

**Issues in Health Sector Regulation**  
**OPI Seminar Series**  
**Trinity Term 2000: Week Six**

**Building a health service in transition economies**  
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*The political and economic reforms that swept northern and central Europe in the 1990's came at a time when health systems in the West were under great pressure to reform themselves without a consensus on the way forward. As a result, they were poorly equipped to offer established 'good practice' advice to their colleagues in former socialist economies. They volunteered proposals that were sometimes inconsistent and naïve. This has contributed to a decade of lost opportunities, with declining health status and, in many cases, increasing corruption. Although some progress has been made, fundamental dilemmas remain: how to match rising consumer expectations with declining public resources; how to reform the institutional arrangements characterising a uniform control and command management system to cope with the demands of an increasingly pluralistic sector; and how to limit regulatory capture by managers and clinicians. Specific technical design mistakes that have been made, leading to escalating costs, need to be corrected but the fundamental requirement is for a different regulatory environment. This should be based on a shift in control to health service consumers, and may be vested in new regulatory organisations that are independent of political control. Clinicians, health managers and their political advocates need to be made more accountable for health service cost, volume and quality.*

**Pressures for health sector reform in socialist Europe**

The Soviet health system and similar systems were built on supply-side principles: investments in public infrastructure and professional staff, with clinical behaviour and priorities governed by centrally established procedures. Visible investment projects were launched with little attention to their recurrent cost implications. The results were the growth of facility infrastructure and personnel to population ratios sometimes higher than anywhere else in the world, including Western Europe. By the end of the 1970's most national health systems were seriously under-financed, quality of care was deteriorating, health indices were falling and under the table payments were becoming common to compensate for inadequate professional remuneration.

After the Berlin wall fell, the fiscal collapse that accompanied post-reform economic turbulence, and the weakening of state power, precipitated a financial and managerial crisis. Consequently, there was great pressure to introduce changes quickly that would preserve some of the earlier, and much admired, health gains.

**International approaches**

Unfortunately for the countries in transition, at the time, the West was not particularly well equipped to advise. They were themselves grappling with rising costs and in the midst of an ideological and technical debate about the relative merits of public and private provision with alternative health service rationing mechanisms. A consensus was lacking on how to approach the reform challenges facing ex-socialist countries.

The approaches offered were erratic at best, at worst, naïve. The former included reform experiments based more on ideological preference than empirical evidence. They ranged from attempts to refinance existing systems with international aid in the face of an unsustainable future fiscal burden, to politically infeasible attempts to relieve the financial burden on public budget by sweeping privatisation programmes. The latter were based on the view that this was primarily a financing crisis. In fact, the institutional crisis was at least as important. Yet rising consumer expectations confronting a tightening financial resource constraint as economic circumstances worsened exacerbated the reformers' dilemma.

By the end of the 1990s a panoply of contradictory measures had been introduced. Although there were some real advances, health costs had risen, health indicators had declined, doctors had become skilful lobbyists and survivors and nepotism, as well as corruption, had grown worse.

### **Unresolved dilemmas**

There is great variation across former socialist countries, with some seeking EU accession while others face an uncertain, even obscure, future. Nevertheless, some general patterns can be identified.

Most attention remains focussed on resource scarcities in transition economies.<sup>1</sup> Two approaches are being applied, singly or in combination. The first aims at finding more public resources, either by transfers from other sectors or by raising more tax revenue. The former may result in political conflicts; the latter is unpopular and induces increased non-compliance. Many former socialist countries have adopted social insurance as a way of raising more revenue for health care while retaining the risk-pooling advantages of compulsory taxation.

The second depends on reassigning the financial burden. In principle, measures can operate on the supply side, on the demand side, or both. On the supply side, improved budgetary management and increased provider competition seeks to cap cost increases. Health infrastructure can be sold, leased or closed down and clinical staff numbers reduced. The system for paying doctors can be altered. Good practice can be encouraged and performance management introduced to improve technical efficiencies. On the demand side, costs can be transferred to users ("cost sharing and price rationing") in exchange for an increased choice of supplier and (sometimes competing) insurer. Users or employee groups can be allowed to opt-out of publicly financed systems and rewarded by tax relief on expenditure for private services.

### **Looking in the wrong direction?**

Many of these measures have been introduced in transition economies. However, results have been mixed at best, and none seems to be particularly easy to implement in the face of frequent political and clinical opposition. Moreover, while many may be necessary, they are not sufficient. The problems besetting countries in transition are as much the result of an institutional crisis as a financial one. Health sector managers

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1. Saltman R & J. Figueras eds (1996) *European Health Care Reform, Analysis of Current Strategies*: WHO-Euro, Copenhagen).

and clinicians have been used to working to pre-determined plans, bureaucratic rules and clinical norms, with little room for initiative. While these controls have been loosened, or become weaker, they have not been replaced with a regulatory structure more suited to the competitive, demand-driven, dynamic, performance-based system intended by the reformers. The reformers intention was that market forces would provide incentives for innovation and the adaptation of services to consumers needs.

But health service

managers have failed to acquire the technical skills required to create newer, more effective incentives and sanctions that would direct provider attention to quality or make them more cost-conscious. Instead, the vacuum in the regulatory environment, has allowed providers to take advantage of provider-consumer informational asymmetries and unleashed innovations in economic rent seeking. Rising costs are driving social insurance funds to the wall. Informal charges have increased the cost of care to patients. At the same time, regulation remains weak. Ministries often fail to recognise the growth in private practice; health policy is erratic and rarely based on evidence; health sector managers fail to establish an effective dialogue with either professionals, or the public; decentralisation has sometimes allowed local political influence to dominate resource allocation. And in the meantime, consumers remain without an effective voice.

### **A consumer-friendly regulatory regime**

A replacement of the now weakened administrative controls with a regulatory regime more suited to the pluralism that characterises health systems in former social economies is *the* key ingredient of reforms. This challenge is just as pressing as changes required to balance increasing healthcare needs and expectations with the public financial means. Moreover, an effective regulatory regime is a necessary precondition for doing stabilising the public health budget and for achieving efficiency and equity objectives.

Perhaps the lost opportunities of the 1990s have allowed rent-seeking behaviour to become embedded and clinical political influence to become consolidated to the point

### **Dichotomies in policy options for Health Sector Reform in CiT**

	<b>For centrally planned &amp; socialist political system</b>	<b>For market economies &amp; democratic political system</b>
<b>Driving force</b>		
<b>Political Factors</b>		
Ideology	Collectivist	Individualist
Political process	Autocratic	Pluralist
Governance	Totalitarian	Democratic
<b>Economic Factors</b>		
Economic model	Socialist	Capitalist
	Command	Market
	State	Laissez Faire
	Public	Private
Ownership & financing	Predetermined	Competitive
Prices & wages	Supply driven	Demand driven
Production	Restricted	Mobile
Labour markets	Bureaucratic	Meritocratic
Incentive structures	Normative	Performance
	Static	Dynamic
Economic equilibrium		
<b>Institutional Factors</b>		
Policy and legal	Five-year Plans	Incremental
Structure	Centralised	Decentralised
Function	Simple & uniform	Complex & diverse
Personnel	Super- specialised	Broad skills

*From: Preker, A.S. and Feachem, R.G.A., 1994, "Health and Health Care", in Labour markets and Social Policy in Central and Eastern Europe, Barr, N. (ed), WB/LSEPS, Oxford University Press, p. 298*

that the introduction of such a regime will be more difficult and costly now than might have been the case earlier. Arguably, now only concerted and sustained consumer action can make politicians and clinicians accountable for the health service mix, quality and cost. New regulatory organisations will be required, reasonably independent of political influence, in which consumer interests are well represented.

However, it is unlikely that changes in the rules, incentives and constraints governing resource allocation and service provider behaviour can be achieved in a normative, one-off move. Rather a process of interaction between the regulator and the regulated needs to be initiated allowing for uncertainties and with enough flexibility to permit new problems to be addressed as they arise<sup>2</sup> Progress is likely to be slow, so that determination and sustained effort may be more important than initial policy design. Helping with this is a crucial challenge for international agencies.

***Further reading:*** Focus on Central & Eastern Europe; Eurohealth Special Issue: Vol 6 No 2; Spring 2000.

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2. Wildavsky, (1979) *Speaking Truth to Power: the Art and Craft of Policy Analysis* (Boston: Little, Brown)