Healthcare Reform Checklist

1st EDITION

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REPUBLIC OF MACEDONIA

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Healthcare Reform Checklist

POINTS FOR THE AGENDA OF THE STEERING COMMITTEE FOR THE ADVANCEMENT of HEALTHCARE in the REPUBLIC OF MACEDONIA

Presented to the Plenum of the Committee on June 15, 2009
By: Sam Vaknin, Ph.D., economist

GENERAL

Healthcare legislation in countries in transition, emerging economic, and developing countries should permit - and use economic incentives to encourage - a structural reform of the sector, including its partial privatization.

KEY ISSUES

- **Universal healthcare** vs. selective provision, coverage, and delivery (for instance, means-tested, or demographically-adjusted)
- **Health Insurance Fund**: Internal, streamlined market vs. external market competition
- **Centralized system** – or devolved? The role of **local government** in healthcare.
- **Ministry of Health**: Stewardship or Micromanagement?
- **Customer (Patient) as Stakeholder**
- **Imbalances: overstaffing** (MDs), **understaffing** (nurses), **geographical distribution** (rural vs. urban), **service type** (overuse of secondary and tertiary healthcare vs. primary healthcare)

AIMS

- To **amend existing laws and introduce new legislation** to allow for changes to take place.
- To effect a transition from individualized medicine to ***population medicine***, with an emphasis on the overall welfare and needs of the community

Hopefully, the **new legal environment** will:

- Foster **entrepreneurship**;
- Alter **patterns of purchasing, provision, and contracting**;
- Introduce **constructive competition** into the marketplace;
- Prevent **market failures**;
- **Transform healthcare** from an under-financed and under-invested public good into a thriving sector with (more) **satisfied customers** and (more) **profitable providers**.

- Transition to **Patient-centred care**: respect for patients' values, preferences, and expressed needs in regard to coordination and integration of care, information, communication and education, physical comfort, emotional support and alleviation of fear and anxiety, involvement of family and friends, transition and continuity.

The **Law and regulatory framework** should ***explicitly*** allow for the following:

I. PURCHASING and PURCHASERS

(I1) ***Private health insurance plans (Germany, Czech Republic, Netherlands)***, including franchises of overseas insurance plans, subject to rigorous procedures of inspection and to satisfying financial and governance requirements. Insured/beneficiaries will have the right to apply contributions to chosen purchaser and to switch insurers annually.

Private healthcare plans can be established by ***large firms***; ***guilds*** (chambers of commerce and other professional or sectoral associations); and ***regions*** (see the subchapter on **devolution** under **VI. Stewardship**).

Private insurers: must provide ***universal coverage***; offer similar ***care packages***; apply the same ***rate of premium***, unrelated to the risk of the subscriber; cannot ***turn applicants down***; must adhere to ***national-level rules*** about packages and co-payments; compete on ***equality and efficiency*** standards.

(I11) ***Breakup of statutory Health Insurance Fund*** to 2-3 competing insurance plans (possibly on a regional basis, as is the case in France) on equal footing with private entrants.

Regional funds will be responsible for purchasing health services (including from hospitals) and making payments to providers. They will be not-for-profit organizations with their own ***boards and managerial autonomy***.

(I12) ***Board of directors and supervisory boards*** of health insurance funds to include:

- Two non-executive, lay (not from the medical professions and not politicians) members of the public. These will represent the patients and will be elected by a ***Council of the Insured***, (as is the practice in the Netherlands)
- Municipal representatives;
- Representatives of stakeholders (doctors, nurses, employees of the funds, etc.).

(I13) The funds will be granted ***autonomy*** regarding matters of human resources (personnel hiring and firing); budgeting; financial incentives (bonuses and penalties); and contracting.

The funds will be bound by rules of ***public disclosure*** about what services were purchased from which providers and at what cost.

Citizen juries and ***citizen panels*** will be used to assist with rationing and priority-setting decisions (United Kingdom).

(I2) ***Procurement of medicines*** to be done by an autonomous ***central purchasing agency***, supervised by a public committee (***drug regulatory authority***) aided by outside auditors.

All procurement of drugs and medications will be done via ***international tenders***.

The agency will submit its ***reimbursement rates*** for drugs on the PLD to external audit in order to accurately reflect pharmacists' overhead costs. At the same time, the profit ***margins on all drugs***, whether on the PLD or not, will be regulated.

This agency should be ***separate from the Health Insurance Fund and the Ministry of Health***. This agency will also maintain **national drug registries**. It will secure volume discounts for bulk purchasing and transparent, arm's-length pricing.

(I21) Use of ***reference prices for medicines.*** If the actual price exceeds the reference price, the price difference has to be met by the patient.

(I3) The ***Approved (Positive) List of Medicines*** will be recomposed to include generic drugs whenever possible and to exclude expensive brands where generics exist. This should be a requirement in the law. Separately, an ***Essential Drug List*** will be drawn up.

(I31) Encourage **rational drug prescribing** by instituting a mixture of ***GP and PHC incentives and penalties***, or a ***fundholding system***: budgets will be allocated to each GP for the purchase of drugs and medications. If the GP exceeds his/her budget, s/he is penalized. The GP gets to keep a percentage of budget savings. Prescription decisions will be ***medically reviewed*** to avoid under-provision.

(I4) ***Payments and Contracting***

Payment to providers should combine, in a mixed formula:

BLOCK CONTRACTS

Capitation - A fixed fee for a list of services to be provided to a single patient in a given period, payable even if the services were not consumed, adjusted for the patients' demographic data and reimbursement for fee-for-service items.

Inflation-adjusted ***Global budgeting (hospitals)*** and ***block (lump sum) grants (municipalities)***

COST and VOLUME CONTRACTS

Provide incentives and reward marketing efforts which result in an increase in demand/referral beyond the limit set in a block contract.

COST PER CASE CONTRACTS

Apply Diagnosis Related Group (DRG)/ Resource-based Relative Value (RBRV) / Patient Management Categories (PMCs) / Disease Staging/Clinical Pathways

Levels of ***reimbursement, case-mix adjusted*** to be decided by ***external auditors***.

Contracts with providers should include:

- ***Waiting Times Guarantee***
- ***Single Contact Person*** ("Case Officer") for the duration of a stay at the hospital
- ***Hospital benchmarking*** (individual-level data on costs, diagnoses, and procedures during entire case episodes: inpatient admissions and outpatient visits; cost-effectiveness of services.
- ***Performance targets*** in performance agreements with all healthcare facilities, both public and private.
- All payments - wages included - will be tied to these targets and their attainment as well as to ***healthcare quality*** as determined by ***objective measures*** (internal, external, and functional benchmarking), ***clinical audits*** (sampling), as well as ***customer satisfaction surveys*** and ***interviews and discussions with patients.***
- ***Provider and Staff Bonuses and penalties*** tied to exceeding/under-performing targets and contract variance
- ***Patients' rights***, including their rights to litigate

Selective contracting will be allowed on all levels (including specialist ambulatory care and hospitals), although all providers, private and public, will be ***permitted to apply*** for contracts with health funds and insurers. The funds will choose from among private providers either following a process of deliberation, or via an ***auction***, or ***public tender*** (United Kingdom).

(I5) Commissioning preference will be given to the purchase of Primary Healthcare over secondary, or tertiary Healthcare**.**

II. PROVIDERS

The **Law and regulatory framework** should ***explicitly*** allow for the following:

(II1) ***Hospital Management***

(See separate document)

The law should allow:

I. ***Co-location*** of a private wing within or beside a public hospital

II. Outsourcing of ***non-clinical support services***

III. Outsourcing of ***clinical support services***

IV. Outsourcing of ***specialized clinical services***

V. ***Private management*** of public hospitals

VI. ***Private financing, construction, and leaseback*** of new public hospitals

VII. ***Private financing, construction, and operation*** of new public hospitals

VIII. ***Sale of public hospitals*** as going concerns

IX. Sale of public hospitals for ***alternative use***

X. ***Consolidation*** of redundant public healthcare facilities by merging them or closing down some of them

XI. Privatization of ***Primary Healthcare (PHC) clinics*** within medical centers

XII. Healthcare institutions will be granted ***autonomy*** regarding matters of human resources (personnel hiring and firing); administering financial incentives or penalties, budgeting; and contracting.

XIII. Privatization ***pharmacies inside medical centers and hospitals***.

(II2) Primary, Ambulatory, and Secondary Care and General Practitioners (GP)

(II21) ***Limit the number of patients*** per GP

(II22) Stimulate and financially incentivize the following activities, which should be declared ***national priorities*** within a National Needs Assessment:

- **Group practices** and **networks** (for continued, around-the-clock services)
- **Day and minimally invasive surgery**
- **Dispensaries**
- **Home and day care services**
- **Long-term care (**nursing homes, visiting nurses, home I.V. and other services provided to chronically ill or disabled persons)
- **Patient hotels**
- **Rehabilitation** facilities and programs
- Provision of **merit goods** (also through **mass campaigns**)
- Conversion of hospital units to **outpatient services**, and **day-care centers**

Example of such financial incentives:

- Physicians will be entitled to see patients who receive services free-of-cost in the public sector in the morning, and ***private patients*** who pay the full cost of the medical consultation in the afternoon.
- Allow ***private beds*** in public hospitals and ***private financing*** of hospital stays (NHS, UK)
- Subsidize or fully cover ***transaction costs*** (legal fees of contracting, compliance, accounting, etc.)

(II23) Allow hospitals to administer **packages of outpatient services** and be reimbursed by the Health Insurance Fund (or funds).

(II24) Impose an ***admission quota*** on medical schools; reduce the ***obligatory number*** of doctors per 1000 population; and make GP a ***medical specialty.***

(II25) Strengthen the ***gatekeeper*** function of GPs and ***healthcare provision in outpatient settings.***

Encourage **gatekeeping** by instituting a mixture of ***GP and PHC incentives and penalties***, or a ***fundholding system (United Kingdom, Estonia, Spain)***:

Budgets will be allocated to each GP for the purchase of secondary and tertiary healthcare (as well as to cover salaries, premises, diagnostic tests). If the GP exceeds his/her budget, s/he is penalized. The GP gets to keep a percentage of budget savings.

Referrals will be ***medically reviewed*** to avoid under-provision.

(II26) Introduce ***GP target income*** and adjust services and fees to reach it (perhaps by using ***tax credits***).

(II27) ***Provide GPs and other types of primary and secondary healthcare providers with financial incentives to relocate*** to remote and rural areas

(II28) Render ***clinical and best practice guidelines mandatory*** (not merely recommended)

(II29) Encourage ***managed care*** (peer review panels, pre-approval procedures for surgery, case management for the chronically ill, formularies limiting pharmacy reimbursement to an approved list, and other contractual provisions).

III. PRIVATE SECTOR

Risks of privatization and private non-managed, imperfect competition: market failure, as patients received ***too many unnecessary services***, due to fee-for-service reimbursement and information asymmetry.

The **Law and regulatory framework** should ***explicitly*** allow for the following:

(III0) Allow ***private primary healthcare physicians*** to offer preventive care, treatments and interventions after office hours, emergency dental and medical care, emergency home treatment, preventive checkups for preschool and school children, patronage and polyvalent patronage services, and all other elements of comprehensive healthcare.

(III1) ***Arrangements with the private sector*** and ***Private-Public Partnerships (PPP)*** for the provision of healthcare:

(III11) ***Service Contract (Dominican Republic), or Contracting-out***

The government pays private entities - including doctors - to perform specific healthcare tasks, or to provide specific healthcare services under a contract. The private service providers can make use of state-owned facilities, if they wish, or operate from their own premises.

Payments by the government are usually based on capitation (a fixed fee for a list of services to be provided to a single patient in a given period, payable even if the services were not consumed) adjusted for the patients' demographic data and reimbursement for fee-for-service items.

(III12) ***Management Contract Outsourcing (Cambodia)***

The government pays private entities to manage and operate public health care facilities, like clinics, or hospitals.

(III13) ***Lease (Romania since 1994)***

Private entities - including doctors - pay the government a lump sum or monthly fees to use specific state-owned equipment, state-employed manpower, clinics, or complete public health care facilities.

The private entity is entitled to all revenues from its operations but also bears all commercial risks, is responsible for management and operations and liable for malpractice and accidents.

The state is still responsible to make capital investments in the leased facility or equipment, but maintenance costs are borne by the private entity.

(III14) ***Concession and Build-Operate-Transfer (BOT) (Costa Rica)***

Concession is exactly like a lease arrangement (see above) with one exception: the private entity is responsible for capital investment. In return, the contract period is extended and can be voided only with a considerable pre-advice.

