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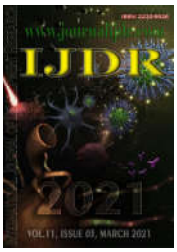

RESEARCH ARTICLE OPEN ACCESS

LESSONS OF HEALTH FINANCING REFORM: A BOOK REVIEW

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ABSTRACT

In 2016, Saudi Arabia announced its 2030 National Transformation Vision. This plan is attempting to change major aspects related to the economy, which, in effect, would require changes in, among other systems, the Saudi health financing system. As much as there seems to be much optimism and hope expressed after the announcement of the vision, careful steps in the reform of the health system, and in particular the health financing system, must be taken. Thus, this paper is attempting to look at experiences and lessons drawn from countries that have had similar transitions; specifically, this paper will review the transition of the former communist countries through a comprehensive book that was put together as a collection of chapters written by different authors about this topic. The book is called "Implementing Health Financing Reform: Lessons from countries in transition."

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INTRODUCTION

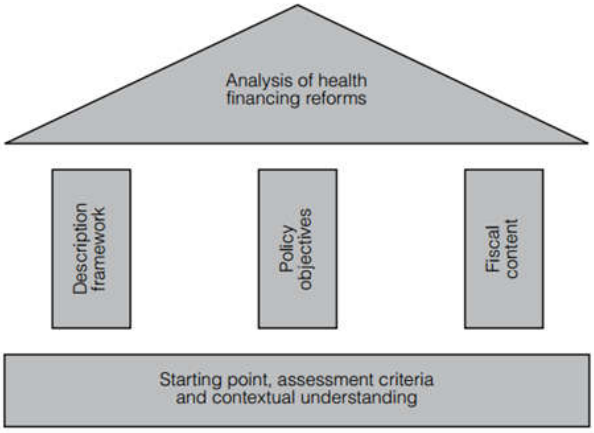
The transition of the former Union of Soviet Socialist Republics (USSR) and other communist countries in Central Europe (CE) after the fall of the Berlin Wall offers valuable lessons. Some of these lessons are related to the development and implementation of health financing reforms. The understanding of such reforms requires a comprehensive assessment of all underlying factors related to the transition itself. That is a consideration of the political, economic, socio-demographic, and cultural backgrounds in these transitional countries. It also requires searching for a collective pattern that can be drawn through analyzing each country's path and experience during the transition. Fortunately, we believe that this book has successfully reflected and considered those features and could offer the opportunity to find comprehensive and well-thought-out information and lessons about this topic. This book is divided into 14 chapters covering multiple concepts and issues related to health financing reform in general, and the health financing reform of transitional countries, in particular. It bases its overall assessment and analysis on a well-defined conceptual framework (discussed in the next section). It covers an array of elements related to health financing systems, such as revenue collection, pooling of funds, purchasing of healthcare services, health data and infrastructure, and financial management concepts and theories.

In this review paper, we will try to highlight the main concepts, issues, experiences, and lessons found in this book. However, due to the extensive and lengthy content of the book, it would be difficult to claim that this paper can be presented as an in-depth book review. At best, this can be an introduction to a more detailed and thorough analysis of health financing reform in transitional countries. This paper will be structured as follows. First, it will outline the framework on which the contents of this book were constructed. Then, it will highlight the pre-transitional background and context of the transition nation, followed by a view of the post-transitional conditions. Next, it will discuss the reforms made in the health financing systems and their impacts on these countries. Finally, it will select some issues facing reforms and policy pitfalls before a conclusion is drawn.

FRAMEWORK

A conceptual framework was constructed in order to shape the systematic approach through which the description and review of health financing reforms in former communist countries were based on, and through which lessons from those reforms were derived. This framework was based on a view that consisted of three elements: (1) assessment criteria derived from explicit policy objectives; (2) a defined structure to describe health financing systems and reforms; and (3) a discussion of vital contextual elements influencing specific reform options [Kutzin, 2010].

