FINAL PROJECT CONFERENCE VILNIUS 2012

FINAL PROJECT CONFERENCE

EQUITY AND EFFICIENCY EFFECTS OF OUT-OF-POCKET PAYMENTS IN EUROPE

3-4 DECEMBER 2012

VILNIUS, LITHUANIA

Organized by Project ASSPRO CEE 2007 - *www.assprocee2007.com*

Project funded by the European Commission under FP7-SSH-2007 (GA no. 217431)

Seminar locations:

Best Western Hotel, Konstitucijos pr. 14, LT-09308 Vilnius, Lithuania

Hosting organization:

Public Enterprise “MTVC”, Antakalnio str. 22B, LT-10305 Vilnius, Lithuania

ABSTRACT BOOK



KEYNOTE SPEAKERS:

Bernd RECHEL
European Observatory on Health Systems and Policies

Paul VINCKE
European Healthcare Fraud and Corruption Network

María del Pilar GONZÁLEZ PANTALEÓN
European Commission

Wim GROOT
Professor at Maastricht University
Council for Public Health and Health Care, the Netherlands

Peter GAAL
Dean of the Faculty of Health and Public Services
Semmelweis University, Hungary

Tengiz VERULAVA
Dean of the Business Faculty,
Ilia State University, Georgia

Other participants and guests:

Researchers and policy makers from the participating partners' countries:
Bulgaria, Hungary, Lithuania, Poland, Romania, Ukraine and the Netherlands

WHY THIS CONFERENCE?

Equity in health care financing and equity in access to health care have been long established as guiding principles in Europe. Although European patients are accustomed to pay for health care commodities, such as pharmaceuticals, extensive patient charges for public health care services are uncommon. Free-of-charge access to essential health care services is even seen as a patient's right in some countries. Nevertheless, the scarcity of public resources, combined with the global economic crises, puts pressure on European governments to set new priorities. As a result, charges for public health care services are being extended in Europe as a means to shift health care costs to consumers and to reduce the need of government funding. Such reforms are expected to limit deficits in the state budget but also to provide incentives to consumers for efficient health care use and a healthier life-style. In view of this, European policy-makers face a major challenge in designing efficient and equitable patient payments mechanisms that maintain a high quality of care for all citizens.

This conference presents the key findings of project ASSPRO CEE 2007 (funded by the European Commission under FP7 Social-Sciences and Humanities theme). The project addresses the need of new, improved and more appropriate indicators for the evaluation of patient payment policies. The research activities within the project are specifically focused on the equity and efficiency effects of out-of-pocket patient payments in Central and Eastern European countries. There is a concern that official patient charges in this region impose a double financial burden to consumers since they are implemented in a context of persistent informal payments. Are patients able to cope with new or increased formal charges? Taking this question as a perspective, the conference presents evidence on the affordability of health care in Central and Eastern Europe, and the future challenges related to the introduction or increase of patient charges. The conference invites broader discussions on the role and effects of patient charges in Europe.

Milena Pavlova, Wim Groot and Godefridus G. van Merode
Project coordinators – Maastricht University, The Netherlands

Key project results can be found in the special issue of Society and Economy, Volume 34, Number 2/June 2012
http://www.akademiai.com/content/k323652v41h8/?p=ab5a7831ff444c90ba2616e79c679f70&pi=1

CONFERENCE PROGRAMME

Programme may be subject to change

Monday, 3-December: Conference day 1

9:00 – 9:15	Participants gather at the meeting location
9:15 – 9:25	Welcoming addresses from the host institution Liubove MURAUSKIENE – Public Enterprise "MTVC", Lithuania
9:25 – 9:35	Welcoming address from the project coordinators Wim GROOT – Maastricht University, the Netherlands
9:35 – 9:45	Welcoming address from the European Commission María del Pilar GONZÁLEZ PANTALEÓN – EC Project Officer
9:45 – 10:45	SESSION 1: The role of formal co-payments in the public health care sector Chaired by: Wim GROOT – Maastricht University, the Netherlands
	"Public coverage in times of crisis" Bernd RECHEL – European Observatory on Health Systems and Policies
	"Stakeholders' opinion on formal co-payments for health care services: evidence from six CEE countries" Marzena TAMBOR – Uniwersytet Jagiellonski Collegium Medicum, Poland
	"From competition to non-competition and out-of-pocket payments in the Georgian insurance system" Tengiz VERULAVA – Ilia State University, Georgia
10:45 – 11:00	Coffee/tea

11:00 – 12:00	SESSION 2: Out-of-pocket payments and health system reforms Chaired by: Bernd RECHEL – European Observatory on Health Systems and Policies
	"Health system reforms, austerity measures and out-of-pocket payments: the case of Greece" Paul VINCKE – European Healthcare Fraud and Corruption Network
	"Out-of-pocket payments in Lithuania: experience and policy challenges" Liubove MURAUSKIENE – Public Enterprise "MTVC", Lithuania
	"Equity in out-of-pocket payments during the period of health care reforms: evidence from Hungary" Petra BAJI – Center for Public Affairs Studies Foundation, Hungary
12:00 – 13:30	Lunch
13:30 – 14:30	SESSION 3: Out-of-pocket payments as an incentive for efficiency and healthy life style Chaired by: Liubove MURAUSKIENE – Public Enterprise "MTVC", Lithuania
	"Limits to lifestyle solidarity" Wim GROOT – Maastricht University, the Netherlands
	"The impact of out-of-pocket payments on prevention and health-related life style" Reza REZAYATMAND – Maastricht University, the Netherlands
14:30 – 14:45	Coffee/tea
14:45 – 16:00	SESSION 4: Informal patient payments in CEE countries Chaired by: Paul VINCKE – European Healthcare Fraud and Corruption Network
	"Patterns of informal patient payments in three CEE countries" Tetiana STEPURKO – School of Public Health, Ukraine
	"Informal payments for health care in Bulgaria – their significance after 10 years of co-payments" Elka ATANASOVA – Medical University of Varna, Bulgaria
	"The role of informal patient payments in the delivery of maternity care in Serbia" Jelena ARSENIJEVIC – Maastricht University, the Netherlands
	"Current attempts to eliminate informal payments in Hungary" Peter GAAL – Semmelweis University, Hungary
16:00 – 16:15	Closure day 1
19:00 – 22:00	CONFERENCE COME TOGETHER Informal discussions with food and drinks.

Tuesday, 4-December: Conference day 2

9:00 – 9:15	Participants gather at the meeting location
9:15 – 10:30	SESSION 5: Willingness and ability to pay for health care services Chaired by: Wim GROOT – Maastricht University, the Netherlands
	"Poverty effects of out-of-pocket payments in the Russian Federation" Vladimir S. GORDEEV – Maastricht University, the Netherlands
	"Patient payments in Romania: between willingness and burden" Constanta MIHAESCU PINTIA – SNSPMPDS, Romania
	"Eliciting willingness to pay for physician services in six CEE countries" Andriy DANYLIV – School of Public Health, Ukraine
	"Paying informally for public health care in Albania: scarce resources or governance failure?" Sonila TOMINI – Maastricht University, the Netherlands
10:30 – 10:45	Coffee/tea
10:45 – 11:45	SESSION 6: Discussion of EU policy brief Chaired by: Milena PAVLOVA – Maastricht University, the Netherlands
11:45 – 12:00	Closure project conference – reflection on project results by policy experts
12:00 – 15:30	Lunch and social event

OPENING FINAL PROJECT CONFERENCE:

WELCOMING ADDRESSES FROM THE HOST INSTITUTION

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WELCOMING ADDRESS FROM THE PROJECT COORDINATORS

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WELCOMING ADDRESS FROM THE EUROPEAN COMMISSION

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SESSION 1: THE ROLE OF FORMAL CO-PAYMENTS IN THE PUBLIC HEALTH CARE SECTOR

PRESENTATION KEYNOTE SPEAKER:

"PUBLIC COVERAGE IN TIMES OF CRISIS"

Bernd RECHEL

European Observatory on Health Systems
and Policies

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ABSTRACT:

The WHO Europe's Oslo meeting in April 2009 "Health in times of global economic crisis: implications for the WHO European Region" resulted in 12 recommendations, including: invest in health to improve wealth; protect health budgets; protect cost-effective public health and primary health care services; ensure "more money for health and more health for the money"; ensure universal access to health services; promote universal, compulsory and redistributive forms of revenue collection; consider introducing or raising taxes on tobacco, alcohol, sugar and salt.

How did the crisis affect Europe so far? Only few countries reduced the breadth of coverage. Ireland removed eligibility for some aspects of public coverage for wealthy individuals older than 70 years; however, this changed with a new government in February 2011. Czech Republic reduced public coverage for foreigners. Spanish central government decided in April 2012 to substantially reduce entitlements for undocumented migrants. Several countries expanded the breadth of coverage (Belarus, Bosnia and Herzegovina, Georgia, Macedonia, Moldova). Belgium, in 2008, extended full statutory coverage to all self-employed people, creating a single health risk pool for the first time. Estonia extended entitlement to health insurance benefits to those long-term unemployed who are registered and actively seeking employment. Statutory benefit packages did not change much. Some countries made reductions, usually at the margin, e.g. lower reimbursement of dental care in Estonia, Ireland, and reduced temporary sickness benefits in Estonia, Hungary, and Lithuania. A number of countries increased or introduced user charges for health services (Armenia, Czech Republic, Denmark, Estonia, France, Greece, Ireland, Italy, Latvia, Netherlands, Portugal, Romania, Russia, Slovenia, Switzerland, Turkey). Other countries reduced user charges, targeting low-income groups in the area of pharmaceuticals (Austria, France, Ireland, Italy, Moldova, Serbia), other health services (Croatia, Serbia), or abolishing user charges altogether (Italy, Hungary).

Public coverage in times of crisis? Or a crisis of public coverage? Not at all. If we want to have a fair, equitable and efficient health system, there is no alternative to public coverage.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusBRechel.pdf

SESSION 1: THE ROLE OF FORMAL CO-PAYMENTS IN THE PUBLIC HEALTH CARE SECTOR

PROJECT PRESENTATION:

"STAKEHOLDERS' OPINION ON FORMAL CO-PAYMENTS FOR HEALTH CARE SERVICES: EVIDENCE FROM SIX CEE COUNTRIES"

Presented by:

Marzena TAMBOR

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ABSTRACT:

Although patient charges for health care services may contribute to a more sustainable health care financing, they often raise public opposition which impedes their introduction in many Central and Eastern European countries. Patients in these countries, however, even if not obliged by law to co-pay for health care services, are accustomed to payments (informal or quasi-formal payments for better quality and/or quicker access). Thus, a consensus among the main stakeholders on the presence and role of formal patient charges should be worked out in order to assure their successful implementation.

The aim of the study was to analyze the acceptability of formal patient charges for health care services in a basic package, among different health care system stakeholders in six Central and Eastern European countries (Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine). Qualitative data were collected in 2009 via focus group discussions and in-depth interviews with health care consumers, providers, policy makers and insurers. The same participants were asked to fill in a self-administrative questionnaire to collect quantitative data. Qualitative and quantitative data are analyzed separately to outline similarities and differences in the opinions between the stakeholder groups and across countries.

Our findings indicate that enhancing public trust and acceptance of patient payments in CEE countries require improving transparency and accountability in the health care system, e.g. a clear formulation of a feasible (considering limited resources) basic package, well-defined quality and access standards, eradication of informal payments. The introduction of obligatory patient payments should be accompanied by investments to assure high-quality health care services, through reinvesting the fee revenues in health care facilities. Further, decision makers should protect the most vulnerable groups against adverse equity effects e.g. applying transparent exemption or reduction mechanisms. Administrative costs and fiscal efficiency should be closely considered when developing a patient payment system.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusMTambor.pdf

SESSION 1: THE ROLE OF FORMAL CO-PAYMENTS IN THE PUBLIC HEALTH CARE SECTOR

PRESENTATION KEYNOTE SPEAKER:

"FROM COMPETITION TO NON-COMPETITION AND OUT-OF-POCKET PAYMENTS IN THE GEORGIAN INSURANCE SYSTEM"

Presented by:

Tengiz VERULAVA

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ABSTRACT:

In Georgia, in the period 2007-2010, there was a growing trend to move away from centralized government control and introduce more market-oriented features, including (1) private sector involvement in health care provision and financing to improve systems efficiency; (2) incorporation of market mechanisms such as competition among insurers and providers, cost sharing, market prices of goods and services, consumer choice. The recent health care reforms, after 2010, move the Georgian health care system from competitive to non-competitive health care market. After the new elections in 2012, the objective is to establish a single social insurance system run by a state insurance company.

There are various causes of out-of-pocket patient payments in Georgia. Supply-side factors include the inadequate and insufficient official income of health personnel, and the lack of transparency in the administration and management of provider units. Demand-side factors are related to: (1) cultural reasons: paying providers has been a cultural norm in Georgia since socialist times; several patients admitted that they used to pay providers also during the "old Soviet days", although on a different scale; (2) gratitude: ". . . when a doctor saves your life you want to thank them", i.e. patients are willing to pay physicians to express gratitude; (3) desire to support doctors: Georgian population believes that health workers are suffering from the same economic hardships as the others; people are willing to help by paying directly in exchange for medical services; (4) lack of trust: respondents and providers expressed a complete distrust in the government. There are also contextual factors, such as the government's underfunding of health services, poor definition of the benefit package (BBP), and overcapacity in the delivery system.

LINK TO PRESENTATION SLIDES:

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SESSION 2: OUT-OF-POCKET PAYMENTS AND HEALTH SYSTEM REFORMