

Opportunities and Obstacles on the Road to Health Care Reform

The costs of treating infectious and chronic diseases can have serious public health implications for the entire global community. In the United States alone, the annual cost of treating infectious diseases exceeds \$120 billion, when indirect costs such as lost worker productivity are included, according to the National Science and Technology Council. In a series of breakout sessions on health care finance reform, participants discussed obstacles to and opportunities for creating cost-effective change in the health care sector.

Yuri Komarov, MD, PhD, DSC, general director of MedSocEconomicInform at the Russian Federation Ministry of Health, attributed the escalating infectious disease rates to an overall decline in effective health sector spending in the NIS. "The rise in infectious diseases is not simply a reflection of a lack of financial resources in the NIS health sectors, but is due primarily to the inefficient supply of medications and to the overspecialization of physicians."

Komarov cited as an example the situation in Belarus, where government funding for medical equipment and supplies increased from 8 percent to 19.8 percent in the past five years. Yet, deaths from infectious diseases rose from 24.7 to 38.8 per 100,000 in that time, evidence of a misdirection of funds, he said.

And the costs of inadequate health care, faltering infrastructure and rising environmental pollution converge in a lowering of life expectancy, according to Murray Feshbach, PhD, research professor at Georgetown University in Washington, DC. This decline "will contribute to losses among the working age population, and will cause serious implications for economic growth."

Creating a Cost-Effective Workforce

Reshaping the workforce is one way to rein in costs in both the US and NIS, panelists said. Common strategies identified included reducing the number of specialist physicians, expanding the role and scope of the nursing profession and reorienting health sectors toward comprehensive, primary health care.

The creation of a highly trained cadre of primary care physicians, "will effectively address the rise in infectious and other diseases that inflate costs. We have no other option," Komarov said.

Turkmen Health Ministry attempts to curb the physician oversupply have been effective in lowering workforce levels from 33 to 28 physicians per 10,000 population since 1990. "What we are actually seeing is an undersupply of qualified, primary care physicians," said Annageldy Gaipov, head of the Department of Treatment and Prevention, Ministry of Health and Medical Industry of Turkmenistan in Ashgabat.

Gaipov is working on a reform strategy to redefine and strengthen the role of family practice. The plan includes a revision in the medical curriculum to encourage medical students to study family medicine. At the same time, however, he is concerned that a curtailment in government subsidies to Turkmen hospitals and a subsequent 20 percent reduction in physician wages may dissuade many students from entering the profession, and prompt current physicians to seek alternative careers.

The US health care workforce faces a similar oversupply of specialized physicians. According to a 1995 study by the US Council on Graduate Medical Education, the US health care workforce

will face a surplus of 105,000 physicians by the year 2000, all of whom will be specialists; currently, two-thirds of the country's 750,000 physicians are specialists.

"The global health care workforce will either restructure to bring quality and quantity to the level of care demanded by society, or meet its own failure," said Bakhyt Tumenova, head of the Social Services Department of Semipalatinsk Health Administration in Kazakhstan.

Evidence-Based Medicine: The Missing Link To Containing Costs

The pressure to improve the quality of patient care while controlling costs affects both wealthy countries and countries going through economic restructuring such as those in the NIS and CEE, said Richard Saltman, PhD, a professor at the Rollins School of Public Health at Emory University.

"Health care providers throughout the NIS are being driven to search for and identify new sources of cost containment, while maintaining a commensurate benefit to patients," Saltman said. "The ultimate goal is the creation of comprehensive health care systems that emphasize equity and access to care."

Saltman noted the lack of empirical evidence to document the actual effectiveness of many reform policies. In some cases, the debate has been driven by ideology and rhetoric more than by evidence that substantiates anticipated benefits, he said. One approach that is being explored to address this lack of data is evidence-based medicine, which uses a careful analysis of the outcome of medical studies to develop guidance for clinicians and administrators.

Saltman encouraged NIS partners participating in the workshop to apply evidence-based techniques when defining their health reform strategies, and reminded the audience that there is no single, correct answer to reforming health systems.

Shaping Health Insurance Strategies

The majority of NIS countries are developing health reform strategies that include tax-based health insurance programs as a means of sharing costs among the public and private sectors. However, a number of factors, including economic recession and the slow pace of these reforms, have led to a series of problems in the shift to insurance-based health care financing. Hindering the transition to health insurance are substantial increases in health expenditure, structural deficits associated with insufficient transfer of funds and a rise in unemployment.

During a workshop on revenue generation, speaker Ioseb Bregvadze, the first deputy head of the State Medical Insurance Company in Tbilisi, Georgia, discussed his country's attempt to address these problems. He explained that a chronic government underfunding of the health sector as early as 1960 has meant that physicians and nurses are underpaid by as much as 20 percent in Georgia. This prompts many highly trained health care workers to leave the profession or to rely on other sources of income, such as bribes from patients.

"Georgian citizens have paid an increasingly high share of total health care costs themselves," he said, explaining that, by 1990, patients covered an estimated 90 percent of total health care costs. "Privatization of health care is not bad, but needs to distribute the costs a little more evenly between government and private sectors," he said.

Bregvadze said the creation of an obligatory state insurance fund, which generates revenue from an employee wage tax, and from government funds, is a necessary first step in alleviating the uneven cost incurred by patients. The introduction of insurance is having "some impact" in Georgia, Bregvadze concluded. Yet, "it has a very long way to go before citizens are no longer expected to pay the majority of their medical expenses."

In Kyrgyzstan, the health care reform process that began in 1994 relied on evidence-based approaches in creating its national health care plan, MANAS--a name taken from a Kyrgyz legend about an ancient warrior king.

"The success of similar health reforms in Europe in shifting to outpatient services proved that this was the right initial step to take," said Kyrgyz Health Minister Naken Kasiev.

As a first step, Kasiev said MANAS put an emphasis on outpatient care, requiring a reduction in the workforce, an elimination of 30 percent of total beds, and a reorientation to community-oriented care. Since the program's creation, more than 35 percent of the Health Ministry budget has been reallocated to meet the costs of outpatient services. The Kyrgyz Health Ministry also developed a state health insurance program to ensure equity in the delivery of health services.

A similar health reform program launched in Tajikistan in 1993 is aimed at creating a state health insurance program. The plan seeks to provide universal health care through the government-sponsored insurance fund, relying on taxes of residents. According to Tajik Health Minister Alamkhan Akhmedov, the health ministry saved \$4 million by reducing the total bed supply by 17,000 and encouraging greater reliance on less costly outpatient services. Akhmedov identified the need to create a national pharmacy plant to eliminate the reliance on and costly import of drugs from Russia.

Meanwhile, in the far eastern Russian region of Primorskiy Krai, regional health administrators developed an innovative public-private health insurance scheme that encompasses federal, regional and municipal level health agencies, said Valery Prikhodko, MD, with the Primorskii Krai Health Department. In 1996, following a 50-percent shortage of budget funds, Primorskii Krai health officials decided to privatize regional health systems, by developing fee-based outpatient services, home health care, and private, voluntary insurance funds.

"In each of our reforms, we have forced our doctors to think in business terms," said Igor Denisov, PhD, deputy rector of the Medical Academy in the Name of Sechenov in Moscow. "The future success of our reforms requires that we bring quality and volume of health services together, by retraining our workforce in primary care."

Yet, added Semipalatinsk's Tumenova, "only with the help and support of citizens can we expect to see positive results from these privatization efforts."