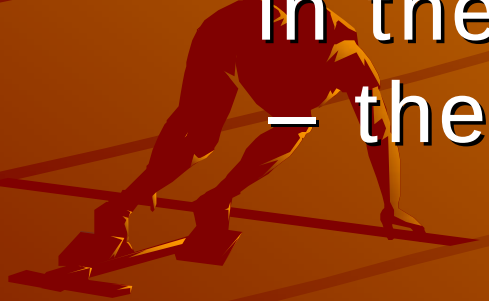
Euro forum 6.

„The role of the state in health care”

PETER MIHÁLYI*

The problems of health care in the context of EU-accession – the economist’s perspective



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What is going on in the health systems of post-communist countries?

1. De-integration

Instead of a monolith system based on the historico-logical heritage of the Soviet Union, we have now 28 countries displaying important variations.

2. Disintegration

Every health care system is critized by patients

	B	DK	D TOTAL	GR	E	F	IRL	I	L	NL	A	P	FIN	S	UK (Tot.)	EU 15
TOTAL weight.	1049	1001	2043	1002	1000	1007	991	1002	600	1014	1018	1000	1005	1000	1350	16129
1. Runs well	23.8	16.5	15.6	2.9	13.2	22.0	3.7	6.5	21.7	6.5	31.8	1.8	24.0	11.4	8.3	13.2
2. Minor changes needed	41.3	35.1	31.5	15.9	32.4	41.9	16.7	24.4	46.0	39.1	35.4	12.5	48.6	36.3	22.9	30.7
3. Fundamental changes needed	22.7	39.4	34.8	50.5	38.6	25.5	39.3	45.6	20.4	46.8	23.0	39.0	21.0	37.8	49.7	38.2
4. Completely rebuild system	5.2	6.1	11.1	27.6	12.1	7.0	32.9	19.9	8.2	6.8	4.3	41.4	3.2	10.6	15.8	13.5
5. Uncertain/Don't know	7	2.8	6.9	3.1	3.7	3.6	7.5	3.5	3.8	0.8	5.5	5.4	3.1	3.8	3.3	4.4

Source: Eurobarometer, 2003

WHY ?

- People are all mortal; ageing implies pain, ill-health and social devaluation. → Health system is the scapegoat
- Health systems are – at least 50% - publicly funded everywhere. → Matter of public choice (Recurrent subject in election debates)
- Health issues often have links to sex and blood → Sells well in the media

Why do voters and politicians need scapegoats?

1. The consequences of harmful life-style are cumulative and (mostly) irreversible
2. Living dangerously – Not a matter of choice. (Socially and economically conditioned.)

→ More money and/or system improvements can't help much.

Summary

- A wrong system – why did it work?
- Disintegration = the health care system breaks down along logical borders
- Hospital sector: waiting for foreign investors
- Insurance reforms (if time permits)

