SOCIAL

THE BLACK HOLE IN THE HOSPITAL SECTOR SUCKS IN THE RESOURCES OF THE HEALTHCARE SYSTEM

Wrong incentives in the hospital sector endanger the viability of the health system. The policy response of the government is weak, and the forthcoming debate on the Hospital Bill is likely 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 this 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 that they were facing a financial crunch. A psychiatric hospital let it be known 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 that it was unable to pay its water bill.

While many of these cases can be blamed on exceptionally poor management, it is clear that systemic causes also play a role in 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 real causes of the crisis.

Reform logic - upside down

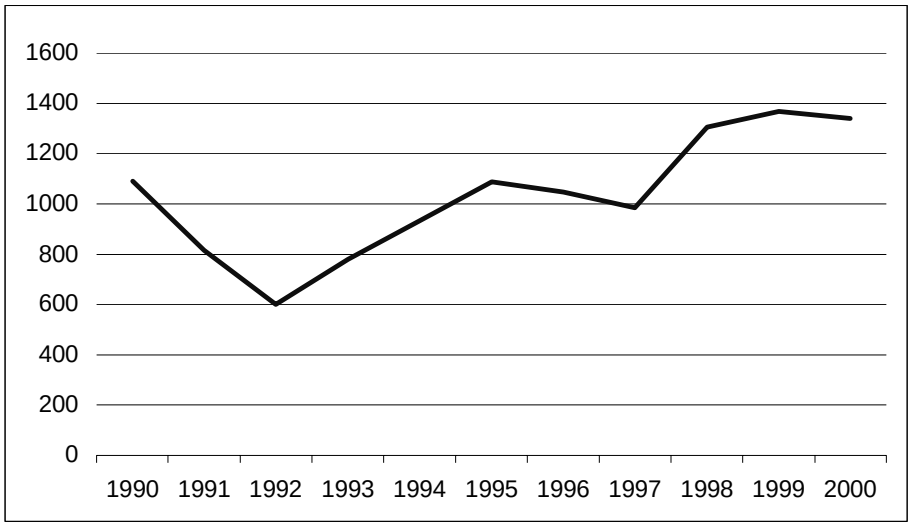
Romanian health reform aimed to increase the overall resources allocated to health care and to shift the emphasis from in-patient to primary care. Four years after the nation-wide introduction of the new funding system, based on social insurance, the pie for health has substantially increased. In spite of comparable utilization rates, however, hospitals consume an even larger share of this pie. This is due to the lack of cost-containment incentives, in a non-competitive system dominated by hospital doctors. This situation presents the risk of crowding out expenditure for the primary care – an essential element of the reform strategy –, and for subsidized drugs – a paramount social issue.

The reform process went further in primary care, which was effectively privatized through the introduction of family practice and the change of the funding system to one based mainly on capitation. There was much less progress in the hospital sector, however. 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.

General health expenditure

Even in absolute terms, the increase in resources brought by social insurance is substantial. Fig. 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% as compared to 1990, and over 30% as compared to 1997 (the last year before the introduction of social insurance funding).

Fig. 1. Total public health expenditure (million USD)



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

Hospital restructuring

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

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

According to the latest data available, Romania's 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, whilst the number of beds (over 7/1000 inhabitants) is in the higher one.

In assessing this performance, one has to take into account that all the countries that 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.

