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AN OVERVIEW OF HEALTH IN THE TRANSITION COUNTRIES

ARTICLE BY AKAKI ZOIDZE, GEORGE GOTSADZE AND STUART CAMERON

Abstract

SINCE THE EARLY 1990S, SOME 32 COUNTRIES IN ASIA, CENTRAL AND EASTERN EUROPE, AND THE FORMER SOVIET UNION[1] – REPRESENTING ALMOST A QUARTER OF THE WORLD'S POPULATION – HAVE BEEN MAKING THE TRANSITION FROM A CENTRALLY PLANNED TO A MARKET-BASED ECONOMY. WHILE THESE COUNTRIES ARE DIVERSE IN TERMS OF GEOGRAPHY, WEALTH, HISTORY, CULTURE, POPULATION AND NATURAL RESOURCES, THEY ARE CONFRONTING COMMON CHALLENGES AS THEY RESTRUCTURE THEIR PUBLIC SECTORS AND ADAPT SOCIAL AND PUBLIC HEALTH POLICIES TO THE REQUIREMENTS OF THE NEW ECONOMIC MODEL. THIS CHAPTER PROVIDES AN OVERVIEW OF THESE ISSUES AND CONSIDERS POLICY RESPONSES TO THEM.

Many of the countries moving towards a market-based economy have faced significant problems of equity and access to basic health services during the transition years, as a result of diminishing public resources available for health care, increasing user charges and rising poverty levels. This chapter, based on an online dossier in the Health Systems Resource Guide (www.eldis.org/healthsytems), provides an overview of these issues and considers policy responses to them. Summaries and full text versions of all of the references, as well as further readings and other resources, can be accessed freely via the online version, at www.eldis.org/healthsystems/te.

Pre-transition health systems

Prior to transition, most transition countries shared similar systems based on the "Semashko model" developed in the Soviet Union in the 1920s. This model involved publicly funded, centralized and integrated health systems with universal or close to universal entitlement to free health care. The Semashko model placed an emphasis on in-patient and specialist care and on wide-scale public health interventions. The burden of financing the health system was evenly distributed across the population, there were few financial barriers to accessing services and geographical coverage was excellent.

From 1950 to 1970, many of these countries experienced a dramatic fall in early mortality and enjoyed better health outcomes than other countries with a similar level of average income. Major achievements included successes in controlling vaccine-preventable diseases, tuberculosis, leprosy and schistosomiasis, and the eradication of malaria.

However, the Semashko model was not without flaws. It tended to be inefficient and unresponsive to patients' demands and needs. Investment decisions were politicized and often inefficient, leading, for instance, to an over-reliance on curative, in-patient and specialist care at the expense of health promotion, disease prevention and primary care.[2] These flaws limited the system's ability to deal with an ageing population and changing disease patterns, and the 1980s saw a decline in some of the major health indicators.

The transition process

Transition to a market economy has resulted in economic liberalization; privatization, deregulation and decentralization; and the introduction of market mechanisms designed to support competition and improve efficiency.[3] However, these changes have had varying degrees of impact on people's health. Some countries, and some groups of people within countries, have fared better than others.[4]

A massive growth in poverty and the emergence of new forms of poverty and regional inequality have been major features of transition for some countries.[5] Even in China and Vietnam, which achieved significant reductions in poverty, growing income inequality and rural-urban and regional disparities have posed serious challenges for access to essential social services.[6]

Attempts to decentralize services and increase the involvement of the private sector and civil society have been hampered by institutional weaknesses, corruption and inadequate legal frameworks. In many countries, central government is still directly involved in the delivery of local services. Local governments have few sources of revenue and intergovernmental transfers often fail to address fiscal equity between regions.[7]

Economic and political volatilities, public policy constraints and growing poverty and inequality have all made transition nations more vulnerable to global health epidemics such as AIDS and

tuberculosis. Some infectious diseases which had been successfully eradicated have also re-emerged. In addition, lifestyle changes in many countries have included an alarming rise in cigarette smoking and alcohol intake[8]. Multinational tobacco companies have been accused of aggressively wooing consumers in the transition countries[9].

