

Financing Health Care: What Can we Learn from CEE Experience?

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ABSTRACT

Our paper is based on four country samples – Bulgaria, Czech Republic, Slovakia and Slovenia. All these countries are new EU member states, where the (official) goal of the health-finance system is to guarantee universal and equal access to health services. In the first part the country studies describe the evolution of new health-finance systems in selected countries as well as the pros and cons of national solutions. The core part of this paper discusses two important health-financing issues – the decision about how to fund health services and particularly the decision about the relations of public and private funding of health care. We propose two core conclusions: first, because the mode of financing does not have a clear impact on outcomes of the health-care system, the decisions of CEE countries to switch from general taxation to social-insurance systems are based mainly on political rationality; second, introducing pluralistic social health insurance during early phases of transition is too risky.

Keywords: health-care; Central and Eastern Europe; reforms; access; health finance

1. Introduction

All Central and Eastern European (CEE) countries implemented large-scale health-care reforms after 1989, trying to convert a “socialist” model of a health-care system into a “modern” one. The starting point was relatively similar, even though certain differences existed between countries. The aim of the “old” systems was to provide

a comprehensive system of health care for all members of society, free at the point of use. All decisions on health care were generally made on political or administrative grounds, and the only accountability was to the Communist party. Financing the system was based on general taxation revenues (Semashko model). Health reforms realised in the CEE region are subject of several, but not too many analytical studies. The core sources of information are provided by the World Health Organization (WHO), but the main WHO sources do not deal with the CEE region specifically (of “older” publications we may mention the well-known publication by Saltman and Figueras (1997), the most recent ones are, for example, Mackenbach and McKee 2013, Jakubowski and Saltman 2013, Papanicolas and Smith 2013). Concerning Europe (again not the CEE region specifically), the public-private partnership European Observatory on Health Systems and Policies, hosted by the WHO Regional Office for Europe, can be a very important source of knowledge – especially via the edition “Health systems in transition”. Many other international organizations are also very active in mapping health care around the world – for example OECD publishes the OECD Reviews of Health Systems; health care is also an issue for the International Monetary Fund. From CEE-based organizations we may mention NISPAcee (Rosenbaum, Nemec and Tolo 2004) or LGI (Shakarashvili 2005). There are also several health care-focused think tanks in CEE (like the Central & East European Health Policy Network), but their results normally do not have real academic character.

Only few articles in academic journals present comparative policy-analysis studies of health-care reforms in CEE (most of them focus only on selected aspects). We provide some examples. Osterle (2007 and 2010) deals mainly with long-term care issues and also focuses on countries neighbouring Austria. Roberts (2009) investigates access issues from a comparative perspective, Deppe and Oreskovic (1996) analyse early stages of introducing health insurance in the CEE region, Waters et al. (2008) focus on health insurance and access, and Ensor (2004) focuses on informal payments and their scale and patterns.

Information provided by existing sources indicates that the changes after 1989 differ among the CEE countries, depending very much on the specific conditions present at the start and during the processes. Regarding finance most countries decided to depart from a general taxation-based system of financing health care and to introduce some kind of health-insurance system. Such changes were typically supported by arguments about plurality, independence and competition, which were viewed as the main positive features of the new system (Lawson and Nemec 2003).

Data indicate that two main health-finance approaches are used by countries in CEE: establishing a monopolistic public health-insurance fund or establishing a pluralistic public health-insurance system, each of which is responsible for maintaining equal and universal access to services. However, former members of the Soviet Union are much more reluctant to switch, and the result for many of them is a “mixed” system (Bjorkman and Nemec 2013). This situation is an important motivation and source for in-depth comparative research; however, such research is still very much missing on the academic level – our aim is to help to fill this gap. Results of our research should be relevant not only for the selected CEE region, but also for all countries in transition with the aim to establish or maintain universal and equal

access to health services for all inhabitants. They may have specific validity for Slovakia, where the government recently decided to switch from a pluralistic to a monopolistic social health-insurance system.

The intention of this paper is to add to the existing discussion by analysing the modes of health-financing in selected CEE countries, with the goal to assess their pros and cons from a comparative perspective (of results mainly) and to try to formulate possible policy recommendations for conditions of developing countries and their health care reforms. The core research questions of this paper are as follows:

1. How has the decision about how to accumulate/collect resources into the national health care systems been made in CEE countries?
2. Are there any visible performance differences between different health-financing systems in selected countries? Is it possible (on the basis of the facts presented and also of theory) to recommend the “best” health-resources allocation system for transitional countries?
3. How should the relations between public and private (formal and informal) health-care funding be managed in transitional countries?

This paper is very much based on the case-study methodology, but its aims and methods are broader. The first research question is answered via the use of four country case studies – Bulgaria, Czech Republic, Slovakia and Slovenia. The case-study methodology is combined with a brief normative analysis of the economics of health financing and especially with an in-depth qualitative comparative policy analysis of selected important dimension of financing health care in transitional conditions. This combination of methods is expected to be the best way to achieve the planned goals.

We selected as the sample four new EU member states on the basis of the following criteria:

- Countries from Central and South-Eastern Europe with more than twenty years of history of health reforms (to avoid relying on short time outcomes in our analysis as much as possible).
- Countries that decided to switch to social health-insurance systems after 1989, but in different ways.
- Countries that are EU members. EU memberships at least indirectly implies (especially on the basis of the European Charter of Human Rights) that the official goal of the EU-country health-finance system should be guaranteeing universal and equal access to health services.

This sample provides a common but also sufficiently different research basis to try to formulate certain conclusions that can be to a larger or lesser extent valid for most transitional countries, independently of their current status. There are more countries that fit the above selection criteria; the purpose of our selection was to cover all existing different system at least by one example (Poland, Hungary, Romania are to a large extent just variations of what happened in Bulgaria).

The paper is divided into three main parts. The first part provides a brief normative excursion into the issues of health-financing from the point of view of accumulating/collecting resources for the health system. We do not deal with the issue of allocation of existing resources between different providers. The second part includes four country case studies – especially brief historical descriptions of health reforms, health-system input and performance characteristics, and its goal is to respond to our first research question. The third part tries, on the basis of comparative qualitative policy-analysis methods, to respond to our second and third research questions, to indicate if there is any “optimal” health-financing mode, and what should be the role of private finance in the financing of health services for countries in transition. Our analysis is to a large extent based on the results of a NISPAcee-supported project on health reforms in CEE, concluded by a monograph (Bjorkman and Nemec 2013).