In BOT (Build-Operate-Transfer) and ROT (Rehabilitate-Operate-Transfer) the capital investment involves the construction or renovation/upgrade of new healthcare facilities. The private entity uses the constructed facility to provide services. After a prescribed period of time has elapsed, ownership is transferred to the government.

(III15) ***Divestiture and Build-Own-Operate (BOO) (Texas, USA)***

The law should permit the outright sale of state- owned health care facilities to a qualified private entity, including physician groups who band together to purchase previously state-run facilities.

Another possibility is a BOO scheme, in which the private entity contractually undertakes to add facilities, improve services, purchase equipment, or all three.

(III16) ***Free entry***

The law should allow qualified private providers to operate freely. Though regulated, these private firms will have no other relationship with the state.

Such entities would have to be licensed, certified, overseen, and accredited for expertise, safety, hygiene, maintenance, track record, liability insurance, and so on.

The state may choose to encourage such providers to locate in specific regions, to cater to poor clients, or to provide specific healthcare tasks or services by offering tax incentives, free training, access to public facilities, etc.

(III17) ***Franchising (Kenya, Pakistan, Philippines)***

A private firm (franchisee) acquires a license from and shares profits with the franchisor (a domestic, or, more often, foreign firm). The franchisee uses the brand name, trademarks, marketing materials, management techniques, designs, media access, access to approved suppliers at bulk (discounted) prices, and training offered by the franchisor. The franchisor monitors the performance and quality of service of the franchisee.

This model works mainly in preventive care, family planning, and reproductive health.

The World Bank ("Public Policy for the Private Sector", Note number 263, dated June 2003):

"Franchisers in the health sector, often supported by international donors and nongovernmental organizations (NGOs), establish protocols, provide training for health workers, certify those who qualify, monitor the performance of franchisees, and provide bulk procurement and brand marketing."

(III18) Allow ***Charities*** and Not-for-profit organizations to run health insurance funds and a variety of providers (including full-scale secondary and tertiary healthcare institutions).

(III9) ***Voluntary Health Insurance*** (substitutive; complementary; and complementary), subject to open enrollment periods and mandatory coverage of dependants (to prevent ***cream-skimming*** and ***adverse selection***).

IV. FINANCING

The **Law and regulatory framework** should ***explicitly*** allow for the following:

(IV0) Institute ***co-payments*** for examination by a GP, emergency medical care, and certain preventive programs.

(IV01) Introduce ***negative co-payments: rebates or credits*** (to be deducted from future contributions) to insured persons who, in the preceding year, did not use services and did not consume interventions or drugs from the positive list above a level determined by the Ministry of Health.

(IV02) Introduce ***provider co-payments*** for hospital stays above the European Union average. Whenever the ***length of stay*** exceeds the EU average, the provider (hospital) will make a co-payment to the Health Insurance Fund or to the insurer.

(IV1) ***Voucher System (Nicaragua)***

The law should allow for experimenting with novel payment and resource allocation techniques, such as **vouchers or prepaid health cards** distributed to needy populations and guaranteeing free basic service packages provided by a limited list of clinics or other healthcare facilities. Such schemes can also be managed by the private sector.

(IV2) ***Medical Savings Accounts (Singapore)***

Allows or mandates people to place money in (tax-free) savings accounts to be used only for medical expenses, usually in conjunction with the purchase of a catastrophic stop-loss health insurance plan.

Contributions by employers and employees accumulate over time and are used, tax-free, to pay for hospital expenses in public and private hospitals, national supplementary health insurance premiums, special procedures (including abroad), and expensive outpatient treatment and drugs for the saver and his immediate family.

(IV3) ***Consumer Organizations and Community Healthcare Financing***

Consumer organizations in the healthcare field (such as buyers' clubs or ***Health Maintenance Organizations-HMOs*** owned by cooperatives, NGOs, municipalities).

These groups will shop and tender for the best, most reasonably priced, and most efficient healthcare services for their members (Switzerland).

Example: HMO in USA – Integrated Model of Healthcare

(Source: WHO)

Health maintenance organization (HMO) is US health care sector term. It is an organization that contracts to provide comprehensive medical services (not patient reimbursement) for a specified fee each month.

The term health maintenance organization arose because doctors under this arrangement have a financial incentive to keep their patience healthy, since they are not paid more for providing more services.

Health maintenance organizations, which focus on providing patients comprehensive medical care and pay doctors a specified monthly fee, have become increasingly popular in the United States, prompted by high costs from the previous fee-for-service, traditional indemnity health insurance plans.

In this model, doctors are typically paid by salary and hospitals are typically funded by global budgets. Benefits are supplied to patients in-kind, often free of charge. The public

version of this model involves government financing and provision of health care and is often funded mainly out of general taxation. In the US, the voluntary form of this model is better known as the staff model of the health maintenance organisation. “Integration” as such is not only used for integrated model, but also for types of care provisions in which providers offering differing services (e.g., ambulatory care, inpatient care, rehabilitative care) provide them in an integrated way.

(IV4) ***Voluntary Health Insurance*** (substitutive; complementary; and complementary) with the right to apply one’s contributions to pay the premium and the right to switch insurers annually.

(IV51) ***Earmark*** a percentage of ***vice (sin) taxes***, customs duties, VAT, and excise (on alcohol and tobacco; drugs and medications) for healthcare purposes.

(IV52) ***Reform healthcare budgeting***. All healthcare budgets (including the budgets of the Ministry of Health; of hospitals, clinics, and primary healthcare facilities) will include ***amortization*** (and ***capital investments***), goodwill and intellectual property, and intangibles (such as environmental externalities).

(IV6) Allow providers to retain a percentage of the ***user-fees*** they collect.

(IV7) Means-tested system: affluent and certain constituencies will be excluded from coverage (Netherlands, Germany) or pay much higher ***co-payments, co-insurance, or deductible (cost-sharing).***

In such a system, ***private insurers*** administer ***compulsory insurance for the excluded groups*** (e.g., civil servants in Netherlands).

(IV8) Introduce **VAT on hospitals** to encourage investment, the purchase of medications, the retention of external services (e.g. training, skilling, continued education, management consultancy, auditing, etc.), where the hospitals can deduct VAT and retain it as an addition to their own budget.

(IV9) ***Community rating system*** vs. ***Demographically-adjusted or experience-rated premiums*** (e.g., the old and sick pay more than the young and healthy or vice versa; people with dependants pay more than insured or subscribers without dependants, etc.)

(IV10) ***Blind Fundholding:*** Financial resources for health care are allocated on a per capita basis; financial resources are held in a fund; and the general practitioner is usually the decision-maker for allocating the funds to purchase hospital and community services (with the patient choosing the providers, not the GP as was the case in the United Kingdom).

V. E-HEALTH

The **Law and regulatory framework** should ***explicitly*** allow for the following:

(V1) Citizen-centered and Mobile Healthcare

(V12) Provide a legal framework for **health data transfer**

(V13) Harmonize **confidentiality and privacy laws**

(V14) Establish **legal liability** or waiver thereof for **e-treatment**

(V15) Settle issues of **entitlement and reimbursement**

(V16) Encourage **Medical e-Tourism (inbound telemedicine)**

(V17) Provide for **infrastructure and interoperability**

(V18) Permit and licence **Web Health and (outbound) Telemedicine** (laws, regulations, forms)

(V19) Establish **early warning systems**

(V110) Foster **patient-driven comparative indicators** (e.g., **online rating** of professionals and providers) and empower **patient organizations**

(V111) Electronic <u>European</u> Health Insurance Card

(V112) Each citizen (or his/her custodian) will have full access to a personal **Health Home Page** with his EMR (**Electronic Medical Records**)/EPR (***Electronic Patient Record***)/EHR (***Electronic Health Record***)

VI. STEWARDSHIP

The **Law and regulatory framework** should ***explicitly*** allow for the following:

(VI0) The ***Benefits Packages*** (basic and supplementary) to be decided by a ***conference of all stakeholders***: Ministry of Health, patient groups and advocacy groups, and medical doctors associations, assisted by healthcare economists and experts.

(VI01) Consider the introduction of a ***Negative Benefits Package***, listing only the interventions and services that are **excluded** from coverage. The **interventions and services not on the Negative List are automatically covered**.

(VI02) Consider exclusion of ***dental and oral care*** from the Benefits Package.

(VI03) Make ***preventive occupational health and safety*** measures, equipment, and training in the workplace mandatory. Re-establish ***occupational dispensaries*** in all workplaces with more than 100 workers.

(VI04) Generate annual ***National Needs Assessment*** reports (including technological needs assessment), including prioritized allocation of funding and foreign aid.

(VI05) Transform ***teaching hospitals*** into publicly-owned independent trusts (Italy, United Kingdom): the ***corporate*** type of hospital (hard budget; autonomous managers accountable to board; board accountable to government).

(VI1) Licencing and accreditation (including periodical renewal and relicencing by the doctors, dentists, and pharmacists chambers) will depend on ***continuing medical education*** (CME) and on education in ***management and finance*** for certain jobs (such as ward, clinic, and hospital directors).

All positions from ward doctor upwards will be subject to ***periodic review and open, public tenders.***

(VI2) ***Private Sector Healthcare Monitoring and Regulatory Agency***

The law should provide for the establishment of an agency to monitor and regulate private sector healthcare provision: compliance with contracts, servicing the indigent and the uninsured, imposing sanctions or "step-in" rights, and dispute resolution.

This agency will also maintain and supervise the operation of internal open-markets in the public sector; the outsourcing of primary care functions; and the purchase of primary care packages from private providers.

(VI3) ***Devolution (Finland)***

Responsibility for the provision of some types of healthcare services (health promotion; preventive care; occupational health; mental health) and the allocation of inputs should be devolved to ***local authorities*** (municipalities), which will be required to produce ***budgets*** of needs vs. costs.

Consider possibility of ***turning municipalities to purchasers*** of secondary and tertiary healthcare from providers of their choice.

Local government will cover ***primary healthcare capital expenditures*** out of municipal taxes and fees and weighted capitation-based transfers from the central budget

The MoH will maintain a **Fiscal Equalization Fund** to ensure consistent quality and availability of healthcare provision across regions and localities.

(VI4) ***Health Academy***

The Ministry should establish an Academy to train healthcare administrators with emphasis on ***systems administration and reform***. The Academy will invite foreign experts as guest lecturers and teachers.

In conjunction with the Republic Institute for Health Protection, the Academy will co-maintain ***databases of case studies and evidence-based practices*** (feeding into the ***Cochrane Network***) and the ***Medical Map of Macedonia***.

(VI5) ***Campaign*** to encourage the public ***to consume generic drugs*** will be launched.

(VI6) ***External audit and cartel (antitrust) investigation regarding tertiary healthcare facilities.***

(VI7) ***Wait Time Reduction Fund (Canada, 2004)***

(VI8) ***National Waiting Times Guarantee***

(VI9) ***Minister of Health Award of Excellence***, presented annually to individuals and institutions of outstanding merit and excellence among healthcare professionals, purchasers, and providers of all types.

(VI10) Appoint a ***Health Ombudsman*** and ***consumer advocates*** in each major healthcare facility. Strengthen ***patients' rights*** and the ***Patients' Charter***. Provide all patients (Or their custodians) with full **access to their medical records**; compensation for ***iatrogenic diseases***; a statutory role for ***patients' associations***; and the establishments of commissions with ***patient representatives in all hospitals*** (France).

(VI11) SPECIFIC PROJECTS

Uniform Emergency Number

Neonatal Emergency Ambulance

Health cabinets in schools

Health Tourism

(VI12) ***National Inventory of Medical Assets***

Extend the current central registry of all medical equipment in publicly-owned healthcare facilities to include ***private healthcare facilities***.

The Inventory should also profile ***medical personnel, real estate, fixtures, infrastructure, and other capital assets***.

(VI13) ***Coordinative Council for Social and Health Services:*** to plan and guarantee inter-sectoral action (together with the ministry of Social Welfare and Labor).

(VI14) Publish ***standardized contracts***, ***forms, and performance criteria*** (including qualitative clinical pathways and benchmarks) to reduce ***transaction costs***.

Example: the ***National Health Service Frameworks*** in the United Kingdom provide a health strategy; list priority interventions, treatment guidelines and performance targets; and proffer model contracts.

(VI15) ***Medical and Health Technology Assessment Board*** (examples: NICE in United Kingdom or SBU is Sweden) to decide all ***purchases of technology*** in secondary and tertiary facilities; to publish ***"Positive Lists" of technology*** for GPs and PHC facilities; and to obtain ***discounts on bulk purchases***.