The ability of health systems to respond well to these changes has itself been limited by the effects of economic and political transition. With the exception of some European states, countries have had difficulties maintaining the strengths – and mitigating the weaknesses – of the Semashko model[10]. Challenges have included declining public expenditure, changes to the structure of the workforce, the drain of skilled human resources from the public sector, and limited and overstretched capacities of institutions and governments to deal with multi-sectoral reforms. Combined with increased user charges for health services, the consequence for many countries has been significant problems of equity and access to basic health services during the transition years.

Changes in health financing

Most transition countries have shifted towards a decentralized, contract-based social health insurance system, resembling the Western European "Bismarck" model. It was hoped that this would generate more finances for health, improve efficiency and make health financing more equitable and sustainable in the long term. While most European transition countries more or less succeeded in achieving the desired outcomes, the experiences in the Commonwealth of Independent States (CIS) and East Asian transition countries so far have been less encouraging.

Implementation of social health insurance has been hampered by weak macroeconomic and institutional contexts, including corruption, the reliance of poorer countries on out-of-pocket payments, low formal employment, poor compliance and lack of transfers from tax or social security funds to health insurance. Purchasing of services tends not to be cost-effective, and performance-related payment systems for health providers have produced mixed results.[11]

Increasing attention is being given to private health insurance (PHI) as a way of making up for low public expenditure, increasing risk pooling, addressing escalating health care costs and improving quality of care. PHI currently plays only a marginal role, but is on the rise in many countries due to growing dissatisfaction with public health care, liberalization of markets and higher and more diversified consumer demand.[12]

Restructuring delivery of health care

One of the most challenging tasks has been to restructure health care delivery systems in order to improve efficiency and establish an optimum "continuum of care" – a range of services that best addresses the highest-priority needs, given resource constraints.

In the hospital sector, transition countries have tried to improve efficiency by closing down hospitals, reducing the number of beds, decentralizing, privatizing, introducing business-like management practices into public sector hospitals, and introducing performance-based pay. The results have been mixed and often disappointing – perhaps not surprisingly, given that hospital systems in all parts of the world have proved very difficult to change. Political economy factors, powerful vested interests and the political and economic turmoil of transition often prevented governments from putting plans – even well-designed plans – into action.[13,14]

Human resources issues, such as adjusting the mix of skills in the workforce and creating adequate motivation systems have also been significant. Most transition countries have too many overly specialized physicians and inadequately qualified nursing staff. Reforms often led to reductions in the workforce, contracting out of health services and increased short-term and temporary employment contracts.

Ineffective payment mechanisms and the resulting low motivation of medical professionals have led to the proliferation of informal payments, dual working and a brain drain to other professions, other countries or the private sector. For those who remain in the public sector[15], the consequences have been worsening working conditions, lack of employment security and dismantling of collective bargaining agreements for those who remain in the public sector. There is a perception that health personnel are underpaid, poorly motivated and increasingly dissatisfied.[16]

In China, growing income differences between the residents of rich and poor provinces, combined with radical devolution of financial management, have made it almost impossible for the government to maintain uniform pay levels for health workers. Individual facilities can pay bonuses from revenues generated from user charges and drug sales, and so employees in more successful facilities earn far more than colleagues working in less well endowed facilities or in poorer regions.[17]

Equity and sustainability

Overall spending on health has risen steadily in transition countries. But reforms have meant that the proportion coming from public spending has shrunk, and private out-of-pocket payments have become a major source of financing. There are two ways in which this has happened. In some cases, governments have introduced formal user charges and co-payments for health services which they were no longer able to cover. But in other cases, a mismatch between public expectations and government funding has led to resources being increasingly overstretched and proliferation of informal ("under the table") payments – especially in lower income countries.

