national cap	FFS	Per diem fee and FFS with a national cap

Sources: PHARE, *Recent Reforms* (Annex); WHO, *Health Care Systems in Transition. Croatia.*

significantly more in every category of service than public (primarily salaried) providers did.[14] The expenditure-increasing effects of FFS proved so powerful that in 1997 Czech policymakers decided to revert to a global-budget method of payment. Providers immediately responded to the new incentives.[15]

Several countries have introduced supply-side cost sharing, such as capitation for PCPs and case-based payment for hospitals.[16] Capitation has already become the most common form of payment for primary care in Eastern Europe.

Doctors' Earnings and Gratuities

Another resemblance between the market-socialist period of the economy as a whole and the health sector of the 1990s is the tension apparent between legal and illegal (or semi-legal) earnings. The market-socialist period saw a strong development of an economic sphere that remains important to this day, known variously as the "second," "shadow," "gray," "informal" or "hidden" economy. This duality appears in its strongest (and furthermore, least palatable) form in the health sector in Eastern European countries, as a major source of physician income.[17]

One aspect of the phenomenon is the disproportionately low salaries of doctors, most of whom remain employed by public institutions. Although physicians are among the best-paid professionals in the traditional market economies (3 to 4 times average earnings), in Eastern Europe, official medical earnings are only 1.3 to 2 times average. This relatively low proportion understandably embitters and annoys the medical profession in light of the widening differentiation of earnings in other fields.

The other side of the coin is the system of what are known as gratuities[18]—under-the-table payments made by a patient or relative to a doctor or other health-care provider for publicly-financed services. Experts on the subject consider that semi-legal payments to doctors are very widespread in Hungary, Romania, Poland and Bulgaria, and much less so in the Czech Republic, Slovakia, Croatia and Slovenia. Research in Poland found that the amount of gratuity doctors received in 1994 was roughly equivalent to their official gross salary. About 60–70 percent of those receiving inpatient treatment gave gratuity to physicians.[19]

There was wide research into the size and frequency of gratuities, and attitudes towards them, in Hungary in 1998, using two samples, one of the population and the other of physicians (see Exhibit 15).[20] As expected, the frequency of gratuity payments depends on the type of medical service received, with gratuities common and sizable for childbirth and surgical procedures. In aggregate, patient gratuity payments account for almost two-thirds (62 percent) of total physician income (net of taxes and other compulsory contributions).

The two sides of the gratuity system—intolerably low official pay and the prevalence and astonishing size of the semi-legal gratuity payments—are inseparably linked. Certainly the majority of doctors accept gratuities; they have become part of their normal income, without which they could not balance their household budget. Nonetheless, the overwhelming majority of doctors considers gratuities demeaning, and would gladly exchange them for income they could declare openly. The prevalence and demoralizing effects of gratuities

Exhibit 15. Opinions on medical gratuities, among doctors and among the public in Hungary

	Agree		Disagree	
Opinion	Wholly	Partly	Wholly	Partly
Giving gratuities reassures patients, because they feel they are buying extra attention.				
Physicians	19.4	44.2	19.5	16.9
Public	26.1	28.4	19.8	25.7
Gratuities make no difference in treatment.				
Physicians	32.0	17.6	23.7	26.7
Public	14.4	17.1	30.0	38.5
Gratuities erode the confidence essential in the doctor–patient relationship.				
Physicians	17.8	17.6	31.9	32.7
Public	15.1	21.7	33.2	30.1
Gratuities are a necessary evil.				
Physicians	58.0	22.2	9.8	10.1
Public	52.3	30.1	9.2	8.4
So long as the state does not pay them properly, doctors have a right to accept gratuities.				
Physicians	54.4	27.5	11.0	7.1
Public	39.1	28.4	17.5	15.0
It is morally reprehensible for doctors to accept gratuities.				
Physicians	3.6	7.5	29.4	59.6
Public	16.6	17.7	33.3	32.4
Gratuities are unpleasant and demeaning to both doctors and patients.				
Physicians	68.0	21.8	7.1	3.1
Public	30.0	32.4	22.6	15.0
The existence of gratuities shows that society considers doctors to be underpaid.				
Physicians	72.6	17.5	6.7	3.2
Public	41.6	28.1	17.0	13.3
Gratuities are not a moral issue.				
Physicians	42.2	29.1	18.1	10.7
Public	33.5	29.3	19.4	17.8

Sources: G. Bognár, R. I. Gál, and J. Kornai, "álapénz a magyar egészségügyben" *(Gratuity money in the Hungarian health sector),* Közgazdasági Szemle *47,* (2000): *295.*

constitute one of the main brakes on the emergence of straightforward private activity and respectable business relations in the health sector.

