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At what price?

Health care reforms in Georgia

The government of Georgia began reforming the health sector in 1995, in response to the country's economic crisis following its transition from a socialist system to a market economy. In their battle to access good health care in light of these reforms, poor households have developed a number of coping strategies. How have these households' economic status and health been affected?

The Georgian government's plan for reforming health care financing was a split between purchaser and provider involving social insurance, revenue generation from income tax and out-of-pocket payments. However, these reforms were undermined by the government's poor economic performance, high unemployment, the growing informal sector and poor budget revenues. As a result the sector was not receiving sufficient public funding. Health care financing was disorganised, with a significant reliance on out-of-pocket (OOP) payments.

A study by the Curatio International Foundation, Georgia and London School of Hygiene and Tropical Medicine, UK examines Georgia's health care-seeking behaviour and the extent of OOP payments by analysing information from a household survey conducted in Tbilisi in 2000. The results indicate that access to quality health care is obstructed by OOP payments, which have had a significant effect on care-seeking behaviour. At the same time, OOP payments have become inevitable due to the economic crisis and the government's inability to finance the health sector.

The study reports the following findings:

- The poorest households spend a higher proportion of their monthly household budget (23 percent) on outpatient care compared with the wealthy (15 percent).
- The biggest financial expense for outpatient care is pharmaceutical fees (averaging 55 percent of private spending), which are not included in the state-financed primary health care benefits.
- The high cost of health care significantly influences whether people seek care, with 11 percent of sick people (mostly poor) not seeking care and 60 percent choosing to self-treat.
- The majority of people (52 percent) choose a specialist as their first point of contact for medical treatment, which indicates the failure of the gate-keeping role of primary care.
- The high use of costly ambulance transport by the poorest households and the elderly suggests that they delay costly medical treatment, but as a result incur higher financial costs.

Public subsidies for outpatient treatment do not protect households, especially the poorest. The high cost of health care appears to affect the use of outpatient facilities. The report makes a number of policy recommendations to improve access to outpatient services:

- The government must change the basic benefit package to improve the targeting of subsidies to poor people and prioritise important services, such as drug benefits for the chronically ill.
- The quality of care and the public's perception of the quality must be improved to boost the demand for primary health care and encourage poorer households to seek cheaper treatment.
- The government needs to look into the practice of drug use as widespread self-treatment, including prescription drugs available over the counter, increases OOP payments.
- OOP payments could be pre-paid, for instance channeled into community-based health insurance schemes, which may help reduce the financial obstacles to health care.

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Making health insurance work for India's poorest

Medical bills often push poor people deeper into poverty. Community-based health insurance could guard poor people against these costs and increase their access to health services.

Members of a community-based health insurance (CBHI) scheme make regular payments and can claim medical costs when they fall ill. The schemes are voluntary and aimed at the poorest members of a population. The London School of Hygiene and Tropical Medicine, UK in collaboration with the Self-Employed Women's Association (SEWA) carried out research amongst the members of SEWA's CBHI scheme in Gujarat, India to discover who benefits most from the scheme and how it could be improved.

While mandatory prepayment schemes have included poorer people, CBHIs have been less successful. All members must pay the same subscription which is often beyond the means of the poorest people. Some CBHI schemes in India reach as little as ten percent of the people they are targeting while few achieve more than 50 percent. The study found that 32 percent of SEWA's rural members and 40 percent of its urban members come from the poorest bottom third of the population.

The study found that:

- Men are more likely to submit claims than women in part because women worry about leaving their domestic duties.
- In rural areas the better off members are more likely to make claims than the poorest members.
- In Ahmedabad city the poorest members and the better off claim equally.
- Members with easy access to health care are more likely to make claims than those living in remote areas because of the cost and time required to travel to the hospital.
- Many of the poorest members are illiterate and this can make it difficult to make a claim.
- Members may face problems getting the bills and doctor's certificate they need to make a claim.

An insurance scheme must:

- carefully consider the obstacles that prevent members, especially the poorest, from using health care facilities
- find ways to overcome these problems: for example, either paying for or providing transport to the hospital and paying people the wages they have lost during their time in hospital
- develop a simple system to reimburse patients for the cost of hospital care.

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Removing health user fees in Africa

Charging patients for basic health care hits the poorest members of society the hardest. Many fall into debt or simply do not seek care from public health services. The Commission for Africa has called for basic health care to be free for everyone. How would this impact on already under resourced health services?

Charging patients may encourage poor people to treat themselves with traditional medicines or with drugs bought from a peddler instead of attending a clinic. Often courses of treatment will not be completed due to the cost of the drugs. Medical fees were introduced in the late 1980s and early 1990s in many African countries in response to pressure from the World Bank and the International Monetary Fund to cut public funding of social services. It is encouraging that fees are now being removed in a growing number of African countries, but this should be carried out without harming health services. National health budgets will have to be increased to meet increased demand once the services become free.

Analysts from the Universities of Witwatersrand and Cape Town looked at the experiences of South Africa and Uganda, where medical fees have been removed, as well as other experiences of implementing changes in financing policies, to discover what lessons can be learned. The analysis indicates that policy changes such as fee removal have problems because:

- policies were pushed through too quickly due to political pressure without sufficient thought and planning
- ministers of health directly intervened to support or oppose specific policies, without clear reference to relevant evidence
- technical analysts, with the expertise necessary to support decision-making, did not have the power or the links with government to push through policy
- governments do not communicate enough with the public or health workers about new policies
- not enough drugs or staff are put in place to cope with increased demand
- there is not enough monitoring of how new policies affect clinics, staff and patients.

Governments should learn from the lesson of past experience in planning for fee removal. The task of coordinating all the actions necessary to remove fees and implement the actions necessary to strengthen health service delivery should be given to a specific government unit. In order to carry out fee removal successfully, it is necessary to:

- start a nationwide campaign, before the policy change, by means of radio, newspapers, posters and meetings with village elders in order to let the public know what to expect
- communicate clearly with health workers about the goals, as well as when and where changes will take place, through meetings, visits and newsletters
- decentralise some portion of budgets to allow health managers to make small-scale spending decisions
- make sure there are enough drugs and staff to cope with the increased demand at health centres
- improve access to health services, for example build more clinics and introduce more health workers based in the community
- encourage feedback from health workers about their experiences in introducing the changes.

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Paying hospital doctors in China

Since the early 1980s, China has introduced radical reforms to improve the efficiency of its health care system. Public hospitals receive a small fixed government budget and increasingly rely on charges for drugs and services to meet costs. Almost all have introduced a system of performance-related pay for doctors, known as the 'bonus' system.

A study by the London School of Hygiene and Tropical Medicine assessed the impacts of this bonus system on hospital revenue, cost recovery and productivity, using data from six hospitals in Shandong province. It also reviewed quality of care using the records of patients treated for appendicitis and pneumonia during the period in which the bonus system was introduced.

The study looked at the impact of switching from no bonus to a flat bonus shared out among all staff, and later to a revenue-related bonus (a bonus based on revenue generated by doctors from the provision of drugs and services). It then examined whether different types of bonus pay created an incentive for doctors to provide care that was clearly unnecessary.

Results revealed a substantial increase in hospital service revenue and cost recovery over the period. However, there was an accompanying increase in unnecessary care. The likelihood of admissions also increased when hospitals changed from a bonus system with a weak incentive to one with a stronger incentive. The study found that:

- The changes in the bonus system contributed significantly to increases in hospital revenue and hospital cost recovery.
- When hospitals changed from a flat bonus to a revenue-related bonus, admissions doubled while the number of visits decreased.
- Coinciding with this change, there was a tripling in the number of operations performed.
- Although hospital productivity decreased over time, a change from a flat bonus to a revenue-related bonus appeared to increase productivity in the year of the change.
- A high proportion of hospital expenditure was unnecessary: 18 percent in the case of appendicitis patients and 19 percent for pneumonia patients.
- The higher the expected incentive of the bonus system, the higher the proportion of unnecessary care.

The performance-related pay system has improved individual hospital finances. However, they argue that this has only been possible by increasing the provision of unnecessary care. The changes to the bonus system had not brought the expected social benefits but instead had increased health costs for the society and wasted resources. They conclude that:

- lack of regulation had enabled doctors to exploit the bonus system to their advantage
- hospital bonus distribution should be based on doctor performance, measured by indicators which relate to the overall performance of the health care system
- there should be closer government monitoring of hospitals
- when increasing public hospital autonomy, there should be regulations to limit opportunistic behaviour.

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