The ***WHO*** defines ***Health Technology Assessment*** as:

"Comprehensive evaluation and assessment of existing and emerging medical technologies including pharmaceuticals, procedures, services, devices and equipment in regard to their medical, economic, social and ethical effects.

The systematic evaluation of properties, effects and/or impacts of health care technology. Health Technology Assessment defines a multidisciplinary activity that systematically examines technical performance, safety, clinical efficacy and effectiveness, cost, cost-effectiveness, organisational impact, social consequences, legal and ethical aspects of the application of a health technology (European Commission, 1999, from EUR-ASSESS 1997)."

(VI16) National Health Accounts *Institute*

(Sourvces: ***WHO, OECD, USAID***)

Will publish the ***Healthcare PPP*** (Purchasing Power Parity), taking into account prices of imported healthcare inputs. Indicators may include total health expenditure, public expenditure, private expenditure, out-of-pocket expenditure, tax-funded and other public expenditure, social security expenditure, public expenditure on health.

The ***National Health Accounts*** will also provide the following ***annual data, analyses, and indicators:***

Sectoral opportunity costs, the value of benefits foregone by failure to apply the resources to the most productive alternative cost;

Sectoral marginal costs, the extra cost of increasing output by one unit;

Sectoral variable costs: costs that vary with changes in output volume, such as the material required to provide a service versus

Sectoral fixed costs: costs which do not vary with quantity or volume of output provided, at least in the short run (e.g. rent for space).

Sectoral direct costs: all the goods, services and other resources that are consumed in the provision of a particular service or area (e.g. hospital supplies), including medical costs (e.g. payments to providers, material) and non-medical costs (e.g. transportation to hospital);

Sectoral indirect costs: total sum of ***morbidity costs*** (goods and services not produced by the patient because of the illness), ***mortality costs*** (goods and services the person could have produced had the illness not been incurred and the person not died prematurely), and ***productivity cost*** (related to lost productivity incurred by an employee who leaves work to provide care for the patient);

Sectoral intangible costs: usually used in economic evaluation, to indicate features like pain, anxiety or grief, which cannot be directly quantified in monetary terms.

Sectoral resource costs are the resources used in the production of goods and services; user cost: cost to the user of purchasing or making use of a product.

Sectoral cost-effectiveness analysis (CEA), a type of analysis that compares interventions or programmes having a common measurement of health outcome in a situation where, for a given level of resources, the decision maker wishes to maximise the health benefits conferred to the population of concern;

Sectoral cost-utility analysis (CUA), a type of analysis that measures benefits in utility-weighted life-years (QALYs) and which computes a cost per utility-measure ratio for comparison between programmes;

Sectoral cost-benefit analysis (CBA), a type of analysis that measures costs and benefits in monetary units and computes a net monetary gain/loss or a cost-benefit ratio.

Outcomes research: the Institute will evaluate the impact of health care on the health outcomes of patients and populations, including an evaluation of economic impacts linked to health outcomes, such as cost effectiveness and cost utility. Outcomes research emphasises health problem- (or disease-) oriented evaluations of care delivered in general, real world settings; multidisciplinary teams; and a wide range of outcomes, including mortality, morbidity, functional status, mental well-being, and other aspects of health related quality of life.

Total expenditure on health: Total (or national) expenditure on health based on: Personal

health care services + Medical goods dispensed to outpatients = Total personal expenditure on health + Services of prevention and public health + Health administration and health insurance = Total current expenditure on health + Investment into medical facilities = Total expenditure on health.

Another formula is: total expenditure on health = * private health care expenditure + * public health care expenditure.

(VI17) ***Hospital League Table and star ranking*** (like with hotels and restaurants) to include ***information made publicly-available*** in various media: number of patients treated; complication rates; waiting times; data about procedures; food and amenities; other quality measures.

(VI18) ***Annual National Health Survey:*** will measure attitudes; customer satisfaction; emerging trends among purchasers and providers; and the increase or decrease in quality and performance standards as well as in capital investments.

Return

The Dying Breed - Healthcare in Eastern Europe

By: Sam Vaknin, Ph.D.

Also published by United Press International (UPI)

Transition has trimmed Russian life expectancy by well over a decade. People lead brutish and nasty lives only to expire in their prime, often inebriated. In the republics of former Yugoslavia, respiratory and digestive tract diseases run amok. Stress and pollution conspire to reap a grim harvest throughout the wastelands of eastern Europe. The rate of Tuberculosis in Romania exceeds that of sub-Saharan Africa.

As income deteriorated, plunging people into abject poverty, they found it increasingly difficult to maintain a healthy lifestyle. Crumbling healthcare systems, ridden by corruption and cronyism, ceased to provide even the appearance of rudimentary health services. The number of women who die at - ever rarer - childbirth skyrocketed.

Healthcare under communism was a public good, equitably provided by benevolent governments. At least in theory. Reality was drearier and drabber. Doctors often extorted bribes from hapless patients in return for accelerated or better medical treatment.

Country folk were forced to travel hundreds of miles to the nearest city to receive the most basic care. Medical degrees were - and still are - up for sale to the highest, or most well-connected, bidder. Management was venal and amateurish, as it has remained to this very day.

Hospital beds were abundant - not so preventive medicine and ambulatory care. One notable exception is Estonia where the law requires scheduled prophylactic exams and environmental assessment of health measures in the workplace.

Even before the demise of central healthcare provision, some countries in east Europe experimented with medical insurance schemes, or with universal healthcare insurance. Others provided healthcare only through and at the workplace. But as national output and government budgets imploded, even this ceased abruptly.

Hospitals and other facilities are left to rot for lack of maintenance or shut down altogether. The much slashed government paid remuneration of over-worked medical staff was devoured by hyperinflation and stagnated ever since. Equipment falls into disrepair. Libraries stock on tattered archaic tomes.

Medicines and other substances - from cultures to vaccines to immunological markers - are no longer affordable and thus permanently in short supply. The rich monopolize the little that is left, or travel abroad in search of cure. The poor languish and die.

Healthcare provision in east Europe is irrational. In the healthcare chapter of a report prepared by IRIS Center in the University of Maryland for USAID, it says:

"In view of the fall in income and government revenue, there is a need for more accurate targeting of health care (for instance, more emphasis on preventive and primary care, rather than tertiary care), and generally more efficient use of benefits (e.g., financing spa attendance by Russian workers can be cut in favor of more widespread vaccination and public education). As the formal privatization (much is already informally privatized) of health care proceeds, and health insurance systems are developed, health care access for poverty-stricken groups and individuals needs to be provided in a more reliable and systematic way."

But this is hard to achieve when even the token salaries of healthcare workers go unpaid for months. Interfax reported on March 9 that 41 of Russia's 89 regions owe their healthcare force back wages. Unions are bereft of resources and singularly inefficacious.

The outcomes of a mere 6 percent of national level consultations in Lithuania were influenced by the health unions. Their membership fell to 20 percent of eligible workers, the same as in Poland and only a shade less than the Czech Republic (with 32 percent).

No wonder that "under the table" "facilitation fees" are common and constitute between 40 and 50 percent of the total income of medical professionals. In countries like the Czech Republic, Croatia, and chaotic Belarus, the income of doctors has diverged upwards compared to other curative vocations. It is not possible to obtain any kind of free medical care in the central Asian republics.

This officially tolerated mixture of quasi-free services and for-pay care is labeled "state-regulated corruption" by Maxim Rybakov from Central European University in his article "Shadow Cost-sharing in Russian Healthcare".

As though to defy this label, the Russian Ministry of Health is conducting - together with the Audit Chamber and the Ministry of the Interior - a criminal investigation against healthcare professionals. The Russian "Rossiiskaya Gazeta" quoted in Radio Liberty/Radio Free Europe:

"According to Shevchenko (the Russian minister of health), there are some 600,000 doctors and 3 million nurses working in Russia today; of this total around 500 medical workers are currently being investigated on suspicion of a variety of offenses such as taking bribes, using fake medical certificates, and reselling medicine at a profit. Shevchenko also stated that the State Duma will soon adopt a law on state regulation of private medical activities, which he said will put the process of commercializing medical establishments on a more legal footing."

The UN's ILO (International Labour Organization) warned, in a December 2001 press release, of a "crisis in care". According to a new survey by the ILO and Public Services International (PSI):

"The economic and social situation in several East European countries has resulted in the near collapse of some health care systems and afflicted health sector workers with high stress, poor working conditions and salaries at or below minimum wage - if and when they are paid."

Guy Standing, the ILO Director of the Socio-Economic Security Program and coordinator of the studies added:

"Rapidly increasing rates of sexually-transmitted diseases, HIV/AIDS, tuberculosis and numerous chronic diseases have created a crisis of care made all the more dramatic by diminishing public health structures, lack of training of health care professionals and general de-skilling of the workforce. All of this has surely contributed to the catastrophic fall in life expectancy rates in Russia, Ukraine and some other countries in the region."

The situation is dismal even in the more prosperous and peaceful countries of central Europe. In another survey, also conducted by the ILO ("People's Security Survey"), 82 percent of families in Hungary claimed to be unable to afford even basic care.

This is not much better than Ukraine where 88 percent of all families share this predicament. Agreements signed in the last two years between Hungarian hospitals and cash-plan insurers further removed health care from the financial reach of most Hungarians.

Healthcare workers in all surveyed countries - from the Czech Republic to Moldova - complained of earning less than the national average and of crippling wage arrears. In some countries - Armenia, Moldova, Kyrgyzstan - few bother to clock in anymore. In others - Poland and Latvia, for instance - a much abbreviated working week and temporary labor contracts are imposed on the reluctant and restive healthcare workers.

One in twenty hospitals in Poland had to close between 1998-2001. In an impolitic spat of fiscal devolution, ill-prepared local authorities throughout the region were left to administer and finance the shambolic health services within their jurisdictions.

The governments of east Europe tried to cope with this unfolding calamity in a variety of ways.

Consider Romania. Half the population claim to be "very satisfied" with its health services.

In Romania, the 1997 Health Insurance Law shifted revenue collection and provider payments to a maze-like coalition of 41 district health insurance houses (HIH) headed by a National Health Insurance House. Romanian citizens are forced to foot one third of their health bills in a country which spends a mere 3 percent of GDP on the salubrity of its citizens - the equivalent of $100 per year per capita. Only a small part of this coerced co-financing is formal and legal.

About 70 percent of the meager state budget is derived from erratic payroll health insurance fund contributions, now set at 14 percent of wages. The national budget supplements the rest. Some of the contributions are distributed among the poorest regions to narrow the inequality between urban and rural areas.

The HIH's pay health care providers, such as hospitals based on capitation, or a projected global budget. They are experimenting now with fee-for-service reimbursement methods. All these payment systems, inevitably, are open to abuse. Monitoring and auditing are poor and relations are incestuous.

The Ministry of Health still makes all major procurement decisions. Many government organs - the Ministry of the Interior, the transport system, the Army - all maintain their wastefully parallel care provision networks. Donor funds, multilateral financing, and government money have all vanished into this insatiable sink of venality.

The only rays of light are private dental and medical clinics, laboratories, and polyclinics working side by side with private pharmacies and apothecaries. These cater to the well-to-do. But the government emulated them and "privatized" the institution of the family physician (general practitioner).

GP's now receive, on a contractual basis, payment per socially-insured patient treated. They make rent-free use of clinics and equipment in their workplace. Many of these doctors now borrow small amounts from willing banks - a scarcity in Romania - to open their own practice.

In an article published on March 2000 in "Central Europe Review" and titled "Trying our Patients", Professor Pavel Pafko, Head of the Third Surgery Department, Charles University Faculty Hospital, Prague, lamented the state of Czech medicine:

"After the 1989 Velvet Revolution, there were fundamental changes in the health service: the market was opened to manufacturers of medical equipment, aids and medicines, and Parliament announced the right for everyone to choose their own doctor. In my opinion, the health service was not sufficiently prepared for these fundamental changes.

In the public's mind the idea of 'free health care' survived and continues to survive from the Communist period, as does the idea that all of us are equal as long as we are healthy. The sick man in many cases loses this equality and cannot himself pay by legal means for what the state, or rather the insurance companies, have no resources to provide."

Expenditure on health amounted in the 1990's to c. 7 percent of GDP per year (compared to 14 percent of a much larger GDP in OECD countries). But medical insurance firms cannot cope with vertiginous prices of imported medicines. Hospitals now receive insufficient lump-sum payments rather than getting reimbursed for procedures and treatments carried out. Naturally, most of these go towards staff wages. Little is left for medical care.