2. Financing health care

There is more or less common agreement among all health economic experts that health and health care cannot only be the individual responsibility of citizens and that it is inevitable for the state to have a specific role. Arguments supporting necessary state interventions are mainly based on the allocative and redistributive roles of government (for example Stiglitz 2000).

From the point of view of allocative efficiency, several obstacles prevent the achievement of allocative efficiency in the health-care market, primarily (for example Feldstein 1993):

- health care is an impure public good;
- informational asymmetry;
- externalities; and
- uncertainty and complexity.

In health care, the exclusion of consumers is technically possible but socioeconomically not desirable. An additional argument is that, especially in the case of an emergency, the transaction costs to check a patient’s ability to pay might be too high. Most authors (like Cullis 1979) argue that the limited information on the part of the patient/consumer is the most important obstacle preventing health care from satisfying free market conditions. Free market conditions imply that the consumers of health services must obtain information about the production relationships that govern the effectiveness of all available treatments and about the likely future effects of these available treatments on their health status. In reality, the consumers have little or no information concerning their needs, the level and form of treatment required, and the effectiveness of the treatment. They must rely on producers for all information. Because of information asymmetry and the nature of “good health care” (Feldstein 1993), the most important factor limiting the individual demand for health services likely is the ability to pay. Health care is associated with several kinds of positive externalities, and its provision as a public good can prevent some negative externalities. Very important positive externalities result, for example,

from preventive measures, vaccination and the support of technical developments. Each case in the health-care system is potentially different from every other case. It is impossible to suppose that two different persons with the same diagnosis will have the same treatment with respect to methods, medicines, length of recovery, reactions and so forth. Thus, the supply of health care represents a complicated sequence of adaptive responses to conditions of uncertainty – uncertainty concerning the best way to treat the patient from the time the illness occurs. From the social point of view, there is a general opinion (at least in developed Europe – see, for example, the European Charter of Social Rights) that everyone is eligible for basic health-care services, independent of his or her ability to pay.

The above arguments are widely respected by the current logistics of health-care systems in developed, but to large extent also developing countries – the state is responsible/co-responsible for all the most important aspects of health-care delivery (namely for financing, accumulating and distributing resources, quality and access assurance). In our paper we deal with one dimension of state interventions into health care – we investigate how health finance is accumulated (collected) – the decision a country makes about the optimal way in which to bring public finance into the system. According to existing knowledge (for example Bjorkman and Altenstetter 1998) the main forms of public financing of health-care services (from the point of view of “getting sources”) are as follows:

- a general-taxation-based model (tax revenues are used for the financing of a dominant part of health services, including in the United Kingdom and Nordic countries; used as the norm in former socialist regimes in CEE);
- a social-insurance-based model (compulsory-health-insurance revenues are used for the financing of a dominant part of health services, frequently called the “Bismarck model”, in which the state provides resources via the insurance market); and
- a program model in which public funds are provided for health care via specific targeted programmes (a typical example is the United States, with Medicare, Medicaid and several other programs serving to improve access to health care).

The social-insurance-based model includes two sub-options – the “classic Bismarck model” with several health-insurance companies delivering social health insurance in the country (Germany), or a system with one health-insurance company responsible for public health-care financing (in Europe, implemented especially in the CEE region after 1989, and among the developed countries maybe France is on the margin of it).

The “borders” between the general-taxation-based model and the Bismarck model are very unclear, in reality all real health-care systems represent some kind of mix. Also the difference between taxation-based revenues and health-insurance revenues is very artificial (Vostatek (2010) argues that social insurance is just a form of a tax). Also because of the above reasons, there is no much direct discussion about pros and cons of systems with monopolistic and pluralistic health insurance in the scientific literature; most authors (see, for example, Maly 1998) compare this issue

from an indirect perspective. Given the important pros and cons associated with any health-financing system, general health-economics theory does not propose any definite solution, and the practice does not apply uniform solutions. Experiences from the history of health systems in the world illustrate both the positives and negatives of the systems of general taxation, monopolistic social insurance and pluralistic social insurance. We provide a few examples of contradicting arguments that can be found in the literature (Bjorkman and Altenstetter 1998, Cullis 1979, Feldstein 1993, Maly 1998 and many others):

- The costs of a public monopoly might have been improved by an internal market;
- Insurance companies are separate from the main government administration, and this separation would improve the quality of the administration;
- The switch to an earmarked insurance system would seem to have the advantage of reducing pressures on general budgets;
- A single-payer system would save money on administrative costs;
- A single-payer system is better to provide fair and quality care for everyone.;
- A single-payer system will not hamper medical research, etc.

Despite this unclear opinion within the theory, most CEE governments decided to switch from a general-taxation model to an insurance-based model after 1989, some of them (in our sample the Czech Republic and Slovakia) for pluralistic health insurance. This situation is our main motivation for positive research, delivered from a comparative perspective. Our research questions, stated above, partly focus on the verification of our preposition that the system of health-care financing (in our case especially the decision about pluralistic or monopolistic health insurance) does not have a direct impact on health-system performance, but also include other already indicated dimensions, such as:

- If there is no clear preference for one concrete health-financing system in theory, what was the basis for concrete decisions in selected countries?
- Is there any optimal level of private co-financing of health care, especially in CEE conditions?

Our decision to use the CEE region to add to theory development and also to provide certain advice to health policy-making is based especially on the fact that reform processes in the region are really unique (for example Shakarashvili 2005 or Dunn, Staronova and Pushkarev 2006) from many points of view (like under-developed economic and political “markets”, prioritization of politics to policy, limited implementation capacity). Experience from such conditions may provide a lot for theory and also practice today, in the situation when major changes of health-care systems in the world are in progress (Mackenbach and McKee 2013), especially from the point of view of transformations of health-care delivery in the majority of developing countries.