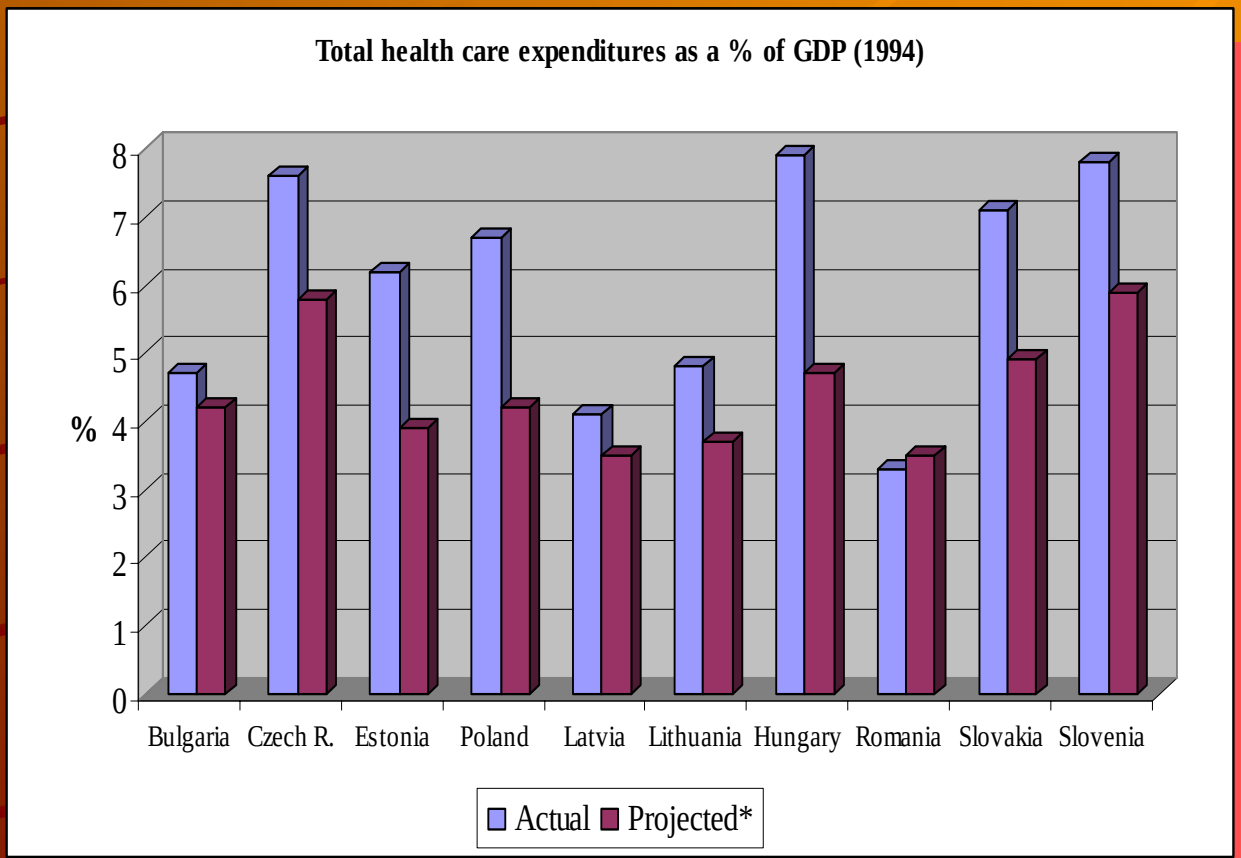
Why did it work under communism? (1)

The Soviet system was a „dictatorship over needs”. Planners valued health more than individual citizens do in market economies at the same level of development (GDP/head).

Why did it work? The details (2)

- Politicization of health → public health programmes
- Planned „doctor-patient" encounters (no choice)
- Polyclinics = economy of scale
- Hospital building for military reasons was a good health investment in peace times (infant mortality, communicable diseases)
- Salaried physicians are „cheap"