II. Recommendations for Reform

What follows is not a survey of others' recommendations or a comprehensive list of reform alternatives. Instead, our recommendations are based on a proposed set of specific guiding principles for reform of social policies in economies undergoing post-socialist transition,

here applied to the health sectors of Eastern Europe. As such, the proposals do not follow the model of any one country or health system, although they draw from the experiences of many.

Unlike most economists, we do not base our recommendations first and foremost on considerations of economic efficiency. Instead, our starting point is the ethical challenge of promoting individual sovereignty and choice while assuring social solidarity.

Guiding Principles

1. *Sovereignty of the individual (choice):* The transformation promoted must increase the scope for the individual and reduce the scope for the government to decide in the sphere of social services.
2. *Solidarity:* Help the suffering, the troubled and the disadvantaged.

To achieve expanded choice and balance individual sovereignty with social solidarity, institutions and coordination mechanisms in the health sector should display several desired attributes. For example, competition can help to assure that patients are not defenseless under a public monopoly but rather have access to real choices. Of course competition also has the desirable affect of promoting efficiency, if structured carefully to avoid market failures. To assure effective choice for all citizens (not just the wealthy, healthy, or well-connected) also requires attention to incentives, a new government oversight role, transparency in policymaking, and allowing time for adjustment:

3. *Competition:* Let there be competition among various ownership forms and coordination mechanisms.
4. *Incentives:* Forms of ownership and control that encourage efficiency need to emerge.
5. *A new government role:* The main functions of the government in the social services sector must be to supply legal frameworks, supervise private institutions, and provide 'ultimate,' last-resort insurance and aid. The government is responsible for ensuring that every citizen has access to basic education and basic health care.
6. *Transparency:* The link between social services provided by the government and the tax burden that finances them must become apparent to citizens; reform should be preceded by open, informed public debate.
7. *Time requirement:* Time must be left for the new institutions to evolve and for citizens to adapt.

Finally, policymakers need to find a socially responsible and fiscally sustainable balance among competing priorities:

8. *Harmonious growth:* Let there be harmonious proportions between the resources devoted to investments that directly promote rapid growth and those spent on operating and developing the social service sector.

Exhibit 16. Guiding Principles for Reform and Related Recommendations

Ethical postulates	Related Recommendations
1 Sovereignty of the individual	Patient choice of provider (at least for primary care); choice of insurer for supplementary and later for basic care; mechanisms for patient appeals and complaints; greater professional sovereignty for providers, within regulations; etc.
2 Solidarity	Risk pooling at broadest level for basic care; risk adjustment of payments to insurers and providers to assure risk solidarity, with complementary policies (mixed payment, high-risk pooling); broad-based health tax for income solidarity; etc.
The desired attributes of institutions and coordination mechanisms	
3 Competition	Evolutionary development of private sector in delivery and financing, including entry and some privatization; managed competition among insurers for supplementary care and later for integrated packages of basic and supplementary care; etc.
4 Incentives	Healthy development of private sector; managed competition; introduction of demand-side and supply-side cost sharing; phasing out gratuity (under-the-table) payments; risk adjustment; etc.
5 A new role for the government	Implement broad-based health tax, or social insurance contributions, to finance basic care for all citizens; develop institutions for prioritizing public financing and delineating basic benefit package; license providers; manage competition—selective contracting, quality assurance, etc.
6 Transparency	Implementation of earmarked health tax for financing basic care; where possible, abolishing the nominal distinction between employee and employer contributions; public involvement in process for prioritizing public financing and defining and updating the basic benefit package; formal demand-side cost sharing rather than gratuity payments; etc.
7 Time requirement	Evolution of insurance organization from 'Form A' (public monopoly for basic care, managed competition for supplementary services) to 'Form B' (managed competition for basic and supplementary care); no forced privatization; etc.
The desired proportions of allocation	
8 Harmonious growth	Basic care financed through transparent health tax; democratic process prioritizes public health spending and basic benefit package, competing with other priorities; etc.
9 Sustainable financing	Incentives to make all participants cost-conscious; cost control measures for overall health sector, not just public health spending; prioritization of basic benefit package, with transparent financing, etc.