3. Health-insurance developments in selected CEE countries

As indicated above the authors selected four CEE health-care systems for evaluation with the goal to cover different patterns in the same (new EU member states) region. Bulgaria is characterized by the relatively late start of the switch to health insurance and applied the model of one public health-insurance company from 2000 (the role of the few private health co-insurance actors is marginal); the country also struggles with the need to provide universal coverage, because of limited resources. The Czech Republic and Slovakia decided for a pluralistic health-insurance model immediately after 1989, but their current attitudes differ. Slovenia also started health-insurance changes very early, but the country implemented the system with one public health-insurance company and several private companies, doing business in the area of co-insurance (the only CEE country with functional co-insurance schemes). The Czech Republic, Slovakia and Slovenia are relatively successful from the point of view of universal coverage, in spite of important financial problems within their health systems.

3.1 Bulgaria

Bulgaria started a real reform of its health system only in 1999. In the 1990s, private medical practices expanded somewhat, but most Bulgarians relied on communist-era public clinics while paying high prices for special care. During that period, national health indicators generally worsened as economic crises substantially decreased health funding. As an attempt to cope with increasing problems, the Health Insurance Law (70/1998) introduced a system of compulsory and voluntary health insurance in Bulgaria that has been implemented in phases since July 2000. Compulsory health insurance is managed by the National Health Insurance Fund (www.nhif.bg) and its territorial divisions (Regional Health Insurance Funds); these undertake risk-pooling and medical-care-purchasing functions on behalf of the population. Voluntary health insurance is optional and is conducted by shareholder companies registered according to commercial law on a marginal scale.

The National Health Insurance Fund (NHIF) is the basic financial institution for primary, specialized and hospital care. Its budget is formed from the compulsory contributions by employed persons and the payments by the state for special groups (for more information, see www.nhif.bg). The problem is that more than one million citizens (out of almost 7 million inhabitants in the country) do not pay health-insurance fees, which significantly decreases the NHIF budget (Delcheva 2011).

In Bulgaria the health policy is oriented to provide health care to those who need it. Emergency services are a public good delivered free of charge to all citizens. Funding is through the national budget. Primary health care and hospital services are based on solidarity principles with payment of health-insurance fees to the National Insurance Fund. All employees and self-employed persons pay compulsory health contributions according to their salary/income level. The government pays health contributions for civil servants, soldiers, policemen, school children, students, registered unemployed and retired people. The number of citizens in these groups is over half of the country's population, which means a strong position of the state. There

are specific regulations for treating groups with special health needs such as free delivery of medicines for people suffering cancer, diabetes and other specific diseases. In this way, the government alleviates pressure on the family budget for many people. The government also established a “special social fund” to support hospital care for citizens with low income and those outside the health-insurance system. The fund covers the cost of treatment for vulnerable groups (for more details, see, for example, Dimova et al. 2012).

Private resources become more and more important in the system today – officially but also unofficially (Tables 1 and 2 describe main economic data about Bulgaria and its health-care financing). The law on health care (70/2004) introduced “user charges” for medical services in two cases. For medical check-ups by General Practitioners, the fee is 1% of the minimal salary (€1.25 in 2010). In 2008, the government decided that user charges for retired people are to be half the regular charge. Another charge is for hospital care not longer than ten days at a rate of 2% of the minimal salary per day (Dimova et al. 2012).

Table 1: **Bulgaria: Main Economic Data**

	1990	1995	2000	2005	2009	2010	2011
GDP (billions USD)	8.1	13.1	13.6	24.1	47.1	50.3	53.5
GDP per capita (USD)	943	1,559	1,718	3,101	6,215	6,797	7,229
Inflation rate (%)	438	62	11.3	6.5	0.6	4.5	4.2

Source: Kostadinova et al. 2013, 51

Table 2: **Funding for Health Care in Bulgaria as Percentage of GDP**

	1995	2000	2003	2004	2005	2006	2007	2008
State Budget	4.1	2.4	2.3	2.0	2.0	1.5	1.5	1.3
National Health Fund	-	1.2	1.9	2.3	2.6	3.5	3.9	4.5
Municipalities	-	0.8	0.5	0.3	0.2	0.2	0.2	1.2
Voluntary Health Funds	-	-	0.1	0.2	0.4	0.6	0.8	1.0
Household Expenditures	1.3	1.3	1.2	1.2	1.2	1.2	1.2	1.2
Total Percentage of GDP	5.4	5.7	6.0	6.0	6.4	7.0	7.6	9.2*

* 2008 percentage is extraordinary, the result of a slight increase in health-care expenditures but a massive GDP decrease, not repeated in consecutive years

Source: Kostadinova et al. 2013, 52

The challenge of keeping health expenditures in Bulgaria in balance is made more difficult by the high levels of out-of-pocket spending for health services at all levels of the system. Direct private expenditure for medicine by the poor is a particularly significant problem (World Bank 2007). The lowest income quintile spends about 40 EUR on drugs annually, when the average is 70 EUR, but these families have to use more than 6% of their annual income to cover these costs.

In order to gain access to high-quality services in hospitals, illegal payments are widespread (Vekov 2009). Sometimes hospitalized patients have to buy drugs themselves. Although there are no reliable estimates of the size of unofficial payments, a 2006 survey by the Open Society Institute (2008) indicates the magnitude of the informal payments to be mainly in cash and totalled over 80 million EUR.

Private health-insurance funds were created at the beginning of the health reforms in 2000 in order to cover a voluntary package of health and mainly hospital services. Due to the lack of a clear distinction between the coverage of treatment by the NHIF and private health funds, the role of private insurance funds is not very significant – only 1.8% of the population has contracted a voluntary private-health insurance (Atanasova, Moutafova and Kostadinova 2010).

In terms of universal access and equity, no Bulgarian has been denied medical care at any level of service – primary, specialized and hospital care – whatever the ethnic, cultural and social differences (Vekov 2009). The current referral system streamlines the transfer of patients from smaller, general facilities to specialized units, depending of the severity and urgency of the case. Although many Bulgarians do not pay their insurance premiums, they receive urgent and elective medical care at all levels as needed at high cost, thus causing significant congestion and shortages of funds (for more details, see Dimova, Popov and Rohova 2007 or Dimova et al. 2012). On the other hand, especially the access to specialized outpatient care is limited due to the restricted financial resources provided by the NHIF. The Fund pays for a defined number of monthly visits to specialists and medical-diagnostic laboratories. Any examinations that exceed this number are put on a waiting list or are paid by the patients themselves. While people with higher incomes can afford to pay for specialized outpatient treatment, this is not possible for patients from low-income groups, who represent a significant proportion of the population (Vekov 2009). Pensioners, pregnant women, children and patients with chronic illnesses need more specialized consultations and medical tests, but quite often they have to wait or pay themselves to receive adequate and timely medical treatment (for more, see Pavlova 2010).

