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The hospital black hole sucks in the healthcare system

The incentive misalignments in the hospital sector endanger the viability of the health system. The policy response of the government is mute, and the coming debate on the hospital bill is going to be irrelevant to the real woes of the health sector.

The Romanian healthcare service is undergoing one of the worst crises after 1989. Since the start of the year, the public has been bombarded with horrific stories about the state of the health system. Family practitioners, the supposedly winners of health reform, and the one medical category that so far had shown in surveys the most consistent support for the reform process, went on strike over funding. The media focused on an apparently endless series of medical and managerial failures: from Iasi to Arad children were dying because of malfunctioning equipment, or a streak of intra-hospital infections. Echoing public sentiment, Kraft Jacobs Suchard, a multinational, launched on Pro TV a campaign for helping children hospitals. Public spirited as this might be, the campaign was certainly depressing, providing images of shocking decay. Finally, hospitals from across the country announced they were facing a financial crunch. A psychiatric hospital let it be known that it that it faced a number of escapes, because it cannot afford to pay for adequate guarding. The crisis hit home when the Fundeni Hospital, one of the most prestigious of the Bucharest hospitals announced it is unable to meet its water bill.

While many of these cases can be put down to exceptionally poor management, it is clear that systemic causes are to blame for such an alarming increase in reported funding problems. More important, the government seems unresponsive to the problems of health suppliers, and its policy recipe fails to address the causes and is rather inconsequential.

Reform logic - up side down

Romanian health reform aimed to increase the overall resources allocated to health care and to shift the emphasis from in-patient to primary care. Four 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 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.

Health funding

Even in absolute terms, the increase in resources brought by social insurance is substantial. Table 1 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 1. 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

In relative terms, total health expenditure moved from around 3% of GDP in the early 1990s, to almost 5% in present.

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 are 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 rather 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 2 are listed 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 2. 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 3 by contrast 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 (NFC, drafted at the start of the year), and of the summer budget – the mid-term correction of the budget (MTB).

Table 3. 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 services	4,32	4,50	3,80	3,67	3-4	3,00	3,00	3
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 the resources actually spent 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 4. 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 5 is presented the break down of resources by sector in healthcare for the OECD countries.

Table 5. 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 breakdown 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 varies 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.

Incentive misalignments

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 (which 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. Moreover, the only instrument for motivating managers is the rather gross firing threat, while no incentive plans are available.

Reform plans of the government

The leadership in the Ministry of Health and Family has identified the reform of the hospital sector as a priority. It is less clear however whether the 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. These matters are going to be settled soon, as starting this year the DRG system has been introduced experimentally in a number of hospitals.

Privatisation is a trickier 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.

A new hospital bill

The current hospital bill is more remarkable through the maters it fails to settle than for any consistent reform. As a sign of the perceived urgency of the hospital sector crisis, the Parliament is faced with two new drafts of the hospital bill. One is coming from the Ministry of Health and Family, and the other is put forward by the College of Physicians (the professional body). The two drafts have many similarities. The main innovation brought by the government is to increase the financial autonomy of the hospital, by allowing it to borrow up to 15% of the contracted income, with the

condition that the overall debt level is no larger than 20% of the yearly budget. The College of Physicians goes a step further by allowing depreciation to be counted as a cost.

However, both drafts fail to address some fundamental issues:

- *hospital ownership*

The alternatives are to transfer them to local government, or even better to grant them the status of autonomous not-for- profit organisations

- *financial autonomy*

In spite of the welcome permission to borrow, the hospital management will continue to be construed, and more important to lack incentives for full financial accountability. The drafts would preserve the situation where the management has no incentive to economise on non-operational costs, which are provided on discretionary basis by the national or local government (equipment purchase, and building development are funded from the central budget, while maintenance costs could be provided by the local government). This contrasts which the situation of the operational costs covered by the County Health Insurance House, according to the National Frame Contact, and which bare some relationship with performance (ie utilization) indicators.

The effects of the envisaged strengthened control over the management ability to accumulate back-payments are unlikely to have much effect unless the incentive structure is changed.

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 government 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. Partial privatisation (as opposed to full privatisation) might even worsen the situation.

The new drafts for the hospital bill increase the financial flexibility of the management. The inclusion of depreciation costs in the balance sheet, proposed by the College of Physicians, is especially welcome. However, they do not go far enough:

- the ability to fund investments is constraint by the limits on borrowing
- no motivation factors for managers are introduced; in contrast, exclusive reliance is placed on administrative controls;
- in addition, the ownership issue is not solved.

The non-competitive nature of the Romanian social health insurance funds is always going to create incentives problems. They can be however partly mitigated by:

- clarifying the ownership of hospitals, by transferring them to the local government, or better by establishing them as independent charities
- creating the incentive for managers to allocate efficient all expenses, by funding capital and operational expenses according to the same mechanism (e.g. from the Health Insurance Fund)
- devising incentive plans for hospitals managers that reward good performance.