9. *Sustainable financing:* The government budget must be continually capable of financing fulfillment of the government's obligations.

Our recommendations flow naturally and systematically from these guiding principles (see Exhibit 16).

Basic and Supplementary Care

The principles of reform in some cases involve trade-offs, such as between increasing the scope for individual choice (Principle 1) and ensuring social solidarity (Principle 2). The proposal here is that solidarity should apply at the level of basic health care. There should be universal and equal access to a basic benefit package. This basic level of health care

should accord with the country's level of economic development (Principle 8). The scope of basic care should be defined by how much society, through its democratic institutions, decides to spend on basic care.

We urge consideration of a transparent, socially acceptable process of explicit priority setting to define a basic benefit package. Appropriate institutions need to be established for coordinating public involvement and otherwise overseeing the continuing process of defining and updating the scope of basic care. Within the frames of the basic benefit package, there should be protection of patients' rights, including allowance for appropriate appeal and complaint processes, avenues for litigation and compensation for malpractice.

In contrast to basic care, there is no guaranteed universal and equal access to supplementary care. Rather, services falling outside the basic benefit package are available to those willing and able to pay for them, and are therefore likely to be distributed unevenly.

Inequality in the distribution of health-care expenditures offends many people's sense of justice (including, there is no denying, the authors'). On the other hand, if a market economy allows all consumers to spend the money on food, housing, cultural pursuits or entertainment that they see fit, what right does the government have to prevent them from spending what they see fit on health care? That would be a grave breach of the first principle, individual sovereignty. Furthermore, it would be hypocritical, because affluent patients will purchase additional services anyway, if not legally, then in the gray or black economy. In coordination with policies designed to assure that differential use of supplementary services does not undermine the integrity of universal equal access to the socially defined basic benefit package, and some attention to enforcing an overall constraint on health spending, allowing supplementary care is a straightforward requirement of individual sovereignty. Citizens should be allowed to choose, not only whether or not to spend their own money on supplementary health care, but also which insurer or provider will give the best value for their money. The moral concerns regarding inequity are lessened by the realization that the willingness of the affluent to purchase supplementary services may allow public financing to be targeted more effectively on the less fortunate and may cross-subsidize purchase and access to specialized equipment.

Financing

The main source of financing for basic care should be public money—an earmarked tax and/or compulsory social insurance contributions. The financing should be sustainable (Principle 9) both fiscally and politically. Public financing implies redistribution, from healthy or low-risk individuals to unhealthy or high-risk individuals, and, depending on the progressivity of the tax system, from high- to low-income individuals. The proposed government guarantee of basic care presumes, therefore, that society accepts the need for such risk- and income-solidarity (Principle 2). Supplementary care, however, is privately financed, through patient out-of-pocket payments, supplementary insurance, and/or a voluntary employer contribution.

The authors' sympathies lie with the idea of an earmarked health tax for basic care, because of its transparency (Principle 6). Where the social-insurance contribution for health care is partly or wholly replaced by a health tax, it is worth considering the possibility

of abolishing the distinction between the employer and the employee mandated contributions. The employee's pay should be "grossed up" by a nominal increase, to a level where it includes the previous employer contribution. The health tax can then be deducted from the increased wage, without affecting the net wage. This would dispel the fiscal illusion that employers were financing part of their employees' basic health care, rather than substituting health benefits for wages as part of the average employee compensation package.

High tax and/or contribution rates in Eastern Europe point to the urgent task of expanding the financial resources for basic health care through expanding the overall tax base. Efforts must be made to convert activities in the tax-evading, informal, semi-legal or wholly illegal economy into parts of the legal, taxed economy.