Post-socialist countries are high-spenders

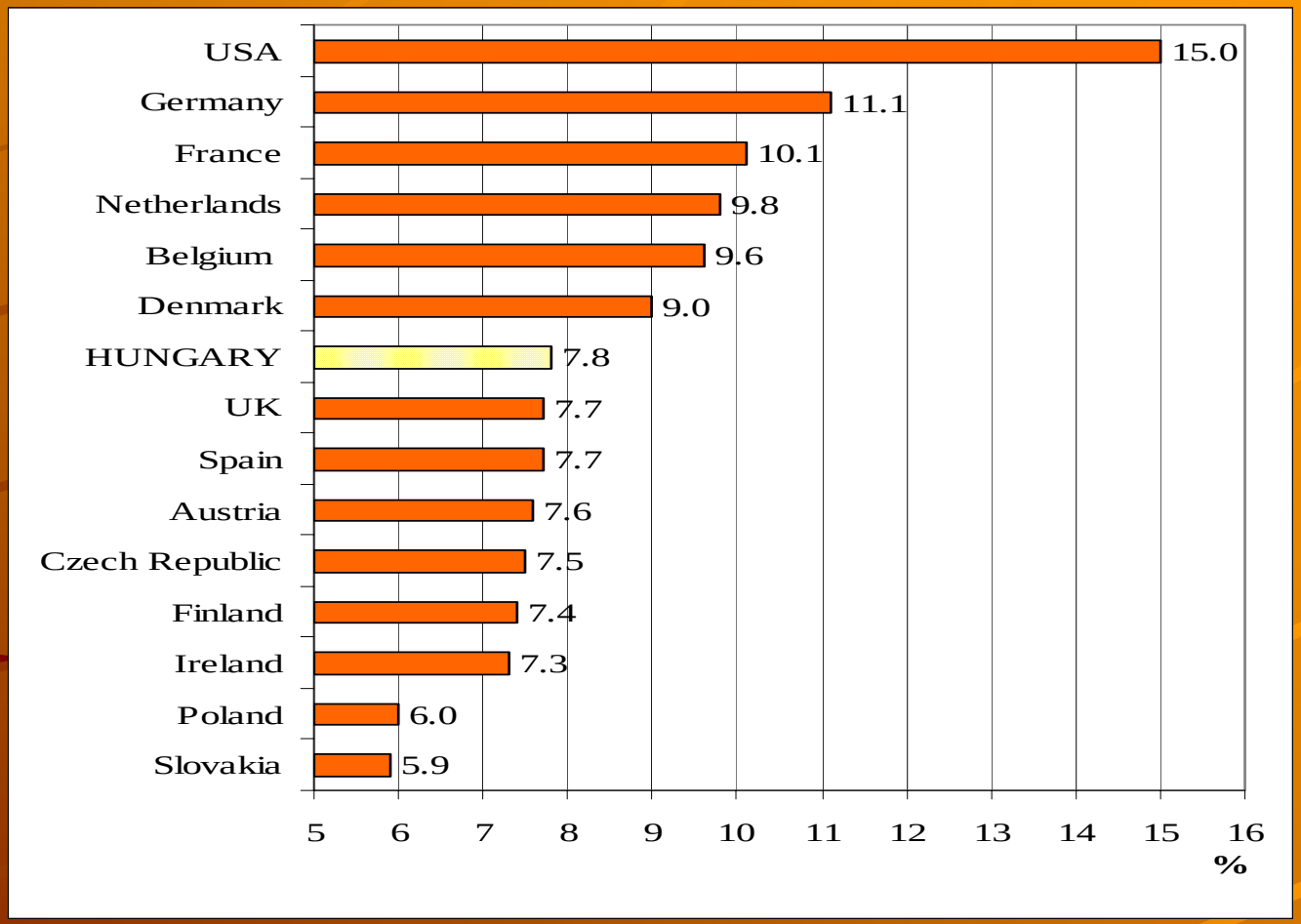


* Projections were based on actual OECD data for 25 countries, including GDP/head, proportions of elderly, share of women in employment.

Note: Estimations for 1990 (i.e. last year of the communist period) show similar results

Source: Kornai – McHale (2000)

The picture is probably similar today (2003)



Source: OECD

The convergence hypothesis

- The planned health care systems of the socialist countries resembled very closely to state-financed and state-run health care systems in the developed market economies.
- The similarity with the British NHS was particularly striking.

- Footnote: The same was true for the military.

Reverse learning

1. State-run systems, where the price mechanism is not allowed to work → shortages*
2. Planning targets don't work (neither physical, nor monetary targets) → bureaucratic bargaining
3. ...but as a second best „market socialism" is superior to state planning → incentive: money follows the patient (DRG, capitation)

* Kornai (1980)

Overlapping system of health care provision – modified Semashko-system

- Territorial model
- Factory-based systems
- Network to cure the members of the party- and state machinery.
- Teaching hospitals
- Private solutions.