Consequently, this view was the basis for generating three primary "pillars," which are more detailed and specific, allowing the framework to cover most aspects in the analysis of health financing systems and reforms in the selected countries. Figure 1 below models this framework and identifies the three main pillars as follows: (1) a set of defined policy objectives drawn from a WHO report on health financing policy; (2) a set of defined functions related to health financing systems such as revenue collection, pooling, and purchasing of services; and (3) analysis of contextual factors specific to each financial system (fiscal context is the primary example) and their effects on the implementation of certain policies and reforms.



Source: [Kutzin, 2010]

Fig 1. Three pillars for analyzing health financing policy

The construction of this framework was essential for the rest of the chapters in the book, as it provided a roadmap in conducting the analyses of health financing systems and reforms in the countries of interest. However, it is important to point out that the following chapters in this book were not exclusively divided according to the framework and its components, but these components were embedded in each chapter and were used as a guideline in order to lead the purpose and content of each chapter into a common conclusion where thorough analyses are made and lessons are drawn.

POLITICAL, ECONOMIC, AND ORGANIZATIONAL STRUCTURES OF THE PRE-TRANSITION PERIOD

In chapter two, the author "kick-started" the analysis of health financing reforms by going back to the pre-transitional era in an attempt to understand the political, economic, and social contexts related to the different reforms of health financing systems in former communist countries [Davis, 2010]. Although most of the USSR and CE countries had similar political structures with a central government controlled by communist parties, there were some variations in the extent and strength of each central authority (the author was describing the political status in the mid-to-late 1980s or what he called the pre-transitional years) [Davis, 2010]. For instance, the political system in Yugoslavia, where political powers varied demographically between the Serbs and the Croats, was significantly different than that in Romania. This variation allowed for the existence of, what the author called, the dictatorial social choice mechanism [Davis, 2010]. This mechanism meant that priorities regarding policies and programs differed inside the central government itself due to different social choices among members of communist parties. These conflicting priorities resulted in various and complex systems that allowed (sometimes out of necessity) for the assembly of small groups and individuals at lower levels in order to tackle social and economic problems. Unlike their political statuses, the economic systems in the USSR and CE countries were less varied and were more similar in their models and dynamics. Under the "command" economy where the states, and not markets, had control over the flow of products and the process of production, economic concepts, such as "competition," "profit maximization," and "cost

This was clear in the unresponsive pricing systems of products and the extensive state subsidies that were intended to ease the accelerating demands for products compared to the shortages in supplies. Therefore, this command economy and state monopoly followed a distinctive model for financing different sectors that were based on the division of sectors into "high-priority" sectors, such as the military, and "low-priority" sectors, such as the health sector. Those "high priority" sectors were usually, and consequently, more productive and profit generators, which allowed the central government to finance other "low priority" and less productive sectors. This particular model made the financing of health systems and services vulnerable and dependent on other external factors. The vulnerability of this model was apparent in the limited ability of such countries to improve its health indicators and systems, and its inability to improve efficiency, quality, and technological advances in health services [Davis, 2010]. Furthermore, such characteristics of the health system organization were also influenced by the process and mechanism of financing and the distinct nature of resource allocation in those countries. Generally, health organizations, services, and providers in USSR/CE countries were administrated, financed, and organized by a central entity, mostly the Ministry of Health (with the exception of Yugoslavia, which had a relatively different health system, and which will not be discussed in this section, as it is beyond the purpose of this review to look at experiences of individual countries but to focus more on the collective lessons obtained from health financing reforms in transitional countries as a whole). Following a hierarchical arrangement, regional health departments functioned under the supervision and control of the Ministry of Health, which made the structure of the health system organization "centrally planned and controlled but structurally fragmented." [Davis, 2010, p. 49]. This centrality and fragmentation allowed for a vertical financing process that through the pooling of funds (generated from public taxation), budgets were allocated to each health department for the "purchase" and "provision" of health services. Often, the allocation of such resources depended on the quantity and size, rather than needs, of regions and health organizations. It depended on the number of beds, doctors, nurses, and the rate of medications' consumption in the organization. Thus, the driving factors behind funding were not organizational performances and quality of services, but instead detailed indicators of organizational inputs and geographical size and importance.

EARLY YEARS AFTER TRANSITION: The radical political, economic, and social changes that happened in the late 1980s and early 1990s in these countries brought with them and uncovered serious problems in the health systems of those countries. Specifically, there were three challenges that faced the transition in the health financing systems and the implementation of health system reforms. First, there was the challenge of incorporating changes in economic policies with the desired health reforms, mostly due to the lack of a multi-disciplinary understanding of economics and health systems among policymakers. The second was the duplication of policies and efforts by different health organizations and policy-makers as a result of a lack of effective coordination between them. Thirdly, the difficulty of blending these countries' health reforms together with multinational, nongovernmental, and other government activities and assistance. In addition to these challenges, most transitional countries had suffered from severe economic declines during the first years of changes, which in turn had significantly affected spending on the health sector, among other sectors, and which had resulted in various health problems to the people in those countries, such as issues related to access to healthcare, health equality, and quality of health services [Davis, 2010]. Other problems related to health financing reforms during the initial phase of transitions were not only results of the radical shifts that took place in most countries but were also the effect of the absence of necessary changes in certain policies and sectors, and the continuation of policies, as well as the work philosophy and ethics inherited from the pre-transition traditions. For example, most transitional countries continued to have unequal distribution of health spending across regions, depending on almost the same indicators set during the

size of region/organization instead of the population's health needs). This was largely a result of another unchanged legacy of the pre-transitional period, which was the lack of public availability and reliable data on the population's health and the absence of effective data infrastructure that could assist priority setting and decision making. Moreover, this variation in spending had undermined one top objective set by most governments in these countries; namely, the "financial protection" (pg. 81) of people, which in effect had worsened the health status of many low-income groups, as access to required services had become difficult [Kutzin & Jakab, 2010].

Table I. Key health financing indicators by country income group, 2006

Country income group[1]	GDP per capita in international $	Government health spending as % of GDP	Private health spending as % of total health spending	Total government spending as share of GDP (fiscal context)	Government health spending as a % of government spending (priority)
Bottom third	3922	2.41	57	30.6	7.7
Middle third	9540	4.51	31	38.4	11.7
Top third	17911	5.17	22	41.0	12.6

Source: Authors' own calculations, based on data from WHO 2009a.

Notes: The 27 countries analysed in this chapter were ranked by per capita gross domestic product (GDP) in international dollars in 2006. The countries were divided into three equal size groups with nine members each. Group averages are not weighted for population size. The bottom third includes Tajikistan, Kyrgyzstan, Uzbekistan, the Republic of Moldova, Georgia, Armenia, Albania, Azerbaijan and Ukraine. The middle third group includes Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Montenegro, Serbia, Belarus, Kazakhstan, Bulgaria, Romania and the Russian Federation. The top third group includes Croatia, Poland, Latvia, Lithuania, Hungary, Slovakia, Estonia, the Czech Republic and Slovenia.

Source: [Kutzin & Jakab, 2010]

But variations in health spending was not only within the transition nations; it also varied between countries. Also, economic conditions were not likely to be the only driving force behind the disparity in spending. For example, Table I shows that even when top income countries had double the GDP per capita compared to middle-income countries, the two group countries did not have as much difference in their national health spending. This was especially true when looking at their national health spending as a percentage of the overall expenditure. This is a strong indication that variation in countries' incomes was probably not the only issue facing the health financing systems in those nations. Other likely reasons could be related to the financial management systems, the low-priority status of health compared to other sectors, and/or other political and economic inefficiencies.

REFORMS OF MAIN FEATURES IN HEALTH FINANCING SYSTEMS

Revenue Collection: Most transitional countries had adopted similar mechanisms of revenue collection that depended predominantly on dedicated taxes collected as a payroll tax [Sheiman et al, 2010]. Generally, these revenue collection mechanisms have not had an apparent effect on the health financing systems in those countries, although there were lessons to learn from them. For instance, there had been a notable trend of more successful implementation of effective revenue collection systems through payroll taxes in countries with a more centralized fiscal context compared to those that decentralized their budgetary systems. This mainly was attributed to the existing nature of the labor market in most transition countries, which had less formal workforce participation. The existence of an informal labor market was partly a cause of difficulty in the implementation of another mechanism of budgetary funding, which is directly related to health. That is the introduction of national and mandatory health insurance systems in some transitional nations. The absence of proper labor laws made it challenging for governments to increase national funds for insurance, as it was difficult to distinguish capable contributors from jobless and low-income groups. More importantly, valuable experiences could also be found in the implications of adopting different health financing functions where revenue collection and pooling approaches for health spending varied, taking the forms of either an integrated or a specialized system. Most transitional states enjoyed the flexibility and the efficiency of revenue collection and funding systems that were the responsibility of an [illegible] This specialized system allowed for adequate collection and pooling of funds and took the burden away from health agencies, which, in turn, enabled them to focus on other responsibilities. But this does not mean that those countries where revenue collection and pooling were integrated and executed by a health agency had no successful practices. For example, health insurance funds in integrated systems such as those found in the Czech Republic and Slovakia had demonstrated direct premium collection that was highly efficient. Perhaps what could be learned from this is that reforms in revenue collection and sources of funds are most effective when a transitional state takes into account its fiscal context, which includes labor market reforms as well as ensuring that the choice of the revenue-collection mechanism is adequate and in line with the overall health financing reforms.

Pooling of Funds: Health financing reforms in transitional countries involved reforms to the pooling of funds as one important step before the purchasing and provision of services [Kutzin et al, 2010]. The major aspect of the pooling system where reforms took place was the attempts to coordinate different pooling channels to ensure the operation of a more efficient pooling mechanism that reduces waste and duplication of efforts, and ensures effective utilization and equal distribution of health resources. Two main forms of pooling fragmentations existed in most transitional nations; a horizontal fragmentation that included decentralized and separate pooling arrangements, and a vertical fragmentation that took the form of an integrated, yet separated pooling system. The problem of a fragmented pooling system can take the form of an overlapping population insurance coverage, lack of coordination in terms of policy and service mandates, and inefficient competition between different pools that made funds unequal in one pool compared to another, regardless of the size of coverage. Successful reform strategies to address fragmentation in the pooling of funds can be found in many of the transition countries. One strategy includes an emphasis on purchasing methods along with the focus on a reduction of fragmentation. It was found that narrowing the number of pools in order to achieve equal distribution and coverage was not enough since the real problem occurred when the money was actually spent. Moreover, this strategy of improving purchasing methods depended on the success of the nature of the health financing system and whether it was a centralized or a decentralized system [Kutzin et al, 2010]. Another effective approach to control for the impact of fragmented pools of funds was to create a single, regional-based pool that had larger coverage bases. In Estonia, for instance, this strategy yielded not only a larger stake of funds and, consequently, a larger distribution but it also enhanced administrative efficiency.

Some important lessons happened in some of the transitional countries in their efforts to reform the fragmentation in the pooling system. One was the realization that "fixing" the fragmented pools of funds was not possible by merely introducing national and compulsory health insurance systems. In fact, some cases showed that the compulsory health insurance system had expanded the fragmentation system, especially in lower-income countries. This expansion was a result of more regulations related to the pooling system after the introduction of the national health insurance since the problem of non-contributors, due to an informal workforce, was critical for the pooling and distribution of funds. Another lesson was understanding the importance of risk-adjustment policies to be enforced in a fragmented pooling system where competitive insurers exist. The absence of risk-adjustment meant that populations with the most healthcare needs were vulnerable to either losing protection or paying expensive premiums. In a fragmented pooling system, ensuring the redistribution of funds from all insurance pools was one effective strategy to address such a problem.

Purchasing of Healthcare Services: Many reforms regarding the purchasing of healthcare services took the form of creating a new and independent purchasing institution [Fuenzalida-Puelma et al, 2010]. The rationale behind this was to ensure the separation of the purchaser from providers and to make sure that providers had no [illegible]

However, this particular institutional structure was not a necessity in some successful reforms of the purchasing system. For example, in countries like Kyrgyzstan, Lithuania, and Hungary, purchasing services was the responsibility of the Ministry of Health, which had succeeded in controlling and enhancing the health delivery system through the control of the purchasing system [Fuenzalida-Puelma et al, 2010], while independent entities in other countries had limited powers to do so. But reforms that created independent institutions for purchasing healthcare services also functioned well in other aspects, especially when these reforms were coupled with advanced accountability and effective governance structures.

Coverage Policies & Decisions: Transitional countries were split according to coverage, benefits, and patient cost-sharing into varying degrees, in terms of the scope of service covered (what health services are covered?), the depth of patient cost-sharing (how much of the cost is covered?), and the breadth of the covered population (how many are covered?). These degrees of coverage, benefits, and cost-sharing depended primarily on the economic hardship occurring after the transitions had affected most transitional states. For instance, CE countries, for the most part, managed to keep national coverage with benefits that included a broad range of services but had some constraints on the depth of the coverage through implementing specific cost-sharing plans for certain services and drugs, whereas other countries (mostly former Soviet states) had to adjust coverage policies that limited the scope of services covered, the depth of cost-sharing, and/or the breadth of coverage [Fuenzalida-Puelma et al, 2010]. Reforms influencing coverage decisions were successful in some cases and less effective in others. The successful experiences were more inclined to be induced by a set of conditions, such as the continuation of the reform process and learning from mistakes, a determined political will to achieve goals, a strong and a transparent legal system, and most importantly, consistency and coordination with other health financing policies and reforms [Gotsadze & Gaál, 2010].

ISSUES RELATED TO REFORMS

Health Infrastructure: The health infrastructure was left in poor shape by the pre-transitional states. After the transition, most countries were struggling to cope with the new market-oriented systems and to enhance building health facilities and equipment. Some strategies were used to reform the financing of the health infrastructure, such as the down-sizing, merging, and re-profiling of facilities, the restructuring of the financial management system through giving providers more power over resources in order to enhance infrastructure internally, and the assurance of such reforms to be included in the country's overall investment and development plans [Haazen & Hayer, 2010].

Informal Payment: One inherited practice from pre-transitional times was the spread of informal payments for health services. This continued in post-transitional times where patients were found to be paying for services that are usually covered by the state's national insurance [Gaál et al, 2010]. Reforms regarding this type of practice offered various lessons. It was realized that a single policy instrument designed to overcome this issue was not enough on its own. A set of interconnected conditions related to policy, laws, politics, economy, and culture were all essential in this regard. In other words, transitional nations needed robust and comprehensive strategies that were well-structured in order to address and restrict informal payments for health services. This was especially true in those states that had national health coverage but with complex copayment and coinsurance payment methods [Gaál et al, 2010].

Transparency and Accountability: The emergence of autonomous institutions responsible for the pooling of funds and purchasing of services required, along with it, a culture of transparency and accountability. The limited experiences of former communist countries in these aspects made it challenging to implement such concepts to ensure effective financing and efficient provision of healthcare services. Attempted reforms were trapped between the need to enforce measures and laws for more transparent and accountable institutions and policymaking and between the ineffective political contexts in such countries. Certainly, the situation today is far from perfect in terms of achieving transparency and accountability in the health financing systems in the transition countries but there is notable progress compared to the early 1990s [Savedoff & Fuenzalida-Puelma, 2010]. However, in order to advance more in these aspects, other nation's experiences can be introduced and practiced in the transition states, such as the separation of the roles of different institutions, enhancing information laws, and improvement in the structure of decision making.

SOME POLICY PITFALLS

Transitions experienced by former communist countries in their health financing systems can also offer some lessons on what to avoid in terms of policy. Some of the pitfalls were derived from the experiences of several nations, which allows for a generalized outline or list of likely harmful policies. One important pitfall was the false expectation that by introducing health insurance systems and policies, other problems would be eliminated. For example, the issue of informal payments was thought to be reduced when health insurance laws were implemented, as people would not continue paying for services that the health insurance system was supposed to pay for. However, the practice of informal payment took other methods and some of these methods were partly because of the health insurance policies that were introduced in countries where accountability and transparent laws were still evolving. Insurance policies were also complex and confusing to the extent that copayments and coinsurance turned, in some transition nations, into alternative methods for informal payment [Kutzin et al, 2010]. Other unintended consequences of a closely related topic in policy was the belief that the most effective way to achieve a functional universal health coverage is to start by offering voluntary private health insurance first. An approach that had been successful for a number of western European countries like Great Britain and Germany. Then, after the evolution of the health insurance experience and the potential growth of national income, universal coverage can be implemented. Such belief usually neglects the fact that apart from the specific historical and cultural contexts of this experience, transition countries already had health financing frameworks with their distinctive and different mechanisms for revenue collection, pooling of funds, and the purchasing of services that had to be considered before the implementation of voluntary private insurance and the hope for it to elevate the health system as a whole.

Lastly, a drawback in the effects of a certain policy arises when there is a lack of coordination that results in a contradictory policy. Often in transitional states, political compromises were inevitable, mostly due to economic turmoil and political unrest. Such compromises are especially harmful when the introduction of new policies to solve an issue turns out to be in contradiction with other, sometimes even functional, policies. For instance, some arrangements at institutional levels, such as the creation of autonomous pooling agencies, were adopted by countries like Albania and the Russian Federation in the early years of transition and which had great potential to positively impact the health financing system. However, the failure to synchronize such efforts with the evolving regulations of the budgetary system had weakened the potential role of those institutions to enhance the financing system for health [Kutzin et al, 2010].

CONCLUSION

Using a systematic approach in the analysis and assessment of the health financing systems in former communist countries during the period that followed their transition, this book review has highlighted various lessons and experiences. This review paper has underlined that a deep understanding of the political, economic, and cultural background of a country is vital in its progress after major changes occur.

We outlined the extensive description of the various contexts that dominated these countries before their transition and which cautiously distinguished between the early transition periods and those that followed later, in terms of the assessment of the health financing systems. The main challenges that faced transition countries during that period have been pointed out, such as the harming partition between health policies and economic concepts, the lack of coordinated efforts within a country and with foreign assistance, and the severe economic difficulties influencing the policies of health financing. We also summarized the background and evolution of the primary cores of the health financing systems; namely, revenue collection, pooling of funds, and purchasing of healthcare services. Overall analysis was made of the different structures of these systems and the effects of centralized, decentralized, fragmented, and integrated organizational and policy structures on the principles of health financing. The paper also touched on the emergence and impact of national and voluntary health insurance systems on policies and programs. It discussed the varying systems and experiences of health coverage and the success and failures of some transition nations in expanding the scope of covered services, the depth of cost-sharing, and the breadth of health coverage of the population. This review has also highlighted several issues pertaining to the financing of health such as the underdeveloped health infrastructures and the high cost of developing them, the problem of informal payment and its effects on the health financing system, and the issues of poor transparency and accountability in health institutions. Finally, this paper ended with a listing of policy pitfalls to avoid, which were derived from the collective experiences of transition countries in implementing their health financing systems.

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