Finally, mention should be made of financing through patient co-payments. Such a tax on the sick weakens the redistributive effects of basic-care financing through broad-based taxation. However, Principle 4—the need to encourage efficiency—gives a cogent motivation for introducing copayments, to limit moral hazard. To balance these considerations, copayments should be relatively low, with a ceiling or stop-loss (which might differ according to family income), and exemptions for the poor.[21]

Organization of Insurance

In light of Eastern Europe's initial conditions, there are at least two forms of organization for basic care insurance that merit consideration, both including some elements of managed competition as articulated by American health economist Alain Enthoven. Under what we term 'Form A,' there would continue to be a public monopoly over insurance for basic care, although risk may be pooled at the central or regional level. Public and private providers could compete in the market for supplementary care.[22]

Under 'Form B,' the public monopoly over insurance for basic care would cease. Private insurers would be free to offer insurance covering basic as well as supplementary care. The sums for financing basic care would flow into a central fund. Consumers would choose among competing insurers, either receiving a voucher or premium support[23] from the central fund. To avoid insurer competition based on selecting good risks rather than lowering cost and/or improving quality, the ex ante payments (vouchers or premium support) should be risk adjusted to reflect differences in health cost risk.

Form A has two big advantages. It is simple to administer, and it covers—pools risk for—the whole population. The primary advantage of Form B is in promoting competition, which will induce greater ingenuity, innovation, and attention to consumers' needs. A notable public-opinion survey was conducted in Hungary on this subject (see Exhibit 17). A high proportion of the sample would support a change from A to B even if it meant higher contributions, but many would only do so if the contributions stayed the same, and some dismiss any idea of competition for both basic and supplementary coverage.

We believe that the only competent judges in the long run are the citizens themselves. Let the reform create the conditions in which individuals may choose, and not just by answering questionnaires, or in parliamentary elections. Let them vote with their feet, by exercising a right to real entry and exit.

Exhibit 17. Distribution of opinions about competition among health insurers and the level of social-insurance contributions in Hungary.

Responses	In Percent of All Responses
I support both raising contributions and introducing competition.	20.1
I support competition as long as there is no contribution increase.	37.3
I don't support competition.	31.5
Don't know.	6.9
No response	4.2

N = 1478.

Sources: TÁRKI, Adótudatosság, fiskális illúziók és az egészségbiztosítás reformjával kapcsolatos vélemények. Kutatási beszámoló "Az állam és polgárai II" című kutatás adatfelvétele alapján (Tax awareness, fiscal illusions, and opinions on the reform of health insurance. Report on "The state and its citizens" research project), eds., Janky Béla és Tóth István György, (1999) mimeographed.

The starting point could be form A, a monopoly public insurer complemented by private insurers offering various supplementary insurance policies. The road towards form B will have to be cleared with careful and diligent oversight, by for example gathering data to support risk adjustment.[24] Form B must not be forced upon society by administrative command or legislative fiat. An attempt to do that in a rapid, radical way was made in the Czech Republic in 1992, without proper preparation or an adequate transition period (violating Principles 5 and 7). It caused much confusion, and in some cases, some serious abuses.

In short, we propose that policymakers develop managed competition for Eastern Europeans, at first for supplementary services only, and then for comprehensive packages of basic and supplementary care. The latter should not be forced on anyone, but the freedom to choose should not be blocked off either.

Delivery System Ownership

A pluralistic delivery system seems most suitable to Eastern Europe, in line with the principle of competition and with international experience. Encouragement should be given to private initiative from below, in all its legally, ethically and professionally correct forms. Regulations should be hospitable to new forms of group practice, partnerships, and contracting between hospitals and physician groups. The aim is to divert into legal, regulated, transparent forms transactions hitherto hidden in the mists of the gratuity system and the health sector's gray economy.

Policymakers should reject any privatization campaign that laid down beforehand when some critical threshold for privatization had to be reached. The healthy thing is to have various kinds of organizational innovations, followed, of course, by natural selection of those most effective. This is roughly what has happened in the other, commercial sectors of the economy. If an organic, bottom–up approach was the correct course of events there, the same is doubly true in the health sector, where special caution is needed.[25] Privatization, if undertaken, should be by regulated competitive sale, at a respectable price.

In addition to allowing entry and privatizing some providers, policy should also strengthen the quasi-market elements in the public sector, such as autonomy for hospital and other managers, performance-based pay and promotion, greater exposure to competitive pressures, and enhanced accountability. In addition, the spheres of ownership rights and associated responsibilities have to be divided more clearly between central and local governments, public hospitals and other health-sector organizations.

Purchasing, Payment and Regulation

There is a danger of the health sector being split into two parts by an inconsistent, distorted process of reform. Private hospitals and individual private medical practices will serve the richer sections of society, who can afford to pay directly or to purchase private medical insurance. Many services that are in the basic package will also be paid for privately. Meanwhile the publicly financed, government-owned hospitals and outpatient clinics, along with their associated primary care providers, will serve the less wealthy.

Signs of such a damaging split are already in evidence. If such a vicious circle develops, it will be difficult to break. It is much better to prevent it developing or becoming entrenched. That is what a consistent application of the principle of 'sector neutrality' can help to achieve.[26] The entitlement to basic care should be "sector-neutral"—available without discriminatory restrictions from public or private providers. Government-owned institutions should be free to obtain their inputs from the supplier who offers the best terms.

The central fund will need to develop skills of selective purchasing on behalf of consumers, with more thorough, intensive bargaining over the price and quality of health-care services. There can be expected to be a protracted process in which market-based prices gradually, but never entirely, supplant administered prices, and the remaining administered prices give better signals regarding real relative scarcities.

No publicly owned or non-profit organization should be allowed to operate with consistent losses. If there are other, similar organizations operating with the same prices and a similar case-mix of sicker and healthier patients, but not making a loss, the fault must be low efficiency, to which the correct response is to augment or dismiss the management and restructure activities. A financial subsidy should be given at most temporarily, accompanied by a firm warning that it will be phased out gradually and cease on a specific date. Loosening financial discipline is not the best way for society to express its respect for the health sector. Instead, political representatives may vote the health sector a bigger *ex ante* macro budget for basic care. *Ex post,* it should not yield to pleas or blackmail to allow looser macro and micro budget constraints or a bail-out.[27]

The new purchaser role for the government (or a semi-autonomous SIF) may be complemented by employer involvement. So far, there have only been traces of such involvement in Eastern Europe, but it could play an important part in the future reforms. Policy designed to encourage employers to act as active sponsors for their employees merit consideration.[28]

Regarding provider payment, we urge Eastern European policymakers to continue experimenting with supply-side cost sharing, including capitation for primary care and case-based payment for hospitals. These forms of payment encourage cost control and leave the micro-allocation decisions in the hands of those most competent to judge effective use of

medical resources, the health care professionals delivering care. However, the incentives of prospective, fixed payments can be overly strong, financially rewarding discrimination against expensive-to-treat patients. We therefore recommend mixed payment, that is, both an ex ante (risk-adjusted) fixed payment and some ex post payment based on patients' actual use of health services.[29] Moreover, countries may consider mandatory high-risk pooling, as proposed for the Netherlands.[30] Policymakers may also wish to experiment with GP fundholding and managed care organizations, based on some encouraging results in the UK and the US respectively. On the other hand, the introduction of them should not be forced or be the subject of an intensive campaign.[31]

Adjustment of payments to reflect expected health cost risk is a critical component of any mechanism that seeks to guarantee choice (of insurers and/or providers) while upholding risk solidarity and financial sustainability. Without it, private insurers may 'cream skim' low-cost consumers through marketing attractive supplementary packages, making considerable profits while leaving the public insurer(s) with an adverse selection of high-cost consumers.

The Czech Republic introduced a simple risk adjustment mechanism, based on age, in 1993. But more accurate, diagnoses-based risk adjustment will take time and incentives to develop. In combination with other policies—regulation, active sponsors, mandatory ex ante high-risk pooling, mixed payment—carefully designed and rigorously implemented, risk adjustment can greatly reduce the chances of selection problems becoming so severe that they overshadow the innovation-spurring advantages of competition.

Finally, under-the-table payments should be redeemed—converted into legal and transparent payments, not banned. One aspect should be an increase in average physician pay and appropriate differentiation of compensation according to experience and skill. Growth of the legal private sector is likely to encourage such changes. Policymakers should also adopt appropriate legal frameworks to govern the frequent phenomenon of public-sector physicians working in the private sector part-time, such as partnerships or medical companies formally contracting with a hospital to provide a specific set of services. Complementary policy changes are needed to induce patients to abandon under-the-table payments as well, including compulsory co-payments and legal purchase of supplementary services.

Conclusion

The health sectors of Eastern European countries suffer from many of the legacies of socialistic planning and have to cope with the dramatic socio-economic transformation accompanying the transition to market-based economies. We hope that our description of the current situation will deepen understanding of and interest in the challenges confronting the region, and that our proposals for reform may contribute to effective and creative policies addressing those challenges.

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Notes

1. The article is based on János Kornai and Karen Eggleston, *Welfare Choice and Solidarity in Transition: Reform of the Health Sector in Eastern Europe,* forthcoming from Cambridge University Press, 2001.
2. See E. Goldstein et al., *Trends in Health Status, Services and Finance* (World Bank Technical Paper, No. 348, 1996); J. Marree and P. Groenewegen, *Back to Bismarck: Eastern European Health Care Systems in Transition* (Aldershot: Avebury, Ashgate Publishing Company, 1997); Pologne, Hongrie, Assistance à la Restructuration Economique (PHARE), "Recent Reforms in Organization, Financing and Delivery of Health Care in Central and Eastern Europe in Light of Accession to the European Union," (PHARE Conference, Brussels, May 24-26, 1998); R. Saltman and J. Figueras (eds.), *European Health Care Reform: Analysis of Current Strategies* (Copenhagen: WHO Regional Office for Europe, 1997); R. Saltman et al., *Critical Challenges for Health Care Reform in Europe* (Buckingham, Philadelphia: Open University Press, 1998); World Health Organization, various years, Health Care Systems in Transition series, WHO Regional Office for Europe; and World Bank, *World Development Report 1993: Investing in Health* (Oxford: Oxford University Press, 1993). Many other studies are country-specific, often including proposals for reform; see citations in Kornai and Eggleston, *Welfare, Choice and Solidarity in Transition.*
3. Kornai and McHale econometrically estimate that Eastern European countries (except for Romania) spent in the mid-1990s as much as, or in some cases more than, would be spent in a market-based economy at a similar level of economic development; J. Kornai and J. McHale, "Is Post-communist Health Spending Unusual? A Comparison with Established Market Economies," *Economics of Transition* 8, no. 2 (2000): 369–399.
4. World Health Organization, *World Health Report 2000 Health Systems: Improving Performance,* statistical annex, World Health Organization.
5. The "classical" socialist system refers to the Stalin period, before "market socialism" reforms appeared; see J. Kornai, *The Socialist System: The Political Economy of Communism* (Princeton, NJ: Princeton University Press and Oxford University Press, 1992).
6. Many places had several grades of privilege, with the best hospital reserved for the highest elite, a less good, but far above average hospital for the rest of the elite, and so on.
7. Under market socialism, in Hungary, and later in Poland, the Soviet Union and (continuing to today in) China, a curious hybrid emerged of public and (formal and informal) private ownership under both centralized bureaucratic control and market coordination.
8. Dependents are usually covered under the contributions of an employed family member. Government financing covers the social-insurance contributions for some other groups, such as the poor, disabled and unemployed.
9. However, in most countries a patient can self-refer to a chosen specialist or hospital by paying a special co-payment, which is quite high in some countries (e.g., Bulgaria, Hungary and Slovenia).
10. M. Chawla et al., *Enrollment Procedures and Self-selection by Patients: Evidence from a Family Practice in Krakow,* Poland (Boston: Harvard School of Public Health, Discussion Paper No. 66, 1999).
11. Most capital cities now possess foreign investor-owned health-care institutions with up-to-date equipment and doctors who speak foreign languages, mainly to cater to foreign residents.
12. The social insurance fund is in some cases separate from the government, with its own governing body, and in other cases is subordinate to the central government. In Hungary, for instance, the fund was autonomous between 1991 and mid-1998.