The process of disintegration

	Territorial structures under MoH	*Territorial structures under other line ministries*	*Other structures*
Levels of provision			
Primary care	Nurse, midwife or *feldsher* lead health posts in rural areas	Primary care provided in educational facilities (kindergartens, schools, universities)	
	Family doctors, district physicians, paediatricians, dentists, in-home nursing	Workplace primary care provision	
	Polyclinics ---single-handed ---group practice	Primary, secondary and tertiary care provided by health care organizations under the ministry of defence, interior, transport or the trade unions (solo practices, occupational health centres, hospitals)	
Secondary (specialized, out-patient) care	Solo practices Ambulatory clinics, dispensaries, centres for emergency care Polyclinics ---Free-standing ---Attached to hospitals Out-patient specialists ---Standard treatments ---New technologies (MR, CT, dialysis, etc.)		Secondary and tertiary care provided by health care institutions attached to medical universities and schools (clinics)
Tertiary (in-patient) care	Municipal hospitals		
	Single specialty hospitals, national institutes, one-day-surgery		Tertiary care provided by religious organizations
Social care	Rehabilitative facilities, sanatoria, resorts, spas Long-stay beds, convalescent care facilities, nursing homes, day-care centres, infants' homes	Rest homes, veteran homes, resorts under the Ministry of Social Welfare or other line ministries.	Social care provided by religious organizations

The heritage of the communist past

- Economy: High levels of industrialization, urbanization and gender equality (stress, smoking, drinking, obesity, etc.)
- Politics: Low level of honestly felt solidarity, no confidence in government

The hospital sector (1)

Hospital = a complex system with long, multi-stage agency chains.* Some of these chains are external (e.g. to suppliers, the system of referrals), others are internal (e.g. co-operation among specialists).

→Long agency chains need to grow incrementally and evolve over decades.

→The problem: political elites don't want to wait.

* Stiglitz (1999)

The hospital sector (2)

- Privatization is the only solution, even if private hospitals are few and far between in OECD countries.
- However, there is negative correlation between development levels and the share of the private sector.
- FDI is the only solution
  - High capital intensity
  - The role of confidence
  - High levels of organizational sophistication

Health insurance – the EU context

- Mobility among MS, atypical employment relations
- Low level of confidence towards the state
- Limited autonomy of MS in taxation matters
- Health financing companies are subject to the financial institution directives

→ Increasing difficulties to maintain the mandatory system, the sole guarantee of universal (100%) coverage

References

1. Kornai, J. [1980]: *The Economics of Shortage*, Amsterdam: North Holland
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3. Stiglitz, J. (1999): „Whither reform?” *The World Bank Annual Conference on Development*, Keynote address

Thank you for your attention!

