HOW TO DESIGN A GOOD HEALTH-CARE SYSTEM FOR SOUTH EASTERN EUROPE

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GOOD HEALTH CARE FOR ALL IS AT THE CENTER OF THE FIGHT AGAINST SOCIAL EXCLUSION

The main reason for large-scale poverty is the fact that many people do not have a "decently" paying job. If they earn little or nothing during their working age, as a rule they do no acquire sufficient pension rights either, and they stay poor in old age as well. Education and training make people fit for the labor market, but they do not provide sufficient decently paying jobs for all those who would like one and fit one. There are many things a government can do to get more people employed. But it can not change hard economic facts at will. And no matter how good a government's employment policy is, there might remain large segments of the population who still do not earn enough money for an acceptable standard of living. Moreover, the government's capacity to tax the rest of the population might be grossly insufficient for lifting the poor out of poverty through income subsidies. In this situation, which describes reality in most of South Eastern Europe, the fight against social exclusion has to focus on the essentials of an acceptable standard of living. While overall poverty might remain a fact of life for a long time to come, *certain* things that money could buy must be accessible for everybody, regardless of how little she or he earns. Access to adequate health-care, in line with the state of medical art, is probably the most important one of these "non-negotiables" of social inclusion. It is a dimension of life chances for which inequality is not compatible with our basic values.

TO ENSURE GOOD-QUALITY HEALTH-CARE THROUGHOUT THE COUNTRY: EQUIP CITIZENS WITH THE MEANS TO BUY IT

The simplest way of making needed medical treatment available to those who cannot pay for it, like, for instance, subsistence farmers in remote villages, old people without adequate pensions or unemployed Roma without a school degree, is certainly *via* public polyclinics, set up by the government and financed out of its tax revenues. But governments are notoriously short of money. They tend to provide insufficient budgets for their clinics and hospitals, forcing or inducing them to deliver health-care services well below the standards of the better funded

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private establishments. Doctors and other medical personnel who get low incomes as public employees prefer to insert themselves into the private segment of the health market. Those who can afford open a private business catering exclusively to the well-paying clients. The others try to get private top-ups from the public patients, neglecting those who cannot pay.

Moreover, governments throughout most of South Eastern Europe have not seen themselves in a position to set up and maintain a good public health-care infrastructure for the country-side, where demand backed up by purchasing power is very low and which, therefore, is not interesting for private suppliers.

In theory, governments could use their tax revenues to provide for the funds needed for raising the standard of public health-care to levels that are adequate in quality and quantity. This would be primarily a matter of adjusting spending priorities – maybe drastically so. But in political reality with its many claims on public money and its incentives to give priority to the more powerful claims, this tends to be extremely difficult. Altogether therefore, the attempt to provide public health-care for those who cannot afford expensive private health-care has resulted in an underfunded second-class system that is part of the social-exclusion syndrome.

In order to avoid this outcome, the poor have to be put in a position to buy those health-care services that are offered on the market for the higher-income groups and the middle classes. They have to be included in the same health-care mechanisms as the well-to-do population. A cheap public system cannot exist side by side with an expensive private system without that the cost difference is reflected in the quality of the services and, ultimately, in health outcomes.

If the need for medical treatment is backed up by sufficient purchasing power it is to be expected that adequate supply will emerge – also in the remoter parts of the country. There is no reason why the health market should work different from the way other markets work. The government might still have to *make* the health market work efficiently and, as the case may be, to supplement it with public supply. But this supply would have to follow the market logic and not the logic of government budgets. Supplementary public health-care, for instance in regions neglected by private suppliers, would have to be sold at market prices. Public doctors and nurses would have to earn competitive salaries.

TO FUND THE HEALTH-CARE DEMAND OF THE POOR: MANDATORY INSURANCE FOR ALL CITIZENS

A robust system of raising the funds needed to back up the health-care needs of the poor with adequate purchasing power should be highly independent of the political process. It should be a system that – once it got established – is autonomous and self-financing. In order to be truly self-financing it must tap the resources of "the rich". We need a health system that obliges all citizens, including

business owners and independent professionals, to join and pay contributions. And the contributions must be high enough to buy good treatment for all members, including those who can pay in much less than they are, on average, expected to take out of the system, in terms of health care. The financing of such a system can be organized several ways.

- All insured persons pay a flat-rate fee that reflects average health-care costs per person. For the poor (and maybe for minors), the fee is paid by the state, i.e., the tax-payers' community.
- The poor (and maybe the minors) pay nothing. Everybody else pays a flat-rate fee that covers the health-care costs for the non-paying persons as well.
- Insurance fees vary with income.

The systems have their advantages and disadvantages. But in a society where large parts of the non-poor population earn themselves a rather low salary, a flat-rate fee that covers the full costs of the intended encompassing high-quality health care might be too high. Fees that vary with income might be preferable.

Whatever the choice, there is no way around rather high average fees, if the system is to offer state-of-the-art health care to all citizens. This is the price of solidarity. If citizens refuse to pay it, or better: if politics is unable to produce acceptance for such an encompassing health-care system, one will have to accept that poor people are less healthy and die sooner.

TO ENSURE COST EFFICIENCY: PRIVATE SUPPLY, COMPETITION AND CO-PAYMENT BY PATIENTS

Efficiency, i.e., the attainment of maximum health-care value for the money paid into the system, depends on the incentives

- the suppliers have to optimize value;
- the patients have to avoid waste and the risk of illness;
- the system administrators have to keep bureaucratic transaction costs as low as possible.

Public delivery of health-care services is ill suited to guarantee efficiency. Neither the resources the system gets, nor the salaries doctors, laboratory analysts, etc. get are easily related to the quality and quantity of the services they deliver. It takes a high degree of conscientiousness to resist the temptation of maximizing private value at the expense of the system's clients, i.e. the patients. A better solution are private suppliers who have to compete for clients to increase their profits and incomes.

To check suppliers' price-setting power, the state might set up public clinics or pharmacies that compete with the private ones. But suppliers can also take advantage of their clients' lack of information on medical matters, selling them unnecessary services and medication. They can do this all the more easily if

patients do not really care, because they perceive insurance fees as something beyond their influence. This makes for higher costs, but not for healthier patients. Therefore, patients need a competent agent who assesses for them the appropriateness of medical treatments. Competing insurance companies or insurance associations would have an incentive to do that, in order to offer their clients/members lower fees. But they themselves would have to be supervised by a public trust agency to make sure that medically meaningful treatment is not sacrificed in an underbidding race between insurance companies. In other words, insurance companies must be obliged to cover all treatments declared as medically meaningful by the public supervisor.

TO AVOID SOCIAL EXCLUSION: FULL COVERAGE FOR ALL, THE SAME DOCTORS AND HOSPITALS FOR ALL, SUBSIDIZED INSURANCE FEES FOR THE POOR

Most important for avoiding social exclusion is that the poor do not get a different kind of health-care, that – when it comes to fighting disease and illness – they have access to the same medical institutions and the same treatment, including diagnosis and medication, as all other citizens. In order to get this, they must be admitted to the same insurance system and the same insurance coverage as all other citizens. This in turn requires three things:

- Insurance companies or associations are forced by law to accept everybody.
- All citizens are forced by law to join an insurance and fund it with adequate contributions.
- A law has to establish that the insurance fee must not exceed a certain percentage of the client's (or the member's) income. In order to stay profitable, the insurance company has to recuperate what it loses on poor clients (members) from its richer clients (members).

FITTING THE ELEMENTS TOGETHER: MANDATORY AND LEGALLY REGULATED, BUT COMPETING INSURERS NEGOTIATE WITH PRIVATE SUPPLIERS OF HEALTH-CARE

Affordable health-care for all requires the pooling of rich and poor peoples' financial resources. For the sake of efficiency and political robustness it is better to do this pooling through an autonomous insurance system, open for everybody, but also mandatory for everybody. The system should consist – also for efficiency reasons – of separate insurance bodies (companies or cooperative associations) that compete for members/clients. To ensure good quality health-care, the suppliers – doctors, hospitals, pharmacies, labs – must be rewarded for good service and be

punished for bad one. This is best done via market competition, which, in addition acts as a check on prices. So does the pooling of demand. This means that the insurance companies (or associations) negotiate on behalf of their members/clients with the suppliers fees, prices, quality standards, limits to coverage, etc.