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**Health Care Systems' Evolvement and the Changing
Role of the State in Selected CEEC**

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Health Care Systems' Evolvement and the Changing Role of the State in Selected CEEC

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Abstract

Despite common heritage, Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, and Slovakia (hereinafter Central and Eastern European Countries – CEEC) opted for different models while reforming their health care systems. A common (and important) component of these reforms was privatization and introduction of various market mechanisms in health care systems. The objective of the paper is to identify main challenges resulting from the health care reforms in CEEC. Review of the literature (using EBSCO and ScienceDirect databases) on the results of the health care reforms in CEEC will be followed by an analysis of the changes in health care financing in CEEC between 1995-2012 with a special emphasis on the role of the state in this process. WHO statistics (data) on national health care expenditures divided further into: total health expenditure, general government expenditure, private expenditure, and out of pocket expenditure (with various configurations) will be used. It is argued that health care reforms led (among others) to shifting the financial risk to patients and the state is slowly (and continually) withdrawing from financing health care in CEEC. This diminishing share of state financing of health care is not compensated by tax deductions and/or other forms of allowances. Also the issue of restricted access to health care is indicated here as a by-product of the health care reforms undertaken in CEEC.

Introduction

Health care systems and their functioning always attract public attention due to the universal value of good health for everybody

Democratic governments have to justify any kind of state intervention by reference to either market failure or distributive goals. As health services are commonly acknowledged as vulnerable to market failures (Arrow, 1963, pp. 941–973) and as a prototype of a merit good (Musgrave, 1959), state involvement can be justified by the public interest in guaranteeing effective, affordable, and accessible healthcare for the entire population (Culyer, 1989, pp.34–58; Barr, 1993, pp. 289–335).

States and governments act as principals in deciding on organization, service delivery and financing of the health care systems. The role of the state in this respect cannot be overestimated and one may maintain that the state's responsibility for proper functioning of health care systems is not being questioned. It seems to be interesting to analyze how is the role of the state in health care organizing, delivery, and financing in countries undertaking profound social and economic transformation. While processes of reforming health care systems in post-communist countries are comparatively well documented in the literature (Voncina et al., 2007, pp.144-157), there is a lack of sources analyzing the evolving role of the state in these processes. The paper is aimed at showing a continuous withdrawing of the state from financing health care systems.

Methodology of the research

The paper is based on a desk study i.e. metaanalysis using sources from EBSCO and ScienceDirect databases. The following keywords (in various combinations) were used: health care reforms, restructuring of health system, CEE countries as well as names of countries at hand: Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, and Slovakia. The selection process had three stages. The first step was to identify sources which titles corresponded to the topic and the goal of the paper. There were 283 results (altogether) showed, out of which 114 were classified as appropriate for further inquiry. During stage two all the abstracts were read and then only papers directly addressing issues of health care reforms in Central and Eastern European countries and the role of the state in these processes were identified (there were 14 such papers). In the end (the last stage) these 14 papers were read in full and analyzed. In addition, publications from WHO Regional Office for Europe were used in this paper.

Empirical component of the paper is built on WHO statistics. Data Explorer available at <http://apps.who.int/nha/database/Select/Indicators/en> was used for the construction of Table 1.

State in health care system organization and functioning

It is assumed here after Foucault (1991, pp. 87-104, p. 91) that the state is not narrowly perceived as responsible first of all for legal regulation and execution, but also is seen as a creator of institutions, a driving force for creating tactics allowing for real execution of political power assuming that political power centers are located also out of governmental agencies (Miller & Rose, 1990, pp. 1-31).

Health system is understood as all the activities whose primary purpose is to promote, restore, or maintain health (WHO 2000) but in this paper it is narrowed down to those activities, which are under complete or partial control of governments. The private sector in health is not excluded from consideration, because of at least two reasons. First is because governments play an important regulatory role that can influence the performance of private providers and second because growing number of governments' tasks is delegated/transferred to private sector organizations (Kruk & Freedman, 2008, pp.263-276).

The role of the state in health care system - like in disputes on the role of the state in economy – is not commonly accepted. The essence of the controversy lies in the role of state intervention, particularly the extent to which it controls the provision, funding, and regulation of medical services. Opponents of state intervention and proponents of “privatization” contend that the deeper government becomes involved in health care, the more bureaucratic, complex, inefficient, and inferior the services (Hamowy, 2000, pp.15-86). Advocates of state intervention, on the other hand, argue that government participation is the best way to improve both cost-effectiveness and accessibility of health services (Barlett & Steele, 2004; DeBakey, 2006, pp.145-157).

The UN's Committee on Economic Social and Cultural Rights (2000) maintains that states are obligated to ensure availability, accessibility, acceptability, and quality of health services.

Following Veillard et al. (2001, pp. 191-199) six governmental tasks in respect to health care sector can be identified:

- setting health care system vision and strategy,
- influencing other sectors to improve public health,
- managing health care system based on shared social values,
- ensuring that health care system is constructed to achieve health goals,
- better implementation of legal and regulatory instruments available,
- collecting, gathering, compiling, disseminating and using information.

These tasks formulate the basic set of the state activities in respect to health care sector. Following Kutzin (2001, pp. 171-204) one can extend this list by insurance function according to which the state should guarantee access to health care without further financial impoverishment of households and citizens.

The role of the state in health care systems has been evolving. Nowadays, one may notice considerable less direct state involvement in health care systems. Böhm et al. (2013, pp. 258-269) using three criteria: regulation, financing, and service provision have distinguished five models of health care systems in OECD countries: National Health Service, National Health Insurance, Social Health Insurance, Private Health System, and Etatist Social Health Insurance. In these models, the state retains its decisive role only in respect to regulation (and even here in four out of five models). Financing is dominated by societal and/or private actors (three out of five models) so is provision of health services (four of five models). This in turn may lead to the conclusion that the state remains to play a decisive role in just one out of these three criteria.

Smart governance for health and well-being

Even limiting its involvement in health care system, the state is responsible for ensuring availability, accessibility, acceptability, and quality of health services. Here the concept of smart governance could help. Smart governance for health defines how governments approach governance for health challenges strategically in five dimensions, through:

- collaboration,
- engagement,
- a mixture of regulation and persuasion,
- independent agencies, and
- adaptive policies, resilient structures and foresight (Kickbusch & Gleicher, 2012, p. 53).

Smart governance can also be understood as the application of smart power, defined as the combination of the hard power of coercion and payment with the soft power of persuasion and attraction. Whereas hard power (such as using or threatening military intervention, economic sanctions) and soft power (such as diplomacy, economic assistance and communication) are wholly descriptive terms, smart power also involves evaluation. Smart governance for health and well-being means that the state is engaged in more complex relations with government and societal actors, using both hard and soft power. This does not inevitably reduce its role or power; indeed, with regard to health governance and governance for health, states have expanded their power to meet new challenges through new collaborative arrangements.

An example of a mixture of regulation and persuasion can be dual practice. Physician dual practice is a widespread phenomenon which has implications for the equity, efficiency and quality of health care provision.

Some governments fully prohibit this practice, others regulate or restrict dual job holding with different intensities and regulatory instruments. The measures implemented include limiting the income physicians can earn through dual job holding, offering work benefits to physicians in exchange for their working exclusively in the public sector, raising public salaries, and allowing physicians to perform private practice at public facilities (García-Prado & González, 2007, pp. 142-152). This phenomenon is observed virtually in all CEE countries.

Health care reforms in CEE countries: main trends

Health care reforms are undertaken virtually everywhere in today's world. This is because of the growing health care costs (Hartwig, 2008, pp. 603-623) pushed by innovations, new medical technologies and innovative pharmaceuticals (Mossialos & Le Grand, 1999). Consequently, reforms aimed at increase of efficiency and cost reduction are introduced (McPake, Kumaranayake & Normand 2002).

There are certain ways and tools widely used in many countries reforming their health care systems to mention decentralization of health care delivery (Mosca, 2006, pp. 113-120), introduction of new concepts like Diagnosis Related Groups, Health Technology Assessment, or Clinical Practice Guidelines (Perleth, Jakubowski & Busse, 2001, pp. 235-250).

One of the common feature of nearly all of the health care reforms is introduction of market mechanisms in health care and private sector development and expansion (Peterson, 1998). Private sector expansion in health care sector is noticed in EU countries (Thompson & McKee, 2004, pp. 281-291), CEE countries including. Further expansion of private sector in health care systems is recommended even in countries where public health care system is effective and positively assessed (Janssen, 2002, pp.145-159).

As stated by Uplekar: „ During the last decade there has been considerable international mobilisation around shrinking the role of States in health care” (Uplekar, 2000, pp. 897-904, p. 897). It is worth to notice that recommendations aimed at further private sector development in health care systems were formulated despite some negative consequences of such attempts documented in the literature (Brockmann, 2002, pp. 593-608; García-Prado & González, 2007, pp. 142-152; Horton, 2006, pp.2702-2714).

The six common features of health care reforms undertaken in Central and eastern European countries were as follow:

1. introduction of an insurance model/scheme (social insurance). According to the new model only insured individuals are entitled for health care

services (enumerated in the law) free of charge. Insurance is obligatory with just a few exceptions.

2. provider-purchaser split. This means that financing health care services was separated from their delivery.

3. empowerment of independent public health units. Public health care units were given more scope of decisions (i.e. more discretion in respect to operational and strategic decisions) but at the same time were obliged to cover possible debts.

4. introduction of competition between health care providers (in respect to both public and private ones) for public funding. The payer is purchasing health services on a competitive basis, i.e. contracts are signed with these providers who offer the best prices and guarantee timely, good quality services.

5. broadening the scope of private sector in the health care including provisions for the possibility to set up and run private establishments in the health care sector.

6. abandonment of financing resources (i.e. beds, wages, facilities) and paying for services only (goals financing) in the form of individual contracts with the purchaser. It can be indicated that there are considerable differences in the assessment of the outcomes of the reforms undertaken. For example the results of the health care reforms in Czech Republic were very positively perceived by some Czech doctors (Antonova et al. 2010, pp. 179–181) while contested by others (Oborna, Licenik & Mrozek, 2010, p. 2071).

Health care expenditures in CEEC : 1995-2012

The development of the private sector in CEE countries was accompanied by growing share of private funds in financing health care systems (see Table 1). The application of patient cost-sharing in health care is occupying political discussions in Europe, since its importance as a tool to control the increasing public spending on health is rising considerably (Baji et al. 2011, pp. 255–262). This is also the case in Hungary, Slovakia, and the Czech Republic. In these countries, cost-sharing for commodities (e.g. pharmaceuticals and medical devices) and payments for services that fall (partly or fully) outside the health insurance funds, have long been applied, and constitute a notable share of total health expenditure (Rechel & McKee, 2009, pp. 1186–1195).

However, these countries also have experiences with user fees for primary, outpatient and inpatient services covered by social health insurance. Such user fees have been recently introduced in the Czech Republic. In Slovakia and Hungary, user fees for services were

implemented and abolished shortly after their introduction (Kossarova & Madarova, 2008, pp.10-12). Experiences from these Central European countries show that the introduction of user fees for health care services meets strong opposition by political opponents and the general public (Hall, 2009). The introduction of user fees for health care services (called visit fee) was part of the reform arrangements carried out by the government in 2007 comprising the Convergence Program of Hungary (Baji et al. 2011, p. 256). The goal of the program was to decrease the deficit of the government budget and to meet the European Union criteria for countries in transition to join the Euro zone (known as “Maastricht Criteria”). The main goals of the introduction of the visit fee were to decrease unnecessary use of health care services and to convert the informal payments into formal health care charges.

The visit fee was introduced in February 2007 for GP, outpatient specialist, inpatient and dental care. The charge for co-payments was 300 HUF (1.1 Euro) for each visit to a GP and outpatient specialist with a referral, and 600 HUF (2.2 Euros) in the case of using outpatient specialist care without a referral. In inpatient care, a charge of 300 HUF (1.1 Euros) was introduced per day of hospitalization. In case of unnecessary use of emergency care, 1000 HUF (3.7 Euros) had to be paid. The beneficiary was the provider institution, or the physician in case of GPs. Children under the age of 18 and users of certain health care services (e.g. emergency care, some chronic care/treatments, prenatal and preventive care) were exempted. Moreover, a limit was introduced and defined by a maximum of 20 visits/days hospitalization per year. The payments after these 20 visits/days hospitalization a year were reimbursed by the state. However, the system of visit fee worked for only one year. In April 2008, the payments were abolished as a result of a referendum initiated by the opposition. Participation in this referendum was high (e.g. higher than in the parliamentary elections in 2010). About 50.5% of the population who was entitled to vote, took part. In total, 82.4% of the voters supported the abolishment of the visit fee for physician visits, and 84.0% of voters supported the abolishment of the user fees for hospitalizations. Evidence shows that during the period of visit fee, health care utilization decreased by 15–20% in GP and outpatient services as well as days spent in hospital (Boncz et al. 2008, pp. A368–9). However, one has to highlight that other elements of the complex reforms could have also contributed to the decrease in the number of visits and days spent in hospital. This could have included the change of the prescription system (i.e. physicians were allowed to prescribe medicine for a longer period, as a result fewer patients’ visits were required) and the structural reform of inpatient care (namely the decrease of acute bed capacity by 25%, which might have also

contributed to less hospitalizations). The amount of revenue generated by the user fee was estimated to be about 22 billion HUF in 2007, i.e. 4–5% of public health care expenditure (Baji et al. 2011, p. 256).

The Hungarian case with the visit fee shows only a part of the bigger picture. Table 1 below offers aggregated data on the share of private funds used in the health care sectors of Central and Eastern European countries between 1995 and 2012.

As indicated in Table 1 the share of private expenditure in the total health expenditure in 2012 varies from 15% in Czech Republic to 44% in Bulgaria. Bulgaria notices also second to the highest share of out of pocket expenditure in private expenditure on health (98%) following Romania with 98% share. Bulgaria leads also the ranking of the highest share of out of pocket expenditure in the total health expenditure (42% as compared to 14% in Czech Republic). Certainly, Bulgarian citizens bear the highest burden of restructurization of their health care sector among the analyzed countries. It is also worth to mention that the high share of out of pocket expenditure in the private expenditure on health to great extent is the result of weak private health insurance schemes in vast majority of CEE countries (Hungary, Poland and Slovakia with their shares ranging from 74-77% being exceptions). Between 1995-2012 in all analyzed countries (but Romania), the share of out of pocket expenditure in the total health expenditure has doubled indicating growing financial burden imposed on households and individuals. This can be interpreted as a way of withdrawal of the state from financing health care. It should be added that this withdrawal of the state is not compensated (at least partially) by various tax exemptions and/or any other concessions. This in turn means that the state is transferring the responsibility for financing health care to the citizens without any compensation.

Table 1. Health care expenditures in selected Central and Eastern European countries: 1995-2012

Country	Indicator	1995	2000	2005	2006	2007	2008	2009	2010	2011	2012
Bulgaria	Private expenditure on health as % of the total health expenditure	26	39	39	43	42	41	45	44	45	44
Bulgaria	Out of pocket expenditure as % of private expenditure on health	100	100	97	97	97	97	97	97	97	97
Bulgaria	Out of pocket expenditure as % of the total health expenditure	26	39	38	42	41	40	43	43	43	42
Czech R.	Private expenditure on health as % of the total health expenditure	9	10	13	13	15	17	16	16	16	15
Czech R.	Out of pocket expenditure as % of private expenditure on health	100	100	84	85	89	90	90	92	93	93
Czech R.	Out of pocket expenditure as % of the total health expenditure	9	10	11	11	13	16	14	15	15	14
Estonia	Private expenditure on health as % of the total health expenditure	10	23	23	26	24	21	22	20	20	20
Estonia	Out of pocket expenditure as % of private expenditure on health	100	89	89	96	94	95	97	92	91	92
Estonia	Out of pocket expenditure as % of the total health expenditure	10	20	20	25	22	20	21	19	18	18
Hungary	Private expenditure on health as % of the total health expenditure	16	29	30	30	33	33	34	35	35	36
Hungary	Out of pocket expenditure as % of private expenditure on health	100	90	83	80	78	78	74	75	74	74
Hungary	Out of pocket expenditure as % of the total health expenditure	16	26	25	24	25	26	25	26	26	27
Latvia	Private expenditure on health as % of	34	46	43	36	39	38	41	40	43	43

	the total health expenditure										
Latvia	Out of pocket expenditure as % of private expenditure on health	100	97	95	90	89	89	87	86	86	86
Latvia	Out of pocket expenditure as % of the total health expenditure	34	44	41	32	35	34	35	35	37	37
Lithuania	Private expenditure on health as % of the total health expenditure	26	30	32	30	27	28	27	27	29	29
Lithuania	Out of pocket expenditure as % of private expenditure on health	87	86	99	98	98	98	97	97	98	98
Lithuania	Out of pocket expenditure as % of the total health expenditure	22	26	32	30	27	27	26	26	28	29
Poland	Private expenditure on health as % of the total health expenditure	27	30	31	30	30	28	28	28	29	30
Poland	Out of pocket expenditure as % of private expenditure on health	100	100	85	85	83	81	81	78	76	76
Poland	Out of pocket expenditure as % of the total health expenditure	27	30	26	26	25	23	23	22	22	23
Romania	Private expenditure on health as % of the total health expenditure	25	19	19	20	18	18	21	20	21	22
Romania	Out of pocket expenditure as % of private expenditure on health	100	100	96	98	97	98	98	98	98	98
Romania	Out of pocket expenditure as % of the total health expenditure	25	19	19	20	17	18	21	19	20	22
Slovakia	Private expenditure on health as % of the total health expenditure	11	11	26	32	33	32	34	36	29	29
Slovakia	Out of pocket expenditure as % of private expenditure on health	100	89	88	80	79	77	74	72	77	77
Slovakia	Out of pocket expenditure as % of the	11	9	23	25	26	25	25	26	23	23

	total health expenditure										
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Source: Health expenditure series, World Health Organization, Geneva. Units of expenditures % General Government Expenditures (GGE). Retrieved from <http://apps.who.int/nha/database/Select/Indicators/en> (8.03.2015)

Conclusions

Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, and Slovakia have been proceeding with health care reforms over the last quarter of the century. Changes in health care systems were implemented according to liberal ideologies aimed at introduction of market mechanisms into health care systems accompanied by the development of private sector in health. Market and private sector development in health resulted in diminishing public funding and health care delivery. The growing share of private expenditure in the total health expenditure shows that the state is slowly but continually withdrawing from the health sector, shifting financial risk on the shoulders of individuals. Citizens are not compensated for growing financial burdens neither private health insurance is promoted and developed. This in turn means that the share of out of pocket payments both in private health expenditure and the total health expenditure is exceptionally high in CEE countries.

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