13. The insurer compensated under-budget hospitals, to prevent institutions straining inappropriately to spend down their budgets before the next round of negotiations.
14. T. Massaro et al., "Health System Reform in the Czech Republic: Policy Lessons from the Initial Experience of the General Health Insurance Company," *Journal of the American Medical Association* 271: 1870–74.
15. Under the new budget system, each health-care organization receives a quarterly budget 100 per cent of its previous quarterly budget, so long as its performance as measured primarily by volume is not less than 70 percent of the performance in the previous period. According to Czech doctors, the effect of the change was immediate, with a 30 per cent fall in those measures of hospital performance upon which payment was based (Benedict, Ágnes, "A cseh egészségügyi reformról" (On the reform of the health sector in the Czech Republic), *Egészségügyi Gazdasági Szemle* 38 (2000): 83–98).
16. Hungary introduced DRG payment in 1993; almost at the same time, hospitals widely adopted a software system known as Sámán, which sought to provide 'optimum' coding for maximizing hospital revenues.
17. This phenomenon also affects nurses and other health workers, but attention here will be focused on the physicians, where it is most prevalent.
18. The term current in the Hungarian medical profession is the Latinate *parasolvencia*. The Polish term translates as "envelope money."
19. M. Chawla et al., *Financing Health Services in Poland: New Evidence on Private Expenditures* (Harvard and Jagellonian Consortium for Health, Mimeographed, 1998).
20. The findings of the survey, undertaken by the TÁRKI research institute, are summed up in G. Bognár, R. Iván Gál, and J. Kornai, "*Hálapénz a magyar egészségügyben*"(Gratuity money in the Hungarian health sector), Közgazdasági Szemle 47 (2000): 293–320.
21. It would also be beneficial to stipulate that consumers cannot buy first-euro supplementary insurance coverage, which would remove the desired disciplinary effect of co-payments on demand.
22. This form already exists in most Western European countries. Although the proportion of supplementary services may not be high, it is increasing in extent and scope of care.
23. See H. Aaron and R. Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs* (Winter 1995): 8–30; and G. Wilensky and J. Newhouse, "Medicare: What's Right? What's Wrong? What's Next?" *Health Affairs* (January/February 1999): 92–106.
24. The original public insurer should have incentive to help refine risk adjustment and other strategies to prevent selection, since it would be the victim of adverse selection if the payment system could not prevent private insurers from 'cream skimming' profitable individuals.
25. There were unfortunate experiences in the Czech Republic, and above all in Russia, with the strategy of forced, hastily executed "mass privatization" of state-owned enterprises in almost all sectors of the economy, the main instrument of which was give-away distribution of state assets. Yet this failed plan is recurring, now that the idea of privatizing public hospitals, clinics and other larger care-providing institutions is cropping up in many Eastern European countries. Influential groups of doctors would gladly get their hands on valuable buildings and equipment obtained free or at nominal prices. There is a danger that the process may be contaminated by political or personal connections and even bribery.
26. The phrase 'sector neutrality' became current in debates in Eastern Europe, for instance in Hungary, Poland and the Soviet Union, during the experiments with market-socialist reform. The legal regulations of the time enforced discrimination in favor of the state sector: state-owned enterprises could only buy from state-owned enterprises. This bureaucratic discrimination was augmented and strengthened by the official ideology, which stipulated that a state manager who was a believer in socialism should not support the development of capitalism by obtaining inputs from private firms.
27. When one Hungarian provincial hospital incurred large budget over-runs in 1998, one of its senior physicians began a hunger strike to force the government to cover its losses, which in the end the government agreed to do.
28. For example, employer coalitions should also be allowed to develop as purchasers on behalf of their employees. Simultaneously, regulations should be developed to avoid replicating "job lock" and other well-known problems of an employment-based insurance system.
29. J. Newhouse, "Reimbursing Health Plans and Health Providers: Efficiency in Production versus Selection," *Journal of Economic Literature* 34 (1996): 1236–63.

30. E. M. van Barneveld et al., "Mandatory High-Risk Pooling: An Approach to Reducing Incentives for Cream Skimming," *Inquiry* 33 (1996): 133–143.
31. This gradual and voluntary approach is essential if there is to be individual sovereignty in choice among competing insurance options. However, it may also exacerbate risk selection, since those who voluntarily choose the new options may very well be healthier-than-average. This problem is best addressed by risk adjustment and mixed payment.

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