To sum up, Bulgaria implemented the system of one semi-independent public health-insurance company with a marginal role for the private co-insurance. No major changes of this system can be expected in the near future. This system delivers limited positive results, but it has a lot of cons. The main pro is that it serves relatively well as a “redistribution” of resources and does not produce large deficits. On the other hand, it does not have the capacity to guarantee universal coverage, despite government promises and intentions. The core purposes for limited universality of access are lack of public resources (Bulgaria spends the lowest amount of resources on health care from our sample) and free-riding. Lack of finances and unclear co-insurance schemes also create private and shadow economies in health care, where rich people receive fast and high-quality services on the basis of official or unofficial private payments.

3.2 Czech Republic

In the Czech Republic the demand for plurality was a reaction to the long-term state monopoly on health services. It is reflected in many elements of the Czech health system, such as freedom of choice for patients, a public-private mix of providers, multi-source financing, and especially health insurance through several, mainly private, Health Insurance Companies (HICs) competing for enrollees (Maly 1998). In 1993 a law introducing obligatory health insurance (592/1992) came in force, which stressed competition. Initially 27 health-insurance companies were established that subsequently merged or collapsed. By 1996 two-thirds of them had become bankrupt, and their liquidation was a problem for the state budget (Bryndova et al. 2009). Today nine health-insurance companies remain in the Czech Republic, with the public “VZP” in the dominant position, covering more than 60% of the insured (Maly et al. 2013).

The core problem of the Czech health-insurance system is the unbalanced combination of pluralist provision of health insurance with too tight state control over the system. The government determines the level of insurance premiums (discounts for low risk or increased rates for high risk are not allowed). For employees and self-employed persons the law determines the percentage of wages to be deducted; for those who are “state insured” – that is, persons who lack income, like students, pensioners, prisoners, – the cabinet decides on the amount to be contributed for each. At present the “state insured” are 58% of all those insured in the system. The amount paid by the government for the “state insured” is always lower than the minimum amount that employees or self-employed persons must pay. Hence any decision about the amount for the state insured has an impact on health-care resources (Krutilova 2012).

The cabinet’s role is also very important during the annual negotiations with health-insurance companies and providers about the level of reimbursement for services. The cabinet also influences the level of reimbursement for pharmaceutical drugs. Finally the cabinet is able to influence the HICs through appointing members of their executive councils or board councils. Although disputed, this practice is typical not only for health care but for all sectors. In such conditions the “plurality” of the health-insurance market is more idea than reality (Veprek, Veprek and Janda 2002).

Health-insurance funds are relatively independent bodies from the point of view of regulating supply. They are responsible for entering into contracts with health-care providers. Contracts are generally for a two-year period. In accordance with health-insurance legislation, there are regular negotiations – usually every six months – among the health-insurance funds, providers (hospital associations, hospitals and private physicians) and professional chambers. These bodies negotiate the range of services to be covered under the compulsory health-insurance system as well as the number of reimbursement points per service in the fee schedule; the monetary value of points used to determine actual reimbursement; and conditions for delivering services in the major sectors of health care. The ministry evaluates the results of such negotiations for their compliance with legal norms and public interests. The government is entitled to make the necessary decisions if no agreement can be reached (for more see Bryndova et al. 2009).

The Czech Republic has a multi-source system of financing health care (Tables 4 and 5 describe main economic data about the Czech Republic and its health-care financing). Insurance contributions are defined by law as a percentage of wages (before tax). Employees pay 4.5%, and employers pay 9% (13.5% combined); the self-employed pay the same total percentage (13.5%); and the Ministry of Finance contributes approximately €30 per month per person on behalf of certain categories of the population – the unemployed, pensioners, children and dependents up to 26 years of age, students, women on maternity leave, men serving in the military, prisoners and people receiving social welfare. Health-insurance contributions are redistributed between HICs in order to lower the potential for risk selection and to ease the financial difficulties of health-insurance funds with adverse risk structures. All collected contributions are reallocated according to two criteria – age and the extent of resource utilization, for example, treating chronic disease or morbidity (for more see Bryndova et al. 2009 or Maly et al. 2013).

Table 4: Main Economic Data Czech Republic (US dollars)

	1990	1995	2000	2005	2010
Total GDP (billions)	626	1,534	2,270	3,116	3,775
GDP per capita	60,428	148,457	220,949	304,478	358,957
Inflation rate	9.7	7.9	4.0	2.2	2.3

Source: Maly et al. 2013, 70

Table 5: Health Expenditures Czech Republic (USD millions, current prices)

	1990	1995	2000	2005	2010
Central Government	x	294	216	515	698
Regional & Local Government	x	274	229	373	583
Total	1,031	568	445	888	1,281
Public insurance	x	2,916	3,001	7,103	11,193
Public expenditures total	1,031	3,484	3,446	7,991	12,474
Private out-of-pocket	x	277	359	965	2,191
Total health expenditures	1,031	3,793	3,805	9,136	17,868
Total health expenditures (GDP %)	4.7	7.0	6.5	7.2	7.5

Source: Maly et al. 2013, 71

Taxes cover expenditure at both the national and regional levels. At the national level, the Ministry of Health finances the capital investments of facilities that it directly manages, such as regional hospitals, university hospitals and specialized institutions for research and postgraduate education. Public-health services are also financed directly by the Ministry of Health. Direct funding by the Ministry of Health covers part of the cost of training medical personnel and of running specialized health programs such as AIDS prevention, drug control, the operating costs of long-term care institutes, research and postgraduate education. Social care is paid partly by the Ministry of Social Affairs and partly by users of the services (for more see Bryndova et al. 2009 or Maly et al. 2013).

