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Health Reform: Knocking at the Wrong Gate

Defying the logic of reform, the hospital sector takes a larger share of health resources. The policy changes under consideration at the Ministry of Health will either be irrelevant or downright detrimental.

Romanian health reform aimed to increase the overall resources allocated to health care and to shift the emphasis from in-patient to primary care. Three years after the nation-wide introduction of the new funding system – social insurance – the pie for health has substantially increased. In spite of comparable utilisation tares, hospitals consume an even larger share of this pie. This is due to no effective cost-containment incentives in a non-competitive system dominated by hospital doctors. The situation has the risk of crowding out expenditure for the primary care – an essential element of the reform strategy -, and for subsidised drugs – a paramount social issue. The new administration has correctly identified the hospital sector as the weak link of the reform. Its key policy proposals however either fail to correct the problem – the new funding system based on the case mix (DRG) – or might make even worse – the partial privatisation of hospital clinics, that runs the risk of shifting private costs to the already over-burden public sector.

Background

Romanian health reform has been under consideration for most of the 1990s. The crucial piece of legislation, the Law of Social Health Insurance, has been passed in 1997, and started to come into force in 1998. The law replaced the old funding system from one based on national taxation, to a payroll hypothecated tax (social insurance), administered by regional (county) health funds.

The two most important objectives of the reform process have been:
- to increase the overall resources for health, and
- to shift the emphasis from inpatient care, to primary care

For exemplification, table 1 summarises the main problems to be solved, in the view of consultants who helped draft the reforms. Low funding and emphasis on specialist care figured prominently.

Table 1. Pre-reform strategy. Bottlenecks and problems in Romanian health care

∗insufficient funding
⇒ especially low incentives for professionals
∗poor health indicators
∗inefficiencies:
⇒ emphasis on specialist care

⇒ high hospitalisation rates (but average length of stay) ⇒ surplus of hospital beds and low occupancy rates (but no staff surplus)
∗ insufficient quality assurance ∗ poor performance of some prevention programmes ∗ existence of parallel health care systems ∗ decreased access in rural areas ∗ unclear ownership of facilities

source: BASYS, 1997

The reform process got further in primary care, which was effectively privatised through the introduction of family practice and the change of the funding system to one based mainly upon capitation. There was much less progress in the hospital sector. The ownership of facilities is still unclear, and funding is still based on historic budgets. The health funds, which theoretically are the purchasers of health services, and have to contract the providers, failed to act selectively and had little impact upon the behaviour of providers.

Healthcare Funding

Romania used to spend for health between 2-3% of GDP. This was one of the lowest shares of GDP devoted to health among CEE countries – even if, according to the World Bank, consistent with the development level of the country. The health status of the Romanian population also looked worse than in neighbouring countries. In this context, policy makers considered the level of spending insufficient, and the social insurance was introduced to mitigate this situation.

Table 2 shows that since its introduction in 1998, social insurance has reached this goal. Public expenditure on health increased to 4% of GDP. When private expenditure is added, the total amounts to almost 5%. While this is still low by European Union practices, and even by the statistics of other CEE countries, it is a considerable increase in relative terms over the early 1990s.

Table 2. Evolution of health expenditure – relative terms

Funding sources	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total public health expenditure (billion ROL, actual prices)	24	62	185	592	1544	2213	3228	7064	11600	20969	28817
Total public health expenditure out of GDP (%)	2,7	2,8	3,1	3,0	3,1	3,1	3	2,8	3,2	4,0	4,0
Private health expenditure (billion ROL, actual prices)	7,5	16,5	-	-	-	-	767	1782	3120	4673	-
Total health	3,5	3,5					3,7	3,5	4,1	4,9	-

expenditure out of GDP (%)											

Even in absolute terms, the increase in resources is substantial. Table 3 presents the evolution of health expenditure calculated in US dollars. The absolute expenditure declined with the start of transition – the share of GDP remained constant, but GDP contracted. The introduction of social insurance resulted in an absolute increase of about 25% over 1990, and over 30% over 1997 (the last year before the introduction of social insurance funding).

Table 3. Evolution of health expenditure – absolute terms

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total public health expenditure (million USD)	1090	816	601	779	933	1088	1047	985	1307	1368	1340

Social insurance has now become the main source of funding for the health sector, by far. Table 4 presents the evolution of sources of funding. Currently, social insurance accounts for over 80% of health finance.