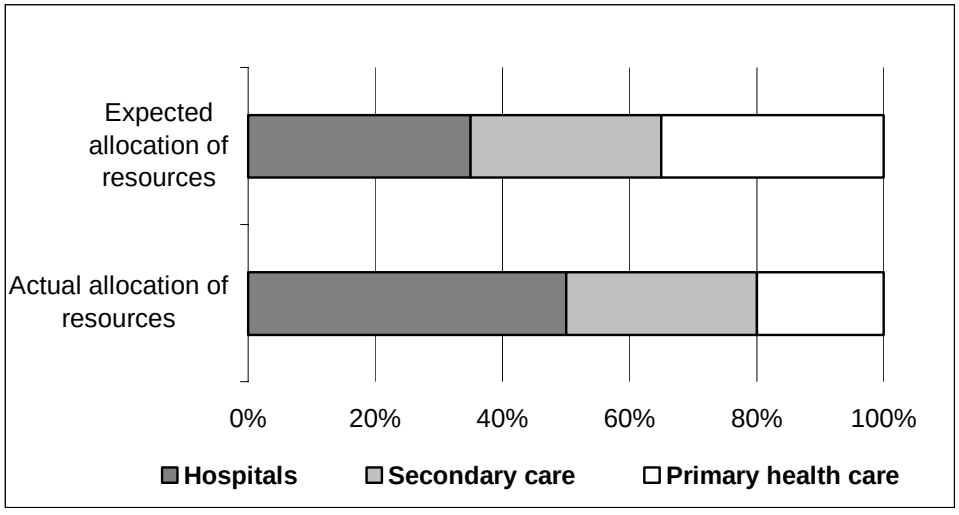
However, it is important that over the 1990s these indicators moved in the right direction. The number of beds declined sharply by about 20%, whilst the admission rate stayed practically the same. This boosted the occupancy rate. The length of stay declined by about 15%.

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

Hospital funding

Fig. 2 shows 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.

Fig. 2. Wishful thinking: the 1997 strategy



Source: BASYS, 1997

Fig. 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).

Fig. 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
Subsidized 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

Even though each year the shares of hospitals increased after the budget rectification, it 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 lower 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. As a consequence, a higher than expected share for hospital expenditure means lower than expected real resources for primary care and subsidized drugs. From the champion of reforms, primary care has become the Cinderella of budget allocations.

Fig. 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, Fig. 5 presents the breakdown of resources by sector in healthcare for the OECD countries.

Fig. 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 striking 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 amongst 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 this elite are 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 setup 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.

Equally, the autonomy of hospital managers is limited, which precludes even the restructuring measures intended by the public-spirited managers. Moreover, the only instrument for motivating managers is the indiscriminate threat to be fired, whilst no incentive plans are available.

Governmental reform plans

The leadership in the Ministry of Health and Family has identified the reform of the hospital sector as a priority. However, it is less clear 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 privatization. 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 will take years. Proof to this is the experience of Hungary, the first CEE country to adopt this method. Therefore, whatever benefits it will bring, DRG is not a solution in the short term.

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

Whilst 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 Hospitals Act

The current proposals for a law dealing with specialized care are more remarkable for what they fail to address than for any consistent reform that they promote. 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 was submitted by the College of Physicians (professional body). The two drafts have many similarities. The main innovation brought by the Government is to increase the financial autonomy of the hospitals by allowing them to borrow up to 15% of the contracted income, provided that 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 are silent on some fundamental issues:

1. Hospital ownership: the alternative is to transfer them to local governments, or even better to grant them the status of autonomous not-for-profit organizations

2. 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 economize on non-operational costs, which are provided on a discretionary basis by the national or local governments (equipment purchase and building development are funded from the central budget, whilst maintenance costs would be provided by the local government). This contrasts with the situation of the operational costs, covered by the County Health Insurance House according to the National Frame Contact, and which are related to performance (i.e. utilization) indicators.

The effects of the envisaged stronger control over the management's ability to accumulate back-payments are unlikely to make a difference, unless the incentive structure is changed.

Conclusions

The operating costs of specialized care are out of control. Hospitals are squeezing out resources that should go to drugs and primary care. In spite of improved overall funding for health and no increase in utilization 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. Whilst the shift to case mix funding and privatization are commendable, their effects will not be seen for years to come. Partial privatization (as opposed to full privatization) 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 specially welcome. However, they do not go far enough:

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

The non-competitive nature of the Romanian social health insurance funds will always 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 efficiently 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.