In our sample the Czech Republic has the lowest level of private funding in health care. Cost-sharing is required for selected drugs, dental services and some medical aids. Since January 2008, with a maximum annual limit, Czechs have paid regulatory fees for medical prescriptions, hospitalization days, emergency visits and visits by medical specialists. The solidarity principle is retained due to the limit of CZK2500 (approximately €100) on total expenditures for direct co-payments per year (Krutilova 2012).

To sum up, the Czech Republic implemented the system of pluralist public social-health insurance, with a marginal role for private co-insurance. The efficiency of such arrangement is limited by too tight governmental regulation of the health insurance system – this combination delivers only limited results and is the source of very contradictory opinions about the effects of having more than one health-insurance company. Currently there are nine insurance companies with no real competition, and many feel that the current situation is not optimal. The future form of the health-insurance system in the Czech Republic is unclear and may depend on future balances of the political powers (right-wing governments may adapt measures to increase the role of HICs, left-wing governments may lead the system towards establishing a single health-insurance company). In any case, the belief in “automatic” benefits stemming from plurality (like cost control, quality and efficiency) has weakened during the 20 years of the existence of the system. The core pros of this system are the capacity to guarantee almost universal and equal access to health services for all inhabitants, limited corruption and the capacity to involve private resources without impacts on the universality of access. However, the system significantly suffers from the point of view of fiscal imbalances (despite a relatively high level of resources, for most years of its existence it produces important deficits); its cost-containment capacity is limited.

3.3 Slovakia

Like most CEE countries Slovakia switched to the so-called “Bismarck” system of social health insurance to replace the old general taxation system of financing health care. However, together with the Czech Republic, it decided to introduce a competitive/pluralistic social health-insurance system, as well. The main laws on health insurance were passed in 1993–94 (especially Laws 7/1993, 8/1993, 9/1993 and 273/1994), which created the basis for establishing health-insurance companies (at its peak there were twelve companies, two of them public). Most of these have since

disappeared from the “market”; in 2002 five existed, but since 2010 only two private and one public company remain (Szalay et al. 2011).

The changes in the health-insurance system were supported by the typical arguments of plurality, independence and competition. However, these “system” attributes have never been achieved in reality. A very limited level of plurality and competition was visible only during the initial phase of the insurance system, when the services to the insured were to some extent different (Lawson and Nemec 2003). Concerning the main elements of the system – the level of premiums and the level of services provided, there is no freedom for HICs to decide, similarly to the Czech Republic HICs have only limited rights to negotiate with providers about volumes (for more details see Szalay et al. 2011).

Especially after 2006 strict governmental control was re-introduced in the area of health insurance, which produced an improper mix of market-based regulation (pluralistic insurance) but strict state control over all aspects of the system. Several changes were realized. The state significantly lowered the limit for the “overhead” expenditures (management/administration costs) of health-insurance companies with different limits for public and private companies. As noted above, the law prohibiting profit in private health insurance was passed but was then found to be unconstitutional. A law on compulsory transfers of all public employees to public insurance companies was prepared but not passed. Two public companies merged, as did two private companies. The result is an oligopolistic structure with two major players and one marginal player (public Vseobecna zdravotna poistovna – about 60% of the population; a large private company Dohvera – for about 30% of the population, and one small private company named Union). Due to these changes many resources were withdrawn from the system when several private insurance companies collapsed (for more see Nemec 2013).

Health care in Slovakia almost fully guaranteed universal and equal access and is predominantly financed by public funds – a combination of health insurance and budgetary resources (transfers to the health-insurance system for social groups financed by the ministry of health and local self-governments). Although marginal at the beginning of transformation, private expenditures began to grow significantly after 2000 (Szalay et al. 2011). To a large extent increased private contributions are the reaction to the pertaining fiscal instability of the health-finance system in Slovakia – except for two or three years, the system has been in permanent deficit, spending more resources than allocated (Tables 6 and 7 describe the main economic data about Slovakia and its health-care financing).

Table 6: **Main Economic Indicators Slovakia**

	1993	1995	2000	2005	2010
GDP current prices (EUR billions)	10.3	14.4	31.2	49.3	65.9
GDP per capita (EUR thousands)	1.9	2.7	5.8	9.2	12.1
Unemployment rate	12.2	13.1	18.6	16.0	14.4
Average monthly income (EUR)	134.5	179.9	379.4	573.4	769.0
Inflation (percent)	23.2	9.9	12.0	2.7	1.0

Source: Nemec 2013, 195

Table 7: **Resources for Health Care Slovakia, millions EUR**

	1995	2000	2005	2008	2010
Health Insurance	500	880	2,400	3,300	3,400
General Taxation	280	390	400	100	200
Direct Payments	45	150	700	1,000	1,100
Total	825	1,420	3,500	4,400	4,700
Percent of GDP	5.7	6.1	7.2	6.5	7.3
Balance of HC system (expenditures/revenues)	-0.5	-7.9	-2.0	-3.1	-2.7

Source: Nemec 2013, 195

In relative terms, compulsory social health-insurance premiums are similar to many developed countries. Initially the level of the insurance premium was set at 13.7% of an income-related basis and increased to 14% from 2002 onwards. Limited collections in monetary terms are the result of two limits (for details see Szalay 2011 or Nemec 2013):

- The state budget is expected to pay into the health-insurance scheme for a large group of persons without regular income – a group representing about 3.5 million from a total of 5.5 million inhabitants. The state funds this group of citizens at a very low level; Parliament sets the amount to be paid on a yearly basis when voting on the state budget. Formally it was expected that the rules for “state” and “private/self” insurers would be similar (14 percent of the basis). However, the state never contributed the full amount (the level of transfer ranged from three to five percent of the minimum wage) so the system is not provided with the expected amount of resources from the state budget.
- The insurance premium is derived from an income-related basis. For employees the maximum basis is 300 percent of an average salary two years

previously (€2,233.50 in 2011), which is very low. Many self-employed taxpayers pay contributions from a minimum basis that is 44 percent of an average salary two years previously (€329.60 in 2011).

In Slovakia the issue of legal and illegal private payments represents significant system problems. The level of official private financing is comparatively high – about 35% in recent years (see data above) and also the level of corruption in health care is estimated to be a real problem (Lewis 2006). According to recent research by FOCUS (2012) health care is the most corrupted area of social life, and many Slovak households have had to pay bribes to ensure good care. Bribes have been estimated to amount to about one-tenth of health costs (unpublished study financed by the World Bank). These developments limit the capacity to guarantee universal (not so much) but especially equal access to health-care services for all inhabitants independently of their ability to pay.