Table 4. Main public funding sources for the health sector

Funding source (%)	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Taxes	100	100	100	100	100	100	100	100	36,2	21,6	19,9
- national	100	100	82,7	61,7	64,6	62,5	64,5	64,3	31,6	18,7	16,5
- local	-	-	-	17,1	17,0	18,2	19,1	18,8	0,6	0,5	0,5
- health tax	-	-	17,3	21,3	18,3	19,2	16,4	16,9	4,0	2,4	2,9
Social insurance	-	-	-	-	-	-	-	-	63,8	78,4	80,1

Hospital sector

Romania entered the reforms with an over-bloated hospital sector – not unlike most EU and CEE countries however. The main indicators used to assess the efficiency of the hospital sectors are:

- number of beds,
- occupancy rate
- number of admissions, and
- length of stay

On the last data available, Romania figures at the higher end, but within the expected range, on all these indicators. The rate of admissions (about 20 / 100 people), and the length of stay (about 10 days) are in the higher numbers in WHO Europe region as a whole, and average for CEE countries. The occupancy rate (about 75%) is in the lower half, while the number of beds (over 7 / 1000 population) is in the higher one.

In assessing this performance we have to take into account that all the countries we benchmark with have a dire situation in the hospital sector: they all attempt to reduce the number of beds, admissions and length of stay, and to increase the occupancy rate. A situation that is slightly worse than their average is still problematic.

However, it is important that over the 1990s these indicators moved in the right direction. The number of beds declined sharply by about 20%, while the admission rate stayed practically the same. This boosted the occupancy rate. The length of stay declined by about 15%.

The most important conclusion from the point of view of funding is that the utilisation indicators have not worsened. This shows that the pressure for increased spending does not come from a larger number of cases.

Hospital funding

In table 5 are listed again the expectations of the artisans of the reforms concerning the allocation of resources inside the health sector. We can clearly see the intended shift of resources away from the hospital sector, and into primary care.

Table 5. Wishful thinking: 1997 pre-reform strategy.

Kind of health care	Current (1997*) financial allocation of resources	Estimated financial allocation of resources
1. Hospitals	50%	35%
2. Secondary care	30%	30%
3. Primary health care	20%	35%

Source: BASYS, 1997
* our remark

Table 6 presents the actual break down of resource allocation inside the health sector. In parallel with the actual expenses, are presented the provisions of the frame contract (drafted at the start of the year), and of the summer budget – the mid-term correction of the budget.

Table 6. Health expenditure: comparison between actual expenses and amounts provided by the National Frame Contract (NFC), and revised mid-term budget (MTB)

Tip serviciu	**1998 Actual (%)**	**1999 NFC (%)**	**1999 MTB (%)**	**1999 Actual (%)**	**2000 NFC (%)**	**2000 MTB (%)**	**2000 Actual (%)**	**CoCa 2001 (%)**
Primary care	9,01	15,5	9,48	9,05	14,5-15	9,78	9,51	14,5-15
Out-patient (specialists)	5,85	11,75	6,62	6,11	8,75	7,85	7,23	8,75
Hospitals	67,25	40,00	61,24	64,18	59-61	63,99	65,48	50-53
Subsidised drugs	6,81	20,0	9,32	8,03	10-11	12,83	12,41	10
Dentistry	2,66	4,25	2,76	2,36	2,5-3	1,58	1,43	3
Rehabilitation services	0,82	1,00	1,17	1,11	1	0,63	0,65	1-1,2
Protesis	3,23	3,00	0,62	0,28	1	0,33	0,28	1
Ambulance	4,32	4,50	3,80	3,67	3-4	3,00	3,00	3

services								
Health programmes	0,06	0	4,99	5,20	0,1-1	0,00	0,00	8
Total	100	100	100	100	100	100	100	100

In each year the shares of hospitals increased in the summer budget is still over-shot by the actual expenditure. The reverse is true for primary care and drug expenditure. These data show the inability of the budget sector to respect budget constrains. We have to bear in mind that, as table 7 proves, the resources actually collected have always been fewer than the estimates: the actual income has been lower in each year compared with the amount in the summer budget. This resulted in lower than expected expenditure. In consequence, a higher than expected share for hospital expenditure means lower than expected real resources for primary care and medicines. From the champion of reforms, primary care is the Cinderella of budget allocations.