Poland is in no better shape. Its embattled minister of health, Mariusz Lapinski, stumbles from crisis to criticism in his doomed effort to reform a ramshackle system. The two current scandals involve heavily and unsustainably subsidized drugs and a new health bill, fiercely opposed by progressive interests, such as medical doctors and nurses. The Polish weekly, Wprost, went as far as comparing Poland's healthcare to Egypt's, Turkey's, and Mexico's.

The World Bank discovered in 1998 that 78 percent of Poles had to pay illicitly to obtain basic care. Lapinski intends to dissolve the regional state health funds and resurrect them in the form of a national edition. But state-run hospitals in Poland are insolvent. Naturally, healthcare workers have little faith in the management skills of the state.

They are calling for open competition among teams of commercial health insurance funds and health care providers. They would also like to increase health insurance contributions to allow Poland to spend on health more than the current 5.5 percent of GDP.

UPI reported recently ("Shock Therapy in Macedonian Healthcare") about a strike of medics in Macedonia as typical of the problems facing the healthcare systems of all countries in transition: privatization, the involvement of the state, and Western influence of the reform process. The transition to the western General Practitioner (GP) model is hotly debated. As far as doctors are concerned, it is a lucrative proposition. But it could exclude poorer patients from medical care altogether.

Still, the main problem is the gap between grandiose expectations and self-image - and shabby reality. East European medicine harbors fantastic pretensions to west European standards of quality and service. But it is encumbered with African financing and Vietnamese infrastructure. Someone must bridge this abyss with loads of cash. Either the government, or the consumer must cough up the funds. The sooner everyone come to terms with this stressful truth - the healthier.

Appendix - Healthcare Legislation

Healthcare legislation in countries in transition, emerging economic, and developing countries should permit - and use economic incentives to encourage - a structural reform of the sector, including its partial privatization.

Private health insurance plans - including franchises of overseas insurance plans - should be allowed, subject to rigorous procedures of inspection and to satisfying financial and governance requirements. Such competition is bound to shake the inefficient and corrupt state Health Fund and reshape it.

Procurement of medicines - should be transferred to an autonomous central purchasing agency. Both this body and its tenders will be supervised by a public committee aided by outside auditors.

The ***Approved List of Medicines*** - will be recomposed to include generic drugs whenever possible and to exclude expensive brands where generics exist. This should be a requirement in the law.

To maintain their license to practice medicine, medical stuff - from nurses to doctors - would be required to acquire ***continuing education*** and to publish in peer reviewed papers. To prevent nepotism and corruption in appointments of doctors to jobs in clinics and hospitals, all positions from ward doctor upwards will be subject to ***periodic review and open, public tenders.***

The law should ***explicitly*** allow for the following ***arrangements with the private sector*** for the provision of healthcare:

Service Contract (Dominican Republic)

The government pays private entities - including doctors - to perform specific healthcare tasks, or to provide specific healthcare services under a contract. The private service providers can make use of state-owned facilities, if they wish - or operate from their own premises.

Payments by the government are usually based on capitation (a fixed fee for a list of services to be provided to a single patient in a given period, payable even if the services were not consumed) adjusted for the patients' demographic data and reimbursement for fee-for-service items.

Management Contract (Cambodia)

The government pays private entities to manage and operate public health care facilities, like clinics, or hospitals.

Lease (Romania since 1994)

Private entities - including doctors - pay the government a lump sum or monthly fees to use specific state-owned equipment, state-employed manpower, clinics, or complete public health care facilities.

The private entity is entitled to all revenues from its operations but also bears all commercial risks, is responsible for management and operations and liable for malpractice and accidents.

The state is still responsible to make capital investments in the leased facility or equipment - but maintenance costs are borne by the private entity.

Concession and Build-Operate-Transfer (BOT) (Costa Rica)

Concession is exactly like a lease arrangement (see above) with one exception: the

private entity is responsible for capital investment. In return, the contract period is extended and can be voided only with a considerable pre-advice.

In BOT (Build-Operate-Transfer) and ROT (Rehabilitate-Operate-Transfer) the capital investment involves the construction or renovation/upgrade of new healthcare facilities. The private entity uses the constructed facility to provide services. After a prescribed period of time has elapsed, ownership is transferred to the government.

Divestiture and Build-Own-Operate (BOO) (Texas, USA)

The law should permit the outright sale of state- owned health care facilities to a qualified private entity.

Another possibility is a BOO scheme, in which the private entity contractually undertakes to add facilities, improve services, purchase equipment, or all three.

Free entry

The law should allow qualified private providers to operate freely. Though regulated, these private firms will have no other relationship with the state.

Such entities would have to be licensed, certified, overseen, and accredited for expertise, safety, hygiene, maintenance, track record, liability insurance, and so on.

The state may choose to encourage such providers to locate in specific regions, to cater to poor clients, or to provide specific healthcare tasks or services by offering tax incentives, free training, access to public facilities, etc.

Franchising (Kenya, Pakistan, Philippines)

A private firm (franchisee) acquires a license from and shares profits with the franchisor (a domestic, or, more often, foreign firm). The franchisee uses the brand name, trademarks, marketing materials, management techniques, designs, media access, access to approved suppliers at bulk (discounted) prices, and training offered by the franchisor. The franchisor monitors the performance and quality of service of the franchisee.

This model works mainly in preventive care, family planning, and reproductive health.

The World Bank ("Public Policy for the Private Sector", Note number 263, dated June 2003):

"Franchisers in the health sector, often supported by international donors and nongovernmental organizations (NGOs), establish protocols, provide training for health workers, certify those who qualify, monitor the performance of franchisees, and provide bulk procurement and brand marketing."

Hospital Management

(See separate document)

The law should allow:

I. Colocation of private wing within or beside public hospital

II. Outsourcing non-clinical support services

III. Outsourcing clinical support services

IV. Outsourcing specialized clinical services

V. Private management of public hospital

VI. Private financing, construction, and leaseback of new public hospital

VII. Private financing, construction, and operation of new public hospital

VIII. Sale of public hospital as going concern

IX. Sale of public hospital for alternative use

X. Consolidation of redundant public healthcare facilities by merging them or closing down some of them

Private Sector Healthcare Monitoring and Regulatory Agency

The law should provide for the establishment of an agency to monitor and regulate private sector healthcare provision: compliance with contracts, servicing the indigent and the uninsured, imposing sanctions or "step-in" rights, and dispute resolution.

Voucher System (Nicaragua)

The law should allow for experimenting with novel payment and resource allocation techniques, such as vouchers distributed to needy populations and guaranteeing free basic service packages provided by a limited list of clinics or other healthcare facilities. Such schemes can also be managed by the private sector.

Medical Savings Accounts (Singapore)

Contributions by employers and employees accumulate over time and are used, tax-free, to pay for hospital expenses in public and private hospitals, national supplementary health insurance premiums, special procedures (including abroad), and expensive outpatient treatment and drugs for the saver and his immediate family.

Consumer Organizations

The law should encourage the formation of consumer organizations in the healthcare field (such as buyers' clubs or Health Maintenance Organizations-HMOs).

These groups will shop and tender for the best, most reasonably priced, and most efficient healthcare services for their members.

Devolution

Responsibility for the provision of some types of healthcare services and the allocation of inputs should be devolved to local authorities (municipalities).

Performance and Payments

The central authority should impose minimum performance targets in performance agreements on all healthcare facilities, both public and private. All payments - wages included - will be tied to these targets and their attainment.

Payment options should include:

Capitation - A fixed fee for a list of services to be provided to a single patient in a given period, payable even if the services were not consumed, adjusted for the patients' demographic data and reimbursement for fee-for-service items.

Diagnosis Related Group (DRG)

Resource-based Relative Value (RBRV)

Return

Better Get Sick in Germany

By: Sam Vaknin, Ph.D.

Also published by United Press International (UPI)

The Germans, ever the pragmatic sort, call their hospitals - "houses of the sick" or "houses of those suffering". In English the word "hospital" derives from Latin and denotes hosting or hospitality. This may well be the main difference between the German health system and the Anglo-Saxon one. While the former is geared to perform a function - the latter is also concerned with the social and economic contexts of healthcare.

The German national health insurance is inordinately comprehensive. It even reimburses its clients for a few prophylactic weeks at a health spa (Kurort). Medicines - including the over the counter generic sort - are taken extremely seriously. They can be bought only in pharmacies.

This coincides with the guild-like and cartelized character of German business. But, even so, Germans find the thought of Aspirin made available in a supermarket reprehensible. Pharmacists are allowed to prescribe medicines for minor ailments, though.

There are many forms of health insurance. The Privatpatient is covered by a foreign, or German private health plan. The much lauded statutory national healthcare system - the Krankeskasse - insures the Kassenpatienten, about 90 percent of the population.

Various national health insurers - BEK, DAK, AOK - compete for the lucrative business of catering to the needs of an ageing and affluent population. Healthcare provision is even more diversified: some providers are federal, others regional, local, voluntary, or private.

In "Healthcare Reform in Germany in Comparative Perspective", Christina Altenstetter of the Graduate School and European Union Studies Center of the City University of New York, summarizes the principles that guided German healthcare since 1883:

"... Membership in the national health insurance program is mandated by law; the administration of the health insurance program is delegated to non-state bodies with representatives of the insured and employers; entitlement to benefits is linked to past contributions rather than need; benefits and contributions are related to earnings; and financing is secured through wage taxes levied on the employer and the employee."

German bureaucracies implausibly combine efficiency with red tape. The healthcare system is no exception. It has been running smoothly since Bismarck's days. The national insurers issue to their members "Krankenscheine" - booklets with coupons or vouchers. Many of them also help obtain the indispensable social security (i.e., identity) card.

Insured patients are entitled to one free consultation every 3 months. The coupon used in lieu of payment is redeemed by the insurance company which pays the doctors. Recognizing the dangers of over-visitation and over-consumption of free services and drugs, in Germany patients partly pay for everything else - from medicines to corrective contact lenses.

Hospital admittance - to both private and public facilities - is conditioned upon referral by a doctor. This apparently onerous demand served to virtually eliminate waiting lists together with the hypochondriacs, factitious disorders, and impostors that infest hospitals elsewhere.

"We have free choice of physicians, we have practically no waiting lists" - bragged Prof. Friedrich Breyer of the University of Konstanz in an interview to the BBC. He added wryly: "I wouldn't call the (British) NHS the envy of the world." Germany spends c. 8 percent of its larger GDP on public healthcare - 40 percent more than Britain. Add to this private expenditure on health and the figure balloons to 12 percent of GDP - almost twice Britain's.

British Conservatives are so impressed that they dispatched their Health Spokesman, Dr. Liam Fox, MP, on a fact-finding mission to German wonderland.

The BBC ("On the Record", December 2001) marvels that two thirds of German patients with prostate cancer survive five years after diagnosis - compared to less than one half in Britain. With leukemia, two fifths of German patients live on for five years - but only 28 percent of Britons do.

Patients can change doctors once a quarter. Within each quarter they require a referral from their original physician. This hybrid system of doctor-referral cum autonomous choice combines the best of both the General Practitioner (GP) model - and the self-referral model.

But not all is wunderbar.

Germany's healthcare market is consumer-tilted (it is called "patient orientation"). Healthcare providers are subject to rigorous quality inspections and, too often, meddlesome micromanagement. Suppliers - like medical device manufacturers - are less cosseted.

Jacoti Insights publishes "Mapping the Maze through Germany". The latest controversial healthcare reforms suppressed sales throughout the $10 billion sector in the last three years - despite a market receptive, not to say addicted, to new technology.

The reform consists of the introduction of the DRG - Diagnosis Related Group - case-based reimbursement system as of January 2004. It is only the latest in a series of panicky cost containment initiatives. Cost awareness has caused the number of hospitals in

Germany to decline considerably over the last decade. Many facilities became more specialized.

According to a report by Thorsten Korner and Friedrich Wilhelm Schwartz from the Hanover medical School ("Recent Healthcare Reforms and Hospital Financing in Germany"), the country has 7 beds per 1000 people and a hospital occupancy rate of 80 percent.

This represents a massive decline from 1991 - of 15 percent in the western Lander and 25 percent in the eastern Lander. Another 2 beds per 1000 people can be found in - mostly private - preventative and rehabilitative centers. One quarter of more than 2000 hospitals - but only 7 percent of all beds - are private. Still, as the public sector shrank by one quarter - the private sector mushroomed by 60 percent.