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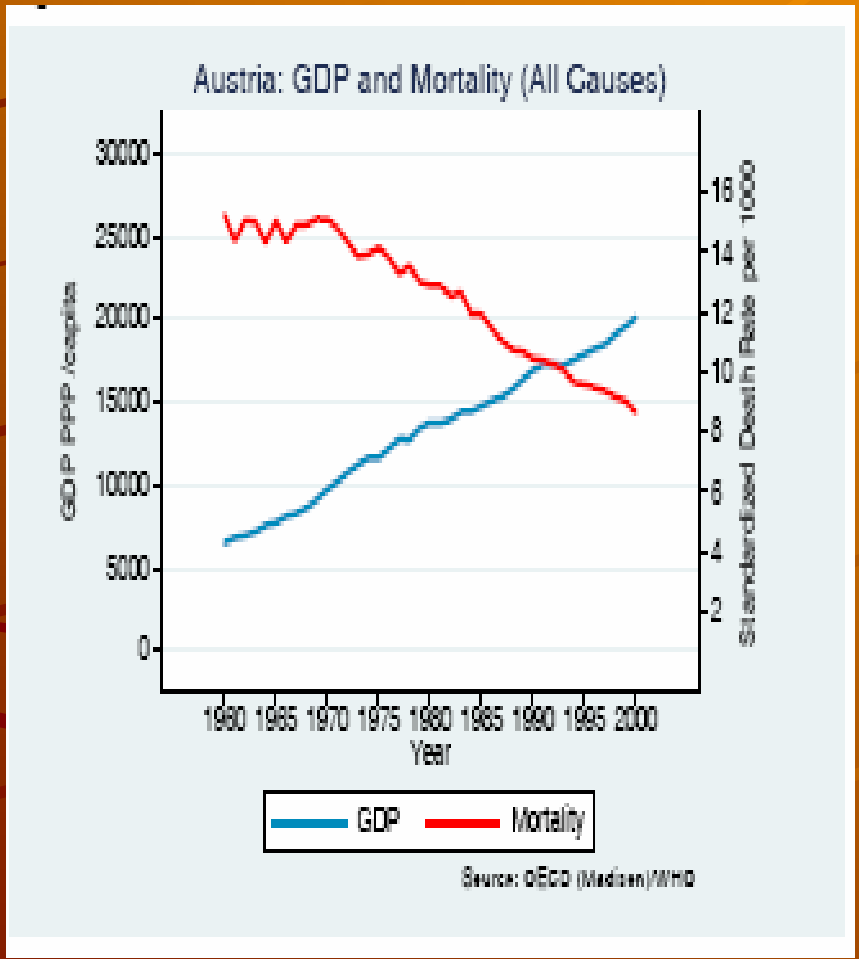
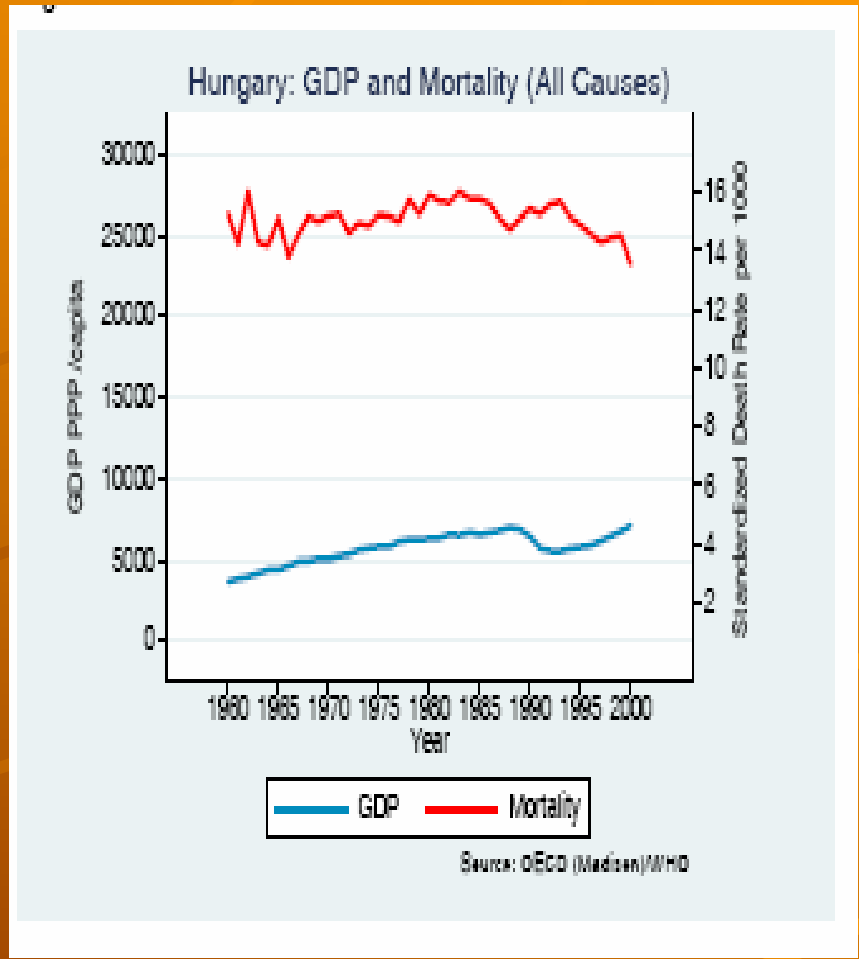
Mortality and economic development





… the direction of causality is unquestionable