Table 7. Income and expenses of the Health Funds 1998-2000

Billion ROL	**1998**			**1999**			**2000**	
	Budget law	Mid-term budget correction	Actual	Budget law	Mid-term budget correction	Actual	Budget law	Mid-term budget correction
Income	10296	9541	8372	11967	20443	18386	26725	29002
Total expenses	7626	7584	7403	11368	16997	15958	23907	25261
Reserve fund	-	-	-	598	962	806	1336	1450
Ballance	2669	1957	969	0	2484	1622	2292	2292

To put things into context, in table 8 is presented the break down of resources by sector in healthcare for the OECD countries.

Table 8. Public health expenditure break down by sector in OECD countries

Public expenditure by health care sector out of total public health expenditure (%)	Median	Average	Maximum	Minimum
Hospitals	52	54	78	30
Drugs	12	13	27	6
Out-patient services	20	21	40	8

The critical fact is that Romania spends, in relative terms, more on hospitals, and less on primary care, and drugs than most OECD countries. In addition, we have to bear in mind that this break down is based on the expenditure of health funds. Were the rest of about 20% of public expenditure to be taken into consideration, the share of hospital expenditure would be even higher.

This is even more surprising if we take into account that in the early 1990s Romania was, together with the Czech Republic, the champion on drug spending. The expectation for a country like Romania is to spend a higher percentage on drugs than western countries, because the price of tradable goods like drugs vary less among countries than the price of labour. Therefore the labour intensive sectors should take a lower share from overall resources in Romania compared with Western Europe.

An institutional explanation

The root of the problem springs from the lack of adequate institutional incentives for cost-containment at the hospital level. The hospital sector is very powerful politically, as it comprises the elite of the medical profession. The matter is made worse by the fact that members of these elite form the decision-makers at all levels of the health system: health managers, Ministry of Health, health funds, medical college, and most of the politicians dealing with health.

The lack of competition between health funds (that are regional monopolies, and therefore do not have to compete for clients) creates an institutional set-up where there is no incentive for the health fund to take on these powerful interest groups and enforce hard budget constrains upon hospitals. The dominant strategy is an alliance of the purchaser with the provider to pass the costs to the budget.

In addition, the autonomy of hospital managers is limited, what precludes even the restructuring measures intended by the public-spirited managers.

Reform plans of the government

The previous administration had come to terms with the profligacy of the hospital sector, and accommodated their increased expenditure. The new leadership in the Ministry of Health (and Family) has identified the reform of the hospital sector as the priority. It is less clear whether the new decision-makers understand the mechanisms that led to the current predicament and if yes how are the policies that have been announced going to mitigate the situation.

The main initiatives consist of changing the funding system to DRG (diagnosis groups), and partial privatisation. Theoretically, basing the funding on the case-mix rather than on actual costs would encourage hospitals to be more efficient. The problem is that DRG per se could lead to more efficient interventions, but not necessarily result in overall cost reduction. More important, the full implementation of DRG is a very complicated process, which is going to take years. That is proven by the experience in Hungary, the first CEE country to use this method. Therefore whatever benefits it will bring, DRG is not going to be a solution in the short term.

Privatisation is a tricky matter. Whether this means outsourcing of some services, or even privatisation of ‘hotel’ services, it will improve efficiency. Partial privatisation of hotel facilities however bears the risk of part of the costs of these private facilities being passed to the public section of the hospital. A much better alternative would be outright privatisation of whole hospitals (or creating new private hospitals out of scratch).

While both policies have things to be commended for, they fail to address the cost containment of hospital expenditure and the looming crises in the primary care and pharmaceuticals.

Conclusions

The hospital expenditure is out of control, and is squeezing out the resources for pharmaceutical products and for primary care. In spite of improved overall funding for health and no increase in utilisation rates, hospitals consume an even larger share of health resources. Romania, despite its low wages, is in the paradoxical situation of allocating to hospitals a larger share of public health resources than OECD countries.

This situation presents obvious social and political risks. In addition, it undermines the role of primary care as the champion of reform.

The initiatives of the new administration concerning the hospital sector fail to address the cost-containment problem. While the shift to case mix funding and privatisation are commendable it their own right, their effects will not be seen for years to come. Moreover, partial privatisation of hospital clinics might even worsen the financial problem in the public sector, resources from the latter being de-toured by managers to private patients.