These informal payments may become major impediments to health care reform.[18] On the other hand, it has also been argued that all fees for health, whether official or not, are associated with major problems of equity and access, and that it is simplistic to focus only on informal payments.[19,20,21] Evidence from China and Cambodia has shown that both types of payment, particularly for in-patient care and management of chronic illnesses, can lead to impoverishment.[22] Evidence from the Soviet Union highlights the importance of a functioning system for referring patients to specialists, and also shows how access is particularly impaired in countries facing major problems such as economic collapse or civil war.[23]

Lessons learned

A number of specific lessons for carrying out health reform have emerged from the literature. These include the following.

Health sector management reform

Some authors have called for a clearer separation between purchaser and provider functions in the health system[24] and for greater hospital autonomy.[25] World Bank research on a range of public sector management reforms[26] endorses managerial autonomy and stronger accountability as ways of improving services, while casting doubt on whether competition can improve efficiency. This research also suggests that decentralization is important, but should not be allowed to compromise the strength of central agencies. Decentralization in China has reduced funding levels and service quality, and increased the use of non-medical personnel in health centres. These experiences highlight the need to take local realities into account and to strengthen local management capacity when decentralizing.[27]

Hospitals

Whilst there may appear to be too many hospital beds in eastern Europe and the CIS, it has to be remembered that hospitals are often the main providers of social care. Hospital closures should only follow the provision of alternative, and more appropriate, forms of social support.[28] Many patients would be better managed outside of hospitals or could be discharged earlier, if better primary care were made available.

The pursuit of efficiency through marketization of hospitals may also lead to undesired side effects. Evidence from China[29] suggests that reforms increased the financial accountability of public health institutions, and led to fewer wasted resources. But there was a high social cost, including reduced use of immunization services and cutbacks to key services and health education programmes. The authors warn that cutting funding to public health can make it less, not more efficient, and market reforms can have unintended consequences which outweigh the intended ones.

Private sector

Governments need to rebalance an already complex mix of public and private roles in the health sector, in order to draw on the respective strengths of each. However, the evidence base on how to do this is limited.[30] Zwi, Brugha and Smith[31] recommend three objectives in relation to the private provision of care for conditions of public health importance: widening access, improving quality and ensuring non-exploitative prices, but note that none of these will be easy to achieve.

Insurance

The level of national income, structure of the economy, population distribution, capacity to administer SHI, and levels of social solidarity are all critical factors to be taken into account when deciding whether an SHI scheme will work. For many countries these factors tend to be unfavourable for the introduction of SHI as the main source of health financing.[32] Private health insurance can be a valuable tool to complement existing health care-financing options, but a crucial challenge is to develop an appropriate regulatory framework.[33]

Pro-poor policy

Action is needed both outside and within the health sector. Sustained economic growth has been shown to be important in determining health outcomes, but is not the only important factor[34]. More emphasis may be needed on reducing inequality and providing safety nets for the poor. Policies to address equity need to be based on evidence and political consensus[35], and the experiences of CEE and CIS countries provide lessons that are likely to be relevant for countries still struggling with this transition. These include exercising caution when bringing in institutions and laws from other cultures[36]; and redirecting resources towards programmes which target the poor, even if targeting does not work perfectly[37].

Expanding coverage of public health services, particularly primary health care, could improve outcomes for the poor. However, the benefits of subsidized government health services often flow primarily to the better off[38]. More realistic benefits packages are needed, targeted at the most cost-effective and pro-poor interventions[39]. Community health financing schemes are being used increasingly in some transition countries, and may be particularly useful for expanding coverage of informal and agricultural workers.[40]

Finally, Poverty Reduction Strategy Papers (PRSPs) may have an important role to play. Twelve transition countries have developed PRSPs – documents designed to set a comprehensive framework on poverty issues during transition. But it has been argued that PRSPs fail to look systematically at the specific health needs of poor people, or at ways in which improved health could play a role in poverty reduction.[41] Better links between the health sector and the PRSP process could be key to addressing the inter-related issues of poverty and health in transition countries. ❑

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   - (in the former Soviet Union) Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan;
   - (in central and eastern Europe) Albania, Bosnia & Herzegovina, Bulgaria, Croatia, Czech Republic, Hungary, Macedonia, Poland, Romania, Serbia & Montenegro, Slovakia, Slovenia;
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