The core issue regarding our topic is the fact that in September 2012 Slovakia officially published its plan of how to switch back to one insurance company – such a decision should be the result of the combination of large disillusiones about capacities of (too heavily regulated) pluralistic health insurance and the strong position of left-wing Prime Minister Fico's government (see for example <http://www.health.gov.sk/Clanok?predseda-vlady-robert-fico-na-ministerstve-zdravotnictva>, 2012).

Thus, Slovakia implemented the system of pluralistic public social-health insurance, with a marginal role for private co-insurance. However, because of too tight governmental control and also a limited number of insurance companies, real competition between health-insurance companies has never been created. With high probability Slovakia will switch to the system of one state-controlled health-insurance company in 2014 (as claimed by the Prime Minister).

The core pro of the Slovak health-care system is its capacity to guarantee almost universal access to health services for all citizens. The core problems are too (?) high private contributions, important financial imbalances (the total amount of resources available is below the needed level, and the cost containment capacity is very limited) and a high level of shadow economy, resulting in large inequalities in access.

3.4 Slovenia

Health insurance has a long tradition in Slovenia. In the early 19th century, workers established “fraternity funds” based on solidarity and mutuality. The first sickness fund in Slovenia was founded in 1889, and similar providers of health insurance followed. Initially health insurance was only compulsory for workers, but gradually it expanded to other population groups (Setnikar Cankar and Seljak 2006). Despite changes in the organization of health protection, Slovenia has retained certain features of health insurance, such as funding by contributions from employers and employees, autonomy and self-governance during all its history, and the system of health insurance based on one public HIC, responsible for the universal access and several competing HICs dealing with co-insurance, was fully re-established almost immediately after gaining independence (Ceglar 2004).

Health-care legislation in Slovenia underwent a major revision in 1992. The new act formed the basis for the current system of compulsory and voluntary health insurance, promoted the process of privatization of the health-care system and defined in detail the role of the key partners. The law created a mixed public-private model for funding health care as well as structural changes in the implementation of health services. These changes led to a partial privatization of health providers within the network of public services and introduced the free choice of doctor at the primary level of health care. The second major Slovenian health reform, which introduced a payment model in which the money was to follow the patient, occurred in 2003. A reform had been planned in 2010 and 2011 to address the problems in Slovenian health care – inappropriate distribution of capacity, lack of adequate information required for decision-making, problems at different management levels in the health system and challenges related to the mission of health care – but it was not realized (Setnikar-Cankar and Petkovsek 2013).

All inhabitants of Slovenia are included in compulsory health insurance. Compulsory health insurance provides insured parties with two basic sets of rights: to health care and to cash benefits or reimbursements. The system provides insured parties with access to health services on the basis of partnerships. Adequate access and appropriate quality of health services are key to the protection of insured parties. Equal provision of doctors and other capacities to the population is an essential component (Ceglar 2004).

Of all CEE countries, Slovenia has the highest health-care expenditures (for details see Albreht et al. 2009 and Setnikar-Cankar and Petkovsek 2013). The share of total expenditures on health care in 2011 was 9% of GDP, with the public share at 71.4% (6.4% of GDP) and the private share 28.6% (2.6% of GDP). These data indicate that most funding of health care in Slovenia is provided by public sources. (Tables 8 and 9 describe main economic data about Slovakia and its health-care financing). The system is fiscally balanced, especially thanks to comparatively large resources (the costs for staff and equipment are growing rapidly and start to create major problems for the system – for more details see Setnikar-Cankar and Petkovsek 2013).

Table 8: **Main Economic Indicators Slovenia, 1995-2011**

Year	GDP € million (current prices)	GDP € per capita	% GDP growth	Inflation rate (percentage)
1995	10,294.3	8,101	4.1	12.6
2000	18,480.7	10,858	4.4	8.9
2005	28,749.6	14,369	4.5	2.5
2010	35,415.8	17,300	1.4	2.1
2011	35,638.6	17,400	-0.2	2.1

Source: Setnikar-Cankar and Petkovsek 2013, 223

Table 9: Expenditures (Percentage of GDP or Total Health Expenditures), 1995-2011

Year	All Public Spending (% GDP)	Total Health Spending (% GDP)	Public Spending on Health Care (% GDP)	Public Spending on Health Care (% total)	Private Health Care Spending (% GDP)	Private Health Care Spending (% total)
1995	52.6	7.5	5.8	77.7	1.7	22.3
2000	46.7	8.3	6.1	74.0	2.2	26.0
2005	45.3	8.7	6.3	71.9	2.4	28.1
2010	50.3	9.1	6.6	71.9	2.5	28.1
2011	50.9	9.0	6.4	71.4	2.6	28.6

Source: Setnikar-Cankar and Petkovsek 2013, 225

Compared to all other countries in our sample, a significant proportion of health spending comes from private funds, but in this case the insurance companies that offer voluntary health insurance contribute most of the private funds (Slovenian Insurance Association 2011). The other private expenditure comprises spending on various goods and health services that people in Slovenia pay directly “from their own pockets”. Since the introduction of voluntary health insurance in 1992, the proportion of public spending on health care in Slovenia has declined, while private spending has increased with intermediate fluctuation. The burden of additional financing for health care has shifted to private spending by the population (see data above).

Access to health services is increasingly achieved via direct payments. In 2011 direct household spending accounted for 13.7% of total health expenditures or 47.9% of all private health expenditures. The increased level of private contributions is a major concern in Slovenia today, but it does not significantly undermine the universality of access (to some extent equality is the concern). The current aim for the development of health care in the future is to increase the share of public funding for health care from 73 to 80 percent with a corresponding reduction in private funding – the latter now to consist mainly of supplementary health-insurance premiums and direct payments (Gregorič Rogelj 2012).

Thus, Slovenia represents a relative unique example of the health-care system in CEE conditions. After 1989 the country re-established the monopolistic social health-insurance system, supported by relatively functional private co-insurance schemes. No major changes of this system might be expected in the near future. The core pros of this system are a comparatively high level of resources, effective access guarantees, functional private co-insurance providing resources to the system without limiting the universality of access and a limited size of the shadow health economy. All these features bring it close to the most developed health systems in the world. Private co-insurance schemes seem to limit the equality of access, but this issue is already reflected in planned future government policies, aimed also at the issue of the proportion of private funding and its impacts. We may argue that this positive situation is not only the result of comparatively more resources available,

but also reflects better health-policy-making in Slovenia compared to other CEE countries (at least in the earlier phases of reforming health care – see for example Setnikar-Cankar and Petkovsek 2013).

4. What can we learn from our sample?

This part of our paper tries to respond to our second and third research questions stated in the introduction. It investigates the performance of analysed health-financing systems and provides our opinion about the issue of selecting the “proper” health-financing mode for transitional countries. A part of this issue is also the role of private finance in health-care financing with a focus on transitional conditions.

4.1 Preferred health-care financing mode for transitional countries

The theoretical part of our paper suggests that there is no one preferable health-financing system that could be prescribed to all. However, as indicated above, CEE countries switched from “Semashko” to social-insurance systems, and these changes were supported by arguments that plurality, independence and competition would help to improve the performance of health systems. In this situation first we need to ask why almost all CEE countries decided during their transformation from centrally planned to market-based democratic societies to switch from general taxation to social health-insurance-based systems of financing health care. Our observations indicate that for post-communist countries the rationale for such a switch are political considerations (for more see for example Lawson and Nemec 2003).

The political considerations for proposing a switch are complex. On the one hand, earmarking taxes for health and sub-contracting their administration to independent insurance funds would have the advantage of distancing government from a contentious area of public policy. And the switch to an earmarked insurance system would have the advantage of reducing pressure on general budgets. But other than the insurance companies, interest groups are not concerned about where extra resources for health will be found. Neither local nor indeed many central policymakers in the health sector are concerned about such trade-offs. They continue to push for increased expenditure, whatever the consequences for either taxation or expenditure on non-health items.

Following the fact that all above-mentioned arguments are not sufficiently solid to serve as the basis of a “well-informed” and effective switch, our opinion is that the core political purposes behind decisions to switch during conditions of transition are straightforward: the need to differentiate a new system from its predecessor as well as to show the willingness to change and improve (at any cost).

4.1.1 Monopolistic or pluralistic social health insurance?

The four selected countries decided in favour of two different health-insurance systems. Slovenia and Bulgaria chose systems with one public health-insurance company, responsible for universal access and several private health-insurance compa-

nies, dealing with co-insurance-based services (however, Bulgaria did not manage to implement the second to any significant degree). The Czech Republic and Slovakia decided in favour of a pluralistic health-insurance system to guarantee universal access and (formally) allowed private health insurance to compete in overregulated health-insurance markets (co-insurance systems never appeared in either country).

Would it be possible to find any relation between the health-financing mode and health-system outcomes in our small sample? To respond to this question and to verify our preposition (see part 2) we decided to construct a highly simplified table (Table 10). The table ranks our four countries for different dimensions of health-system outcomes (if the performance is similar, countries receive equal mark, 1=best, 4=lowest performance). Some input for this table can be found directly in our text (health resources, share of private resources, cost-containment quality, access). Health outcomes are measured by mortality and morbidity data as well as health resources – for detailed data see Bjorkman and Nemec 2013. Concerning corruption several international studies indicate that corruption in health care is a less serious problem in Slovenia and the Czech Republic, but an important issue in Bulgaria and Slovakia. The World Bank (2007) and also Transparency International (FOCUS 2012) estimate that the perceived level of corruption in health care in Bulgaria and Slovakia is about 60%. Transparency International (2013) states that the perception of corruption in health care for our sample is as follows – Slovenia and the Czech Republic with 3.3, then Slovakia with 3.8 and finally Bulgaria with 4.2.

Table 10: **Health finance and health performance**

Dimension	Bulgaria	Czech Republic	Slovakia	Slovenia
<i>Health-financing system</i>	<i>A*</i>	<i>B**</i>	<i>B</i>	<i>A</i>
Health outcomes	4	2	3	1
Health resources	4	2	3	1
Share and type of private resources	3	1	4	2
Corruption level in health care	4	2	4	1
Cost containment in health care	3	2	3	2
Access: universality	4	2	2	2
Access: equality	4	2	3	2
Average, non-weighted	3,71	1,86	3,14	1,56

* A: one public insurance-company system

** B: pluralistic health-insurance system

Source: own construction on the basis of data in Bjorkman and Nemec 2013

Rankings in Table 10 (despite being just rough estimates) do not show any relation between the mode of financing and the system performance. Though similar the Slovak and Czech as well as the Slovenian and Bulgarian health-finance systems perform

significantly different. This small sample and simplified methodology is probably not enough to confirm our proposition about the (almost zero) relation between the health-financing system and the health-care-system performance in a non-disputable way, but adds to the existing theory. We may argue that there should be other purposes for different system results – our opinion is that the following two are crucial: more and effectively used resources and the “quality” of the system of health governance have an important positive impact on the system performance (for both factors Slovenia is in the best position). We are far from generalizing this conclusion for the world-wide level, but we feel that our sample also confirms general health-economic-theory arguments that a “best” health-finance system does not exist.

4.1.2 Pluralistic health insurance and transitional countries

Two countries from our sample decided to switch to pluralistic health-insurance systems. One of them – Slovakia – is currently switching back to the single-insurance-company system, the second – the Czech Republic – keeps the future an open issue. Examples of the Czech Republic and Slovakia indicate that it is difficult to expect in transitional conditions for competition between health-insurance companies to have a real potential to improve system performance. Country studies also indicate that problems linked with pluralistic health insurance can be exaggerated in transitional countries due to many factors. Two core limits are obvious:

- There is the issue of improper government interventions in health insurance; despite formal delegation of authority, the state is not willing to lose control. If insurance premiums and benefits are strictly regulated, competition is stifled, and insurance companies become redistributors rather than the intended regulators.
- Implementation problems with pluralistic health insurance can also be expected if undertaken too early in the transformation period when financial markets do not yet perform in a standard way (Czechia and Slovakia suffered large losses of public resources because of bankruptcies of many newly established HICs).

Pluralistic health insurance may be effective, if not always efficient, in a well supervised but not overly regulated competitive market environment (Maly 1998). But it is not clear that such preconditions exist in any CEE country or any other region or country in transition.

4.2 The role of private health-care funding

The share of private (official) funding for health care in our sample ranges from app. 15% in the Czech Republic to app. 35% in Slovakia. In Table 10 we ranked the Czech Republic as the best from the sample for this criterion with about 15%, but the reality might be slightly different. Economic theory (for example Cullis 1979) argues that some level of individual participation, which does not impact universality of

access, might be feasible (the core economic arguments used are regulation of demand, increased interest and consumer control, transactions costs). The obvious practical argument for private participation today is also the limited capacity of public finance systems.

Health care is not a purely public good, and because of this fact it should not be fully publicly financed (Stiglitz 2000). This would mean that during any type of transition the level of private co-payments should be discussed. In our case, where the transition is from “socialism” to “capitalism”, the private co/payments need to be established somehow. The core question is, what is the proper percentage (if any) of private funding and what are effective mechanisms for involving private resources into the system? Concerning the first issue – the size of private payments – data about the level of private participation in developed countries differ significantly also for well performing systems (Denmark may be one pole of the scale and France, eventually USA, the opposite). This situation suggests that there is no generally valid optimal percentage of private health-care expenditures. We propose to look at other dimensions – does the private co-payment influence universality of access? Or maybe, what is the proportion of private health-care expenditures from family budgets for different income groups.

From our sample, it seems that relatively high co-payments in Slovenia do not impact universality of access in any significant way; the same is valid for the Czech Republic. In Slovakia, where the official level of private payments is the highest, social impacts are still not too visible (however, there are no effective research data about the impact of co-payments for the most vulnerable groups). This would mean that in economically developed countries, with effective social systems, even 30-40% of private co-payments might not become a crucial social problem from the point of view of universality of access.

From the point of view of managing private payments, the positive example from our sample is Slovenia. The limited capacity of public finance in Slovenia seems to be effectively solved by the functional private co-insurance schemes. Such arrangements do not deteriorate the universality of access, but equality is affected. This situation might be acceptable, especially in countries with limited resources – as Le Grand (1991) proved many years ago, there is almost zero chance to create a fully equitable health-care system.

Surprisingly, the Czech Republic, with fewer resources, somehow manages to finance its health-care needs and maintains real universal access for all citizens. The only valid purpose for this should be a relatively effective cost-containment system. Private co-insurance is still politically unacceptable for this country with a very strong position of two major left-wing parties (social democrats and communist), effectively opposing needed changes in this direction.

In Slovakia, the system of co-insurance has been formally established in 2005, in Bulgaria even earlier. In both countries this system is non-functional – the obvious question is why? We may propose to test two arguments. First, because of political reasons in both countries governments are not willing to define which health services belong to the basic package and which to co-insurance systems (as in the Czech Republic). Second, most important actors may prefer shadow-economy benefits to official ones, like:

- medical staff may prefer under-table payments to taxable extra revenues from co-insurance,
- patients may prefer non-transparent, but fast, money and relations based access to services).

The Bulgarian and Slovak cases indicate that lack of finance, combined with non-existing co-insurance schemes, has the potential to exaggerate the most difficult private health-financing problem – they provide a motivation for unofficial (under-table) payments. Both countries, according to many available data, suffer from a large-scale shadow economy, serving both as a tool of better access for the rich and as an extra income source for medical staff, especially doctors. Effective co-insurance schemes may have the same impact (better care for the rich and more money for medical personnel), but inside the official economy.

5. Conclusions

Our paper focused on important questions connected to the decision about the most suitable system of financing health care, with a focus on transitional conditions. Its basis are four country case studies – Bulgaria, Czech Republic, Slovakia and Slovenia. The collected information about selected health systems, in combination with a normative evaluation of economic and social aspects of health-financing models, serves as the basis to respond to our research questions.

Country cases describe the ways how the decision has been made in CEE countries about how to accumulate/collect resources in the national health-care systems. A comparative qualitative analysis of the second core part of this paper provides important information about core performance differences between different health systems in selected countries and at least for our small sample confirms (as expected by our proposition) that it is impossible to recommend a “best” health-resources allocation system for transitional countries. This part also responds to the issue of the role and relations between public and private (formal and informal) health-care funding, with a focus on transitional countries.

The paper is very much based on the case-study methodology, but its aims and methods are broader. The case-study methodology is combined with a brief normative analysis of the economics of health financing and especially with an in-depth qualitative comparative policy analysis of selected important dimensions of financing health care in transitional conditions.

Our paper does not have any intention to (and obviously cannot) provide any definite answers to our research questions, but its findings might be interesting for all actors – politicians, health professionals and academics and should serve for further discussion. The core proposed findings are as follows:

First, there is no preferred system of health-care financing for transitional countries. However, despite the fact that any change involves large transaction costs, many transitional countries may decide in favour of changing the mode of financing health care simply because of political reasons, to show the will to reform.

Second, establishing pluralistic social health insurance in countries in transition is a risky behaviour, especially if financial markets are under-developed and governments incapable of switching from managing to regulation and coordination.

Third, private co-payments are necessary today in any health-care system (economic and fiscal arguments tell us so), but there is no one optimal size for their percentage of total health-care expenditures. Slovenia provides an interesting example of managing private co-payments dominantly via co-insurance schemes; this system can be recommended to all more developed transitional countries. Without the existence of such a system, and in countries with a higher level of corruption, the shadow health-care economy might flourish.

Our findings significantly add to the relatively limited literature focusing on the issues included in our paper. They confirm the proposition of the general economic/health-economics theory that there is no single optimal model of accumulating resources for health care. They also provide extra evidence about the problem of dominance of politics over policy in transitional countries – and may provide a warning for Slovakia (the costs of the change from pluralistic to monopolistic social health insurance will be in the billions; the benefits are disputable). Another important issue is the suggestion that pluralistic social health insurance might not be the best option for the early phase of transition for many reasons. Our article also calls for further research on the topic. To help to improve evidence-based decision-making, we need to know much more about concrete experience with different health-financing systems in different conditions. The fact is that there is no general optimum (one health-finance model to fit all), but at least certain unacceptable solutions should be avoided.

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