More than a million people (in a population of just over 80 million) work in healthcare - one eighth of them physicians. These figures mask a 10 percent contraction of the private health sector workforce - compared to 5 percent in the public segment. Thus, the average staffing per bed is one of the lowest in the OECD.

The number of doctors increased by 10 percent in the last decade but all other medical professions - including nurses - suffered sharp cutbacks. Moreover, despite an increase of admissions by 9 percent in the west and 30 percent in the east - the average length of stay has dropped precipitously by 25 percent in the west and 35 percent in the east.

Many hospitals find it difficult to adjust to the new, profit and loss (deficit) orientated environment. Mini-"revolutions" such as fixed budgets, prospective payments, and the shift from in-patient to out-patient treatments as represented by ambulatory surgery, integrative care, and disease management initially met with stiff resistance.

The forthcoming transition to case-fee reimbursement, for instance, forces hospitals to invest massive amounts of resources in information technology and re-training. This led to a wave of mergers, alliances, and acquisitions.

It wasn't always this way. A 1972 law on hospital financing provided hospitals with a "full cost coverage". The state footed all investment bills while the various "sickness funds" and private patients financed all the operational costs. The resulting growth in healthcare costs was exponential.

The "Health Insurance Cost Containment Act" of 1977 tried in vain to stem the flood. Contributions by the funds were effectively frozen. When this failed, an increasingly alarmed Bundestag tried a variety of solutions in 1989, 1993, 1996, 1998, 1999, and 2000: sectoral budgets, price lists for providers, reference prices for medicines, cost limits on procurement of medical technology, restrictions on the number of physicians per geographical unit, and, finally, unpopular co-payment schemes.

While expenditures per capita stabilized - contribution rates skyrocketed by 40 percent between 1975 and 1999. As the population ages, demand for healthcare is likely to increase. As technology invades every nook and cranny of medicine, further investments are required. As costs skyrocket, budget tightening and micromanagement will increase together with a commensurate shift of power from physician to administrator.

To cap it all, Christina Altenstetter notes the possible conflict with the European Union:

"... It is difficult to predict the future role of the European Court of Justice in raising the question whether national fees schedule and benefits catalog are a violation of free trade because corporatist decision-making by German organized medicine and sickness funds is in conflict with European competition policy. If the Court were to rule on this issue against corporatism and price fixing in national practices, impressive changes can be anticipated (in the) long term."

German healthcare is comprehensive and efficient. It is also unsustainably expensive. Patients pay twice - indirectly through their heavy taxes and directly in medical fees and the cost of medicines. A guild-like, corporatist approach still stifles the competitive provision of services.

The hidden costs of such monopolistic and cartel behavior is best evident in ambulatory surgery. Only recently were hospitals allowed to provide this service - previously the preserve of the ambulatory care services. Now half of all hospitals have ambulatory surgery units and the costs of most such procedures has fallen off a cliff.

Return

The Sickly State of Public Hospitals

By: Sam Vaknin, Ph.D.

Hospitals are caught in the crossfire of a worldwide debate. Should healthcare be completely privatized - or should a segment of it be left in public hands? As the debate infects countries adhering to the "social model of capitalism" (e.g., Scandinavia and France) and spreads to countries in transition in Central and Eastern Europe - it is worthwhile to study the experience of the bellwether in privatized health care: the USA.

Of the many mutations of the hospital, most people experience the Public Hospital. These are all-purpose, universal, and all-pervasive (inpatient and outpatient) institutions, which service even the indigent, criminals, illegal aliens, and members of the minorities.

Public hospitals are the descendents of almshouses, poorhouses, correction facilities, and welfare centers. Like other modern fixtures - the university, the school, the orphanage - most hospitals were originally run by the church and included a medical school.

Later on, local communities established their own hospitals. As the functions (and area) of these initially modest facilities expanded, hospitals were gradually taken over by regional authorities and state governments. Federal funding for hospitals - in the form of Medicaid and Medicare - is relatively new and dates back only to LBJ's (President Lyndon B. Johnson) Big Society in 1965.

Hospitals are now reverting to communal management. Bruce Siegel, President and CEO of Tampa General Hospital, notes in "Public Hospitals - A Prescription for Survival" that between 1978 and 1995 the number of government-owned acute care public hospitals declined by one quarter.

Most hospitals were or are being transformed into small, communal, suburban or rural facilities. In the USA, less than one third of hospitals are in inner cities and only 15% have more than 200 beds. According to the American Hospital Association, the 100 largest hospitals averaged a mere 581 beds in 1995.

Public hospitals are in dire financial straits. Even in the USA, one third of their patients do not pay for medical services (compared to less than 5 percent in private hospitals). Medicaid barely - and belatedly - covers another third. Yet, the public hospital is legally bound to treat one and all.

In other countries, national medical insurance schemes, the equivalents of Medicare/Medicaid in the USA, (e.g., the NHS in Britain), or mixed public-private ones (e.g., Kupat Kholim or Maccabbee in Israel) provide fairly extensive coverage. Community medical insurance plans are on the rise in both the USA and Europe. Corporate plans cover the rest.

Still, uniquely in the USA, many potential patients remain exposed. More than 40 million Americans have no medical insurance of any kind. A million new disenfranchised join their ranks annually. This despite sporadic - and oft-unsuccessful - initiatives, on the state level, to extend insurance - in lieu of charity care - to the uninsured.

This kind of deprived patient often consumes less profitable or loss leading services such as trauma care, drug-related treatments, HIV therapies and obstetrical procedures. These are lengthy and costly. Private healthcare providers corner the more lucrative end of the market: hi tech and specialty services (e.g., cardiac surgery, cosmetic surgery, diagnostic imagery).

In "Our Ailing Public Hospitals - Cure them or Close Them?" published in "The New England Journal of Medicine", J.P. Kassirer mentions that public hospitals provide "culturally competent care". This fashion is the bane of public medicine. Providers are expected to deliver to their patients a politically correct package of social services and child welfare on top of the inanely expensive - and frequently unpaid for - medical treatment.

"Essential Community" hospitals are heavily dependent on public funding. State governments foot the bulk of the healthcare bill. Public and private healthcare providers pursue this money. In the USA, a majority of consumers organized themselves in Healthcare Maintenance Organizations (HMOs).

The HMO negotiates with providers (=hospitals, clinics, pharmacies) to obtain volume discounts and the best rates. Public hospitals - under-funded as they are - are not in the position to offer an attractive deal. So, they lose patients to private hospitals.

Public hospitals derive more than half their revenues from federal insurance schemes such as Medicaid. This is five times the national average for all types of hospitals. They also benefit from state and local matching funds tied to their Medicaid receipts. This addiction to dwindling - and unreliable - federal and state financing spells doom.

Medicaid Managed Care programs - intended to optimize the use of Medicaid funds - had the dual effect of reducing the coverage rate of public hospitals (i.e., their income per patient) and diverting business to ferociously competitive private ones. Public facilities are closing at a torrential pace.

In some states, one in twenty calls it a day every year. Many states (e.g., New York) and municipalities (e.g., Los Angeles) seriously considered the abolition or privatization of all public hospitals. In some states, private hospitals now enjoy almost as much Medicaid business as public ones. HMO's (Health Maintenance Organizations) have discovered Medicaid as well.

Yet, private, for profit hospitals, discriminate against publicly insured (Medicaid) patients. They prefer young, growing, families and healthier patients with Medicaid, Blue

Cross/Blue Shield, or commercial medical insurance. These clients gravitate out of the public system, transforming it into an enclave of poor, chronically sick patients.

This, in turn, makes it difficult for the public system to attract human and financial capital. It is becoming more and more desolate, under-staffed, and poorly-qualified.

But public hospitals are partly to blame for this sorry state of affairs.

There are striking similarities between these decrepit institutions all over the world. Public hospitals in New York are often indistinguishable from their counterparts in Ljubljana, Moscow, Tel-Aviv, or Skopje. Their bloated management and heavily unionized staff are opaque and non-accountable. They refuse to measure up to performance targets lest their revenues and remuneration be linked to the results.

No one can tell how (in)effective and (non-)productive public hospitals are. There are no reliable statistics regarding the most basic parameters of service quality, such as wait times. Financial reporting and network development are dismal. As even governments are transformed from "dumb providers" to "smart purchasers", public hospitals must reconfigure, change ownership - privatize, lease their facilities long term - or perish.

But privatization is far from being a panacea.

It is difficult to imagine the private sector - private hospitals and HMO's - assuming the full load of patients now treated by the public sector. To start with, existing laws would have to be changed in constitutionally dubious ways. It is even more difficult to conceive of the government as a ideal and long-term "smart purchaser" of healthcare services from the private sector. Additionally, to cover all the uninsured would cost a fortune. The communities that phased out public hospitals in favor of Medicaid managed care suffered greatly according to various studies.

Siegel notes that there is no data to support the contention that public hospitals provide inferior care at a higher cost - and, indisputably, they possess unique experience in caring (both medically and socially) for low income populations. He poses the following questions:

- What are the costs and quality of public hospitals relative to their non-government peers in selected cities? These data would need to be adjusted for case mix, socioeconomic status, degree of teaching activity and other variables.

- What segment of the public hospital market has been "captured" by competing HMOs and non-government hospitals? What are the risk profiles of these segments?

- What are the legal obligations of health care providers to treat indigent patients in selected states?

- Where public services have closed or been privatized, what is the impact on access to care for the Medicaid and uninsured populations? What is the impact on remaining providers?

- What lessons can be learned from major cities and counties that lack publicly owned health care systems?

In the absence of factual answers to these questions, the arguments boil down to differences in worldview and politics. Is healthcare a fundamental human right - or a commodity? Should healthcare be left to the invisible hand and distributive justice of the market? Should prices serve as the mechanism of optimal allocation of healthcare resources - or are there other, less quantifiable, but pertinent parameters?

Whatever the philosophical predilection, healthcare should be reformed. Siegel and Altman and Brecher ("Competition and Compassion - Conflicting Roles for Public Hospitals") survey the landscape of hospital reform in the USA:

Public hospitals are increasingly governed by healthcare management experts who are likely to emphasize clinical and fiscal considerations - and not by politicians. This is coupled with the vesting of authority with hospitals, taking it back from local government.

Some hospitals are organized as (public benefit) corporations with enhanced autonomy (e.g., Memphis Regional Medical Center). Others organize themselves as Not for Profit Organizations with independent, self perpetuating boards of directors.

This is often coupled with increased transparency and accountability. Clear quantitative criteria are applied to the use of funds. Some hospitals started by revamping their compensation structures to increase both pay and financial incentives to the staff and thus attract talented people. In these reformed institutions, pay is linked to objectively measured performance and skills-related criteria. A system of bonuses, incentives, and - more rarely - penalties has been applied to senior management.

The management of many public hospitals is trained now to use rigorous financial controls, to improve customer service, to re-engineer processes and to negotiate agreements and commercial transactions. In some cases, staff is employed through employment contracts with clear severance provisions that allow the management to take commercial risks.

All this cannot be achieved without the full collaboration of the physicians employed by the hospitals. Their very profession is being revolutionized. Siegel:

"Most major public hospitals obtain a majority of their physicians through affiliations with nearby medical schools ... But the nature of these contracts and of health care has changed. Public hospitals are now under intense pressure to improve continuity of care, expand primary care capacity, reduce lengths of stay and meet a host of managed care

and budgetary constraints. It will be impossible for them to do this so long as the physicians who make the bulk of the clinical decisions practice in ways that are not aligned with the imperatives of managed care and capitation. Physicians must adapt their styles of practice and accept an emphasis on absolute productivity."

Some hospitals in the USA (e.g., Cambridge Hospital in Massachusetts) formed business joint ventures with their own physicians (PHO - Physicians Hospital Organizations). They benefit together from the implementation of reforms and from increased productivity. Scheduling of patient-doctor appointments, laboratory tests, and surgeries are computerized. Obsolete information systems replaced. Long turnaround times and redundant lab tests and medical procedures eliminated.

According to various studies published in "Modern Healthcare", public hospitals have been downsizing for well over a decade now. They reduced their labour costs from more than 70 percent of their budgets 8 years ago - to less than 60 percent today. Many cut their labour force by half. Union membership is on the decline.

Public hospitals all over the world are transforming themselves into outright businesses.

They lease to their physicians - for use in their private, after-hours, practice - space (e.g., operating theatres) or time slots, or underutilized equipment. This kind of arrangement cropped up in countries as diverse as Israel and Macedonia, Russia and Germany. The lessee physician pays the hospital - either in the form of fixed fees or in the form of revenue sharing (franchise arrangement).

In some countries, the physician also commits himself to provide community-oriented, non profit or pro bono services in return for the right to use what is, essentially, community property.

Another method of using the hospital's excess capacity is to sell it, rent it, or lease it to entrepreneurs who are not members of the hospital staff: small laboratories, specialty medical services, primary care, and specialist practitioners. All these make use of the superior infrastructure of the hospital under a concession, a franchise, or a rental arrangement.

The hospital provides these professionals with a "captive market" of patients. This is very much like the relationship between an "anchor" in a shopping mall and the small retail shops surrounding it.

Hospitals - mainly in eastern Europe - also sell medical - and, sometimes, non-medical - products and services to the community on a commercial, competitive basis. Some hospitals offer for-pay medical legal services, or print jobs by the hospital's print shop. They operate the hospital's social services as a profit centre, offer medical consultancy on a fee per service basis, and even sell food from the hospital kitchen through a catering service, or data to researchers from its archives.

A hospital is a galaxy of small (to medium) size businesses operating under one organizational roof. Laundry, cleaning services, the kitchen and its attendant catering functions, the provision of television sets and telephones to patients, a business centre for the inpatient businessmen - these are all profit or loss centers.

"Internal privatization" (or intrapreneurship) transforms the hospital into a holding company. This holding company owns and operates a host of business entities. Each such entity constitutes a separate contractor which provides the hospital with a service or a product.

Thus, all laundry is done by a company which charges the hospital for its services. The same goes for the kitchen, the print shop, the legal services department and so on. These corporations employ the former staff of the hospital. This way, institutional knowledge and experience are preserved.

These corporations, owned by former employees, usually maintain a "right of first refusal" in the first five years following the transformation. They are allowed to match the best offers obtained in yearly tenders conducted by the hospital. They are also allowed to offer their services to other customers. Thus, they reduce their dependence on one client, the hospital. They become truly entrepreneurial entities, competing for profits in a market environment.

A part of the re-engineering process is to determine which of the roles of the hospital are "core competencies". All "non-core" functions are outsourced in a tender to the most competitive bidders. The hospital is likely to benefit from the transfer of these functions, in which it has no relative competitive advantage, to expert outsiders. This is somewhat akin to international (free) trade, where each nation optimizes its resources and passes the (beneficial) results to its trading partners.

To control this kind of transformation, medical information management systems need to be introduced. These improve both the quality and the quantity of data available to the management of the hospital and, as a result, the decision making process.

This makes it easier for the management to pinpoint which areas require doing what - for instance, what kind of incentives should go to which members of the staff, where could costs be cut, and where and how could productivity be improved.

Finally, a novel concept is emerging. Universities and hospitals are two important repositories of human knowledge and experience. Virtually every hospital somehow collaborates with an academic institution, or with a medical school.

But, during the last two decades, hospitals have re-cast themselves in the role of partners to the commercial exploitation of the results of research conducted within their premises or with their co-operation. Hospitals now collaborate in pharmaceutical, medical, genetic and bioengineering studies. Hospitals believe that by refraining from getting

commercially involved - they give up money which really is not theirs to give up in the first place.

Large hospitals also entered the managed care market - where laws permit it. Some have established MCOs (Managed Care Organizations of patients). Others insure patients outright and market their services directly. Most hospitals now maintain their own network of suppliers. HMO's are inevitably less than thrilled with the emergence of these new competitors - but this process of disintermediation is thought to have increased both the profit margins and the absolute profits of public hospitals.

Public hospitals also pool resources to benefit from advantages of scale. They relegate services - from auditing and accounting to political lobbying - to commonly owned or merely centralized service providers. These providers also negotiate contracts with suppliers and specialists on behalf of the hospitals.

Some observers decry the apparent convergence between public hospitals and their private brethren. Such derision is misplaced. Public hospitals still treat the destitute and the immigrant. They still provide a medical safety net where no alternative exists. They are just doing it better, more rationally, and more cheaply. They should do more to open up to scrutiny. They should spin doctor. They should streamline. But one thing they should not do is regress to where they have been in the early 1990's. This is what the doctor ordered.

Return

Global Differential Pricing

By: Sam Vaknin, Ph.D.

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In April 2002, the World Health Organization (WHO), the World Trade Organization (WTO), the Norwegian Foreign Ministry, and the US-based Global Health Council held a 3-days workshop about "Pricing and Financing of Essential Drugs" in poor countries. Not surprisingly, the conclusion was:

"... There was broad recognition that differential pricing could play an important role in ensuring access to existing drugs at affordable prices, particularly in the poorest countries, while the patent system would be allowed to continue to play its role in providing incentives for research and development into new drugs."

The 80 experts, who attended the workshop, proposed to reconcile these two, apparently contradictory, aspirations by introducing different prices for drugs in low-income and rich countries. This could be achieved bilaterally, between companies and purchasers, patent holders and manufacturers, global suppliers and countries - or through a market mechanism.

According to IMS Health, poor countries are projected to account for less than one quarter of pharmaceutical sales this year. Of every $100 spent on medicines worldwide - 42 are in the USA, 25 in Europe, 11 in Japan, 7.5 in Latin America and the Caribbean, 5 in China and South East Asia, less than 2 in East Europe and India each, about 1 in Africa and the Commonwealth of Independent States (CIS) each.

Vaccines, contraceptives, and condoms are already subject to cross-border differential pricing. Lately, drug companies, were forced to introduce multi-tiered pricing following court decisions, or agreements with the authorities. Brazilians and South Africans, for instance, pay a fraction of the price paid in the West for their anti-retroviral AIDS medication.

Even so, the price of a typical treatment is not affordable. Foreign donors, private foundations - such as the Bill and Melissa Gates Foundation - and international organizations had to step in to cover the shortfall.

The experts acknowledged the risk that branded drugs sold cheaply in a poor country might end up being smuggled into and consumed in a much richer ones. Less likely, industrialized countries may also impose price controls, using poor country prices as benchmarks. Other participants, including dominant NGO's, such as Oxfam and Medecins Sans Frontieres, rooted for a reform of the TRIPS agreement - or the manufacturing of generic alternatives to branded drugs.

The "health safeguards" built into the Trade-related Aspects of Intellectual Property Rights (TRIPS) convention allow for compulsory licensing - manufacturing a drug without the patent holder's permission - and for parallel imports - importing a drug from another country where it is sold at a lower price - in case of an health emergency.

Aware of the existence of this Damocles sword, the European Union and the trans-national pharmaceutical lobby have come out last May in favor of "global tiered pricing".

In its 2001 Human Development Report (HDR), the United Nations Development Program (UNDP) called to introduce differential rich versus poor country pricing for "essential high-tech products" as well. The Health GAP Coalition commented on the report:

"On the issue of differential pricing, the Report notes that, while an effective global market would encourage different prices in different countries for products such as pharmaceuticals, the current system does not. With high-tech products, where the main cost to the seller is usually research rather than production, such tiered pricing could lead to an identical product being sold in poor countries for just one-tenth-or one-hundredth-the price in Europe or the United States.

But drug companies and other technology producers fear that knowledge about such discounting could lead to a demand for lower prices in rich countries as well. They have tended to set global prices that are unaffordable for the citizens of poor countries (as with many AIDS drugs).

'Part of the battle to establish differential pricing must be won through consumer education. The citizens of rich countries must understand that it is only fair for people in developing countries to pay less for medicines and other critical technology products.' - stated Ms. Sukaki Fukuda-Parr" the lead author of the Report.

Public declarations issued in Havana, Cuba, in San Jose, Costa Rica in the late 1990's touted the benefits of free online scholarship for developing countries. The WHO and the Open Society Institute initiated HINARI - Health InterNetwork Access to Research Initiative. Peter Suber, the publisher of the "Free Online Scholarship" newsletter, summarizes the initiative thus:

"Under the program, the world's six largest publishers of biomedical journals have agreed to three-tiered pricing. For countries in the lowest tier (GNP per capita below $1k), online subscriptions are free of charge. For countries in the middle tier (GNP per capita between $1k and $3k), online subscriptions will be discounted by an amount to be decided this June. Countries in the top tier pay full price.

The six participating publishers are Blackwell Synergy, Elsevier Science Direct, Harcourt IDEAL, Springer Link, Wiley Interscience, and Wolters Kluwer. The subscriptions are given to universities and research institutions, not to individuals. But they are identical in scope to the subscriptions received by institutions paying the full price."

Of 500 bottom-tier eligible institutions, more than 200 have already signed up. Additional publishers have joined this 3-5 years program and most biomedical journals are already on offer. Mid-tier pricing will be declared by January next year. HINARI will probably be expanded to cover other scientific disciplines.

Authors from developing countries also benefit from the spread of free online scholarship coupled with differential pricing. "Best of Science", for example, a free, peer-reviewed, online science journal subsists on fees paid by the authors. It charges authors from developing countries less.

But differential pricing is unlikely to be confined to scholarly journals. Already, voices in developing countries demand tiered pricing for Western textbooks sold in emerging economies. Quoted in the Free Online Scholarship newsletter, Lai Ting-ming of the Taipei Times criticized, on March 26, "western publishers for selling textbooks to third world students at first world prices. There is a 'textbook pricing crisis' in developing countries, which is most commonly solved by illicit photocopying."

Touchingly, the issue of the dispossessed within rich country societies was raised by two African Special Rapporteurs in a report submitted last year to the UN sub-Commission on Human Rights and titled "Globalization and its Impact on the Full Enjoyment of Human Rights". It said:

" ... The emphasis on R & D investment conveniently omits mention of the fact that some of the financing for this research comes from public sources; how then can it be justifiably argued that the benefits that derive from such investment should accrue primarily to private interests? Lastly, the focus on differential pricing between (rich and poor) countries omits consideration of the fact that there are many people within developed countries who are also unable to afford the same drugs. This may be on account of an inaccessible or inhospitable health care system (in terms of cost or an absence of adequate social welfare mechanisms), or because of racial, gender, sexual orientation or other forms of discrimination."

Differential pricing is often confused with dynamic pricing.

Bob Gressens of Moai Technologies and Christopher Brousseau of Accenture define dynamic pricing, in their paper "The Value Propositions of Dynamic Pricing in Business-to-Business E-Commerce" as: "... The buying and selling of goods and services in markets where prices are free to move in response to supply and demand conditions."

This is usually done through auctions or requests for quotes or tenders. Dynamic pricing is most often used in the liquidation of surplus inventories and for e-sourcing.

Nor is differential pricing entirely identical with non-linear pricing. In the real world, prices are rarely fixed. Some prices vary with usage - "pay per view" in the cable TV industry, or "pay per print" in scholarly online reference. Other prices combine a fixed element (e.g., a subscription fee) with a variable element (e.g., payment per broadband

usage). Volume discounts, sales, cross-selling, three for the price of two - are all examples of non-linear pricing. Non-linear pricing is about charging different prices to different consumers - but within the same market.

Hal Varian of the School of Information Management and Systems at the University of California in Berkeley summarizes the treatment of "Price Discrimination" in A. C. Pigou's seminal 1920 tome, "The Economics of Welfare":

"First-degree price discrimination means that the producer sells different units of output for different prices and these prices may differ from person to person. This is sometimes known as the case of perfect price discrimination.

Second-degree price discrimination means that the producer sells different units of output for different prices, but every individual who buys the same amount of the good pays the same price. Thus prices depend on the amount of the good purchased, but not on who does the purchasing. A common example of this sort of pricing is volume discounts.

Third-degree price discrimination occurs when the producer sells output to different people for different prices, but every unit of output sold to a given person sells for the same price. This is the most common form of price discrimination, and examples include senior citizens' discounts, student discounts, and so on."

Varian evaluates the contribution of each of these practices to economic efficiency in a 1996 article published in "First Monday":

"First-degree price discrimination yields a fully efficient outcome, in the sense of maximizing consumer plus producer surplus.

Second-degree price discrimination generally provides an efficient amount of the good to the largest consumers, but smaller consumers may receive inefficiently low amounts. Nevertheless, they will be better off than if they did not participate in the market. If differential pricing is not allowed, groups with small willingness to pay may not be served at all.

Third-degree price discrimination increases welfare when it encourages a sufficiently large increase in output. If output doesn't increase, total welfare will fall. As in the case of second-degree price discrimination, third-degree price discrimination is a good thing for niche markets that would not otherwise be served under a uniform pricing policy.

The key issue is whether the output of goods and services is increased or decreased by differential pricing."

Strictly speaking, global differential pricing is none of the above. It involves charging different prices in different markets, in accordance with the purchasing power of the local clientele (i.e., their willingness and ability to pay) - or in deference to their political and legal clout.

Differential prices are not set by supply and demand and, therefore, do not fluctuate. All the consumers within each market are charged the same - prices vary only across markets. They are determined by the manufacturer in each and every market separately in accordance with local conditions.

A March 2001 WHO/WTO background paper titled "More Equitable Pricing for Essential Drugs" discovered immense variations in the prices of medicines among different national markets. But, surprisingly, these price differences were unrelated to national income.

Even allowing for price differentials, the one-month cost of treatment of Tuberculosis in Tanzania was the equivalent of 500 working hours - compared to 1.4 working hours in Switzerland. The price of medicines in poor countries - from Zimbabwe to India - was clearly higher than one would have expected from income measures such as GDP per capita or average wages. Why didn't drug prices adjust to reflect indigenous purchasing power?

According to the Paris-based International Chamber of Commerce (ICC), differential pricing is also - perhaps mostly - influenced by other considerations such as: transportation costs, disparate tax and customs regimes, cost of employment, differences in property rights and royalties, local safety and health standards, price controls, quality of internal distribution systems, the size of the order, the size of the market, and so on.

Differential pricing was made possible by the application of mass manufacturing to the knowledge society. Many industries, both emerging ones, like telecommunications, or information technology - and mature ones, like airlines, or pharmaceuticals - defy conventional pricing theory. They involve huge sunk and fixed costs - mainly in research and development and plant.

But the marginal cost of each and every manufactured unit is identical - and vanishingly low. Beyond a certain quantitative threshold returns skyrocket and revenues contribute directly to the bottom line.

Consider software applications. The first units sold cover the enormous fixed and sunk costs of authoring the software and the machine tools used in the manufacturing process. The actual production ("variable" or "marginal") cost of each unit is a mere few cents - the wholesale price of the diskettes or CD-ROM's consumed. Thus, after having achieved breakeven, sales revenues translate immediately to gross profits.

This bifurcation - the huge fixed costs versus the negligible marginal costs - vitiates the rule: "set price at marginal cost". At which marginal cost? To compensate for the sunk and fixed costs, the first "marginal units" must carry a much higher price tag than the last ones.

Hal Varian studied this problem. His conclusions:

"(i) Efficient pricing in such environments will typically involve prices that differ across consumers and type of service; (ii) producers will want to engage in product and service differentiation in order for this differential pricing to be feasible; and, (iii) differential pricing will arise naturally as a result of profit seeking by firms. It follows that differential pricing can generally be expected to contribute to economic efficiency."

Differential pricing is also the outcome of globalization. As brands become ubiquitous and as the information superhighway renders prices comparable and transparent - different markets react differently to price signals. In impoverished countries, differential pricing was introduced illegally where manufacturers insisted on rigid, rich-world, price lists.

Piracy of intellectual property, for instance, is a form of coercive (and illegal) differential pricing. The existence of thriving rip-off markets proves that, at the right prices, demand is rife (demand elasticity). Both piracy and differential pricing may be spreading to scholarly publishing and other form of intellectual property such as software, films, music, and e-books.

Consumers are divided on the issue of multi-tiered pricing tailored to fit the customer's purchasing power. Not surprisingly, rich world buyers are apprehensive. They feel that differential pricing is a form of hidden subsidy, or a kind of "third world tax".

On September 2000, Amazon.com conducted a unique poll - this time among customers - regarding differential pricing (actually, non-linear pricing) - showing different prices to different users on the same book.

Forty two percent of all respondents though it was "discrimination" and "should stop" - but a surprising 31 percent regarded it as "a valid use of data mining". A quarter said it is "OK, if explained to users". The comments were telling:

"I work over 80 hours a week. As a small business owner, I may make good money, but does that mean I should be charged more than unmotivated individuals who are broke because they don't want to work more than 30 hours a week. I don't think so ... Should (preferred) customers disappear in (the) off-line world? Should Gold Cards or Platinum Cards disappear? ...

The interesting thing is that discrimination of pricing is very common in the insurance industry - the basis for actuarial work and in airlines - based on load factors. The key is the pricing available to groups of customers with similar profiles ... Simple supply and demand, competition from other suppliers should offset ... A dangerous policy to implement ... As a consumer I don't necessarily like it, (unless I get a lower price!). However, economically speaking, (think of a monopolist's MR curve) the ideal is to have each person pay the maximum amount that they are willing to pay."

Also Read: ***The Revolt of the Poor*** Return

Social and Cultural Values as Guidelines for Health System Reform

By: Sam Vaknin

There are as many health systems and models as there are countries. This is because healthcare is a public good and, thus, reflects the social and cultural values of the societies that design and adopt them.

I. Social and Cultural Values

We should distinguish social and cultural values from economic and operational values. ***Efficiency***, for instance, is an economic-operational value, not a social-cultural one. ***Equity*** (though often considered an economic criterion) is actually a normative social-cultural value whose pursuit often comes at a steep economic price and is non-efficient. Health systems can be categorized according to which class of values they emphasize: the American (US) health system is geared to satisfy economic-operational requirements while European health systems place a premium on social-cultural ones.

In this paper, I deal with three social-cultural constraints: ***solidarity***, ***equity*** (vs. inequity), and ***progressivity*** (vs. regressivity), including the issue of ***redistribution***. There are many other social-cultural values that I do not cover in here: ***fairness, dignity***, and ***choice*** come to mind. Finally, I provide a discussion of the concept of ***"public good"*** in current literature.

II. Social Solidarity

Social solidarity is both vertical and horizontal and both contemporaneous and inter-generational.

Members of the same society ought to strive to share the burdens of the sick, the young, the poor, the weak, and the disenfranchised. This is usually done by transferring economic resources among population groups and by promoting fairness. At the same time, people should feel morally obliged to provide aid and succor to their peers and relatives, neighbors and colleagues, compatriots and friends by encouraging social cohesion and sharing of responsibilities (for instance, within the nuclear or extended family).

Such attitudes cut also across generations, so that the current generation is held answerable to future generations for their well-being and the reasonable fulfillment of their needs. This "solidarity across time" is at the foundation of most modern pension systems, for instance.

Some health systems are explicitly founded on social solidarity, others only implicitly so. However, there are health systems which partly or altogether eschew social solidarity as a defining principle and a determinant.

Health systems of the first type are usually universal, uniform, and comprehensive. They rely on tax revenues or a social insurance scheme or on a combination of both. Health systems of the second type depend on private insurance, are not universal, and are more diverse in the types of medical coverage offered (albeit this diversity comes with increased transaction costs).

Introducing ***means-testing*** (asking the rich to pay additional or higher user-fees, co-insurance, deductibles, or participation) does not affect social solidarity. On the contrary, taxing the rich to pay for the poor is the very essence of a solidary state. Similarly, introducing ***safety nets*** (such as voucher systems) is a solidary act. Whether such an approach is ideal, from the economic point of view is outside the scope of this paper.

III. Equity

There are three types of equity:

1. ***Equity of financing*** (affordability): can the poor, the unemployed, the homeless, the old, the young, the weak, the chronically sick, and the disenfranchised afford the healthcare offered? Are the expenses they have to incur catastrophic? Do certain expenditures (for instance user fees, or participation in the costs of medications) deter utilization? Do the payments reflect one's income or wealth, are they "fair"?

2. ***Equity of utilization*** (accessibility) is comprised of two components:

(i) ***Vertical equity***: Can everyone access healthcare services and facilities and make use of them easily and equitably (on the same terms and conditions, regardless of income)? This type of equity correlates with the ***progressivity*** of the health system (see chapter below.)

(ii) ***Horizontal equity*** is the extent to which people with identical incomes are treated similarly. This type of equity correlates with the ***redistributive*** aspects of the health system (see chapter below.)

3. ***Equity of quality***: Is the level of quality healthcare provided in all regions of the country and in rural vs. urban settings the same?

Medical savings accounts adversely affect equity because they skew economic incentives and the allocation of healthcare resources towards the rich and men. Women and the poor cannot save as much and have greater healthcare needs.

User fees may actually increase equity under certain conditions: (1) That the income they generate is targeted at the poor and the chronically ill (2) That the poor and chronically ill are exempted from paying them and (3) That the level of funding from other sources (taxes, contributions) is not reduced.

Devolution of healthcare services may create inequity as rich municipalities are able to spend more on healthcare than poorer ones. The government should create an ***equalization fund*** or use general tax revenue to transfer resources from wealthier to more destitute regions. ***Pooling of funds*** among regional or competing funds guarantees more equity.

Regional health insurance funds increase inequity as they are faced with the same problems described under "Devolution" above: poorer regions cannot compete with richer regions on the purchasing and provision of healthcare.

Social health insurance and ***tax-based healthcare*** financing maintain the same level of equity of financing. ***Negative co-payments*** (no-claim bonuses); ***income caps*** (or ceilings) on contributions; the inclusion of ***dependants*** in the coverage at no additional cost; and the extent of ***cost-sharing*** determine how equitable and progressive the social insurance scheme is.

The introduction of ***private health insurers*** and ***voluntary health insurance*** to compete with the statutory health insurance fund or even merely to complement or supplement it would increase inequity especially with regards to women and low-income groups. Women are usually charged higher premiums though their incomes are often lower than men's.

Risk-rated premiums decrease equity as they discriminate against the already ill and may deter them from seeking care. On the other hand, ***exemptions*** granted to specific population groups (and not based on income) increase inequity: the sick and the old may gain better access to quality healthcare than other, equally deserving beneficiaries.

Risk-adjusted (e.g., DRG) capitation systems enhance vertical equity.

Informal payments dramatically decrease equity because: (1) Access is restricted to those who can afford to pay (2) Payments terms and levels are arbitrary and changeable (3) Certain services and goods are rendered unaffordable (4) Public, more equitable services suffer (5) Lack of regulation creates variable quality of healthcare, fiscal irresponsibility, and lack of fairness.

IV. Progressivity and Redistribution

Though progressivity (and redistribution) are often conflated with equity, these are two separate issues. We can imagine a progressive system of health funding which is not equitable and can conceive of the reverse as well.

We say that healthcare funding is ***progressive*** when rich people pay more (as a proportion of their income) than poorer folk; the system is ***proportional*** when both rich and poor use up the same proportion of their disposable income to defray healthcare costs; it is ***regressive*** when poor people pay a higher portion of their income than the affluent to consume healthcare goods and services.

Progressivity largely determines whether there is a ***redistribution*** of resources from the rich to the government (not necessarily to the poorer segments of the population). How extensive and ubiquitous the redistribution from the government to the poor is depends on how involved the state is in the economy (in other words, it depends on the tax burden, the incidence of public spending, and on the absolute level of tax revenue, among other factors).

Tax-funded healthcare is progressive (assuming that most of the tax revenue is generated from direct taxes, not from consumption or indirect taxes which are regressive). It is less progressive than social health insurance when: (1) Indirect taxes constitute a major source of budget revenue and (2) The informal sector that does not pay taxes is large.

Earmarked ("sin", or hypothecated) taxes on alcohol, tobacco, motor vehicles, and medicines are regressive (though their regressivity is intentional as they are intended to deter consumption).

Social health insurance is generally less progressive than a tax-based system because it does not tax income from interest, rent, capital gains, and non-wage types of income. This is especially true when there is an income ceiling (above which contributions are not levied); when there are no exemptions for low-income groups; and when the rates are uniform regardless of the size of the wages they are levied on.

Still, ***Social health insurance*** is more redistributive than private insurers: (1) It charges uniform or community rates (2) It insures dependants at no extra cost (3) The length and extent of healthcare goods and services provided is not related to previous or cumulative contributions (4) It caters to the needs of the old (inter-generational redistribution). Still, this type of redistribution has negative economic effects (which are outside the scope of this paper).

The introduction of ***private health insurers*** to compete with the statutory health insurance fund is neutral as far as progressivity goes. Only where private insurance has supplanted social insurance as the main source of funding did regressivity increase markedly. ***Risk-rated premiums***, however, are regressive.

Medical savings accounts have no regressive or progressive effect as they do not redistribute income. All types of savings are neutral as far as progressivity or regressivity go.

User fees are highly regressive, regardless of any supplementary policy measures (such as exemptions). Only the introduction of ***means-testing*** can reduce regressivity.

Informal payments are highly regressive as the poor are asked to pay a high proportion of their income or assets (even when they are charged less than richer patients).

Tax deductibility of healthcare expenses is highly regressive (people with higher income tax rates receive a higher deduction).

V. Public Goods, Private Goods

Contrary to common misconceptions, public goods are not "goods provided by the public" (read: by the government). Public goods are sometimes supplied by the private sector and private goods - by the public sector. It is the contention of this essay that technology is blurring the distinction between these two types of goods and rendering it obsolete.

Pure public goods are characterized by:

I. ***Nonrivalry*** - the cost of extending the service or providing the good to another person is (close to) zero.

Most products are rivalrous (scarce) - zero sum games. Having been consumed, they are gone and are not available to others. Public goods, in contrast, are accessible to growing numbers of people without any additional marginal cost. This wide dispersion of benefits renders them unsuitable for private entrepreneurship. It is impossible to recapture the full returns they engender. As Samuelson observed, they are extreme forms of positive externalities (spillover effects).

II. ***Nonexcludability*** - it is impossible to exclude anyone from enjoying the benefits of a public good, or from defraying its costs (positive and negative externalities). Neither can anyone willingly exclude himself from their remit.

III. ***Externalities*** - public goods impose costs or benefits on others - individuals or firms - outside the marketplace and their effects are only partially reflected in prices and the market transactions. As Musgrave pointed out (1969), externalities are the other face of nonrivalry.

The usual examples for public goods are lighthouses - famously questioned by one Nobel Prize winner, Ronald Coase, and defended by another, Paul Samuelson - national defense, the GPS navigation system, vaccination programs, dams, and public art (such as park concerts).

It is evident that public goods are not necessarily provided or financed by public institutions. But governments frequently intervene to reverse market failures (i.e., when the markets fail to provide goods and services) or to reduce transaction costs so as to enhance consumption or supply and, thus, positive externalities. Governments, for instance, provide preventive care - a non-profitable healthcare niche - and subsidize education because they have an overall positive social effect.

Moreover, pure public goods do not exist, with the possible exception of national defense. Samuelson himself suggested [Samuelson, P.A - Diagrammatic Exposition of a Theory of Public Expenditure - Review of Economics and Statistics, 37 (1955), 350-56]:

"... Many - though not all - of the realistic cases of government activity can be fruitfully analyzed as some kind of a blend of these two extreme polar cases" (p. 350) - mixtures of private and public goods. (Education, the courts, public defense, highway programs, police and fire protection have an) ***"element of variability in the benefit that can go to one citizen at the expense of some other citizen"*** (p. 356).

From Pickhardt, Michael's paper titled ***"Fifty Years after Samuelson's 'The Pure Theory of Public Expenditure': What Are We Left With?"***:

"... It seems that rivalry and nonrivalry are supposed to reflect this "element of variability" and hint at a continuum of goods that ranges from wholly rival to wholly nonrival ones. In particular, Musgrave (1969, p. 126 and pp. 134-35) writes:

'The condition of non-rivalness in consumption (or, which is the same, the existence of beneficial consumption externalities) means that the same physical output (the fruits of the same factor input) is enjoyed by both A and B. This does not mean that the same subjective benefit must be derived, or even that precisely the same product quality is available to both. (...) Due to non-rivalness of consumption, individual demand curves are added vertically, rather than horizontally as in the case of private goods".

"The preceding discussion has dealt with the case of a pure social good, i.e. a good the benefits of which are wholly non-rival. This approach has been subject to the criticism that this case does not exist, or, if at all, applies to defence only; and in fact most goods which give rise to private benefits also involve externalities in varying degrees and hence combine both social and private good characteristics'.

VI. Is Healthcare a Public Good?

Healthcare used to be a private good with positive externalities. Thanks to technology and government largesse it is no longer the case. It is being transformed into a nonpure public good.

In theory, all forms of healthcare are exclusionary, at least in principle. It is impossible to exclude a citizen from the benefits of his country's national defense, or those of his county's dam. It is perfectly feasible to exclude patients from access to healthcare. This

caveat, however, equally applies to other goods universally recognized as public. It is possible to exclude certain members of the population from being educated, for instance - or from attending a public concert in the park.

Public goods require an initial investment by the user or consumer (the price-exclusion principle, demanded by Musgrave in 1959, does apply at times). One can hardly benefit from the weather forecasts without owning a radio or a television set - which would immediately tend to exclude the homeless and the rural poor in many countries. It is even conceivable to extend the benefits of national defense selectively and to exclude parts of the population, as the Second World War has taught some minorities all too well. Similarly, user-fees are required in order to benefit from certain types of healthcare.

Nor is strict nonrivalry possible - at least not simultaneously, as Musgrave observed (1959, 1969). Our world is finite and so is everything in it (the principle of scarcity). The economic fundament of scarcity applies universally - and public goods are not exempt. There are only so many people who can attend a concert in the park, only so many ships can be guided by a lighthouse, only so many people defended by the army and police. This is called "crowding" and amounts to the exclusion of potential beneficiaries (the theories of "jurisdictions" and "clubs" deal with this problem).

Nonrivalry and nonexcludability are ideals - not realities. They apply strictly only to the sunlight. As environmentalists keep warning us, even the air is a scarce commodity. Technology gradually helps render many goods and services - books and education, to name two - asymptotically nonrivalrous and nonexcludable.

From the book ***"Funding healthcare: Options for Europe"*** (p. 216):

Substantial research shows that improving quality, efficiency and equity critically depends on supportive policy contexts and policy measures, and government capacity to implement policy effectively (Gilson et al. 1995; Kutzin 1995; Nolan and Turbat 1995; Bennett et al. 1996; Gilson 1997). Mills et al. (2001) identify the following as being the most critical:

• Decentralized retention of revenue to provide incentives to collect fees and

to allow local improvements in quality.

• Information systems for accounting, auditing and financial management that support management at all levels.

• Financial management skills, especially at sub-national levels where revenue is managed.

• Well-motivated staff with balanced financial incentives that encourage adopting new charging and management practices but discourage overzealous or illegal charging.

• A well-designed and appropriate exemption system, with information that permits the target group to be reached.

• Central leadership, training and guidance on implementing exemption policy and using revenue.

• Maintaining government funding levels to ensure that fee revenue is additional and can be used to improve quality and motivate staff.

• Public willingness and ability to pay.

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Born in 1961 in Qiryat-Yam, Israel.

Served in the Israeli Defence Force (1979-1982) in training and education units.

Education

Completed a few semesters in the Technion – Israel Institute of Technology, Haifa.

Ph.D. in Philosophy (major: Philosophy of Physics) – Pacific Western University, **California**, USA.

Graduate of numerous courses in Finance Theory and International Trading.

Certified E-Commerce Concepts Analyst by Brainbench.

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Full proficiency in Hebrew and in English.

Business Experience

1980 to 1983

Founder and co-owner of a chain of computerised information kiosks in Tel-Aviv, Israel.

1982 to 1985

Senior positions with the Nessim D. Gaon Group of Companies in Geneva, Paris and New-York (NOGA and APROFIM SA):

– Chief Analyst of Edible Commodities in the Group's Headquarters in Switzerland
– Manager of the Research and Analysis Division
– Manager of the Data Processing Division
– Project Manager of the Nigerian Computerised Census
– Vice President in charge of RND and Advanced Technologies
– Vice President in charge of Sovereign Debt Financing

1985 to 1986

Represented Canadian Venture Capital Funds in Israel.

1986 to 1987

General Manager of IPE Ltd. in London. The firm financed international multi-lateral countertrade and leasing transactions.

1988 to 1990

Co-founder and Director of "Mikbats-Tesuah", a portfolio management firm based in Tel-Aviv.
Activities included large-scale portfolio management, underwriting, forex trading and general financial advisory services.

1990 to Present

Freelance consultant to many of Israel's Blue-Chip firms, mainly on issues related to the capital markets in Israel, Canada, the UK and the USA.

Consultant to foreign RND ventures and to Governments on macro-economic matters.

Freelance journalist in various media in the United States.

1990 to 1995

President of the Israel chapter of the Professors World Peace Academy (PWPA) and (briefly) Israel representative of the "Washington Times".

1993 to 1994

Co-owner and Director of many business enterprises:

– The Omega and Energy Air-Conditioning Concern
– AVP Financial Consultants
– Handiman Legal Services
Total annual turnover of the group: 10 million USD.

Co-owner, Director and Finance Manager of COSTI Ltd. – Israel's largest computerised information vendor and developer. Raised funds through a series of private placements locally in the USA, Canada and London.

1993 to 1996

Publisher and Editor of a Capital Markets Newsletter distributed by subscription only to dozens of subscribers countrywide.

In a legal precedent in 1995 – studied in business schools and law faculties across Israel – was tried for his role in an attempted takeover of Israel's Agriculture Bank.

Was interned in the State School of Prison Wardens.

Managed the Central School Library, wrote, published and lectured on various occasions.

Managed the Internet and International News Department of an Israeli mass media group, "Ha-Tikshoret and Namer".

Assistant in the Law Faculty in Tel-Aviv University (to Prof. S.G. Shoham).

1996 to 1999

Financial consultant to leading businesses in Macedonia, Russia and the Czech Republic.

Economic commentator in "Nova Makedonija", "Dnevnik", "Makedonija Denes", "Izvestia", "Argumenti i Fakti", "The Middle East Times", "The New Presence", "Central Europe Review", and other periodicals, and in the economic programs on various channels of Macedonian Television.

Chief Lecturer in courses in Macedonia organised by the Agency of Privatization, by the Stock Exchange, and by the Ministry of Trade.

1999 to 2002

Economic Advisor to the Government of the Republic of Macedonia and to the Ministry of Finance.

2001 to 2003

Senior Business Correspondent for United Press International (UPI).

2007 -

Associate Editor, Global Politician

Founding Analyst, The Analyst Network

Contributing Writer, The American Chronicle Media Group

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Columnist and analyst in "Nova Makedonija", "Fokus", and "Kapital" (Macedonian papers and newsweeklies).

2008-

Member of the Steering Committee for the Advancement of Healthcare in the Republic of Macedonia

Advisor to the Minister of Health of Macedonia

Seminars and lectures on economic issues in various forums in Macedonia.

Web and Journalistic Activities

Author of extensive Web sites in:

– Psychology ("Malignant Self Love") - An Open Directory Cool Site for 8 years.

– Philosophy ("Philosophical Musings"),

– Economics and Geopolitics ("World in Conflict and Transition").

Owner of the Narcissistic Abuse Study Lists and the Abusive Relationships Newsletter (more than 6,000 members).

Owner of the Economies in Conflict and Transition Study List , the Toxic Relationships Study List, and the Links and Factoid Study List.

Editor of mental health disorders and Central and Eastern Europe categories in various Web directories (Open Directory, Search Europe, Mentalhelp.net).

Editor of the Personality Disorders**,** Narcissistic Personality Disorder, the Verbal and Emotional Abuse, and the Spousal (Domestic) Abuse and Violence topics on Suite 101 and Bellaonline.

Columnist and commentator in "The New Presence", United Press International (UPI), InternetContent, eBookWeb, PopMatters, Global Politician, The Analyst Network, Conservative Voice, The American Chronicle Media Group, eBookNet.org, and "Central Europe Review".

Publications and Awards

"Managing Investment Portfolios in States of Uncertainty", Limon Publishers, Tel-Aviv, 1988

"The Gambling Industry", Limon Publishers, Tel-Aviv, 1990

"Requesting My Loved One – Short Stories", Yedioth Aharonot, Tel-Aviv, 1997

"The Suffering of Being Kafka" (electronic book of Hebrew and English Short Fiction), Prague, 1998-2004

"The Macedonian Economy at a Crossroads – On the Way to a Healthier Economy" (dialogues with Nikola Gruevski), Skopje, 1998

"The Exporters' Pocketbook", Ministry of Trade, Republic of Macedonia, Skopje, 1999

"Malignant Self Love – Narcissism Revisited", Narcissus Publications, Prague, 1999-2007 (Read excerpts - click here)

The Narcissism Series (e-books regarding relationships with abusive narcissists), Prague, 1999-2007

Personality Disorders Revisited (e-book about personality disorders), Prague, 2007

"After the Rain – How the West Lost the East", Narcissus Publications in association with Central Europe Review/CEENMI, Prague and Skopje, 2000

Winner of numerous awards, among them Israel's Council of Culture and Art Prize for Maiden Prose (1997), The Rotary Club Award for Social Studies (1976), and the Bilateral Relations Studies Award of the American Embassy in Israel (1978).

Hundreds of professional articles in all fields of finance and economics, and numerous articles dealing with geopolitical and political economic issues published in both print and Web periodicals in many countries.

Many appearances in the electronic media on subjects in philosophy and the sciences, and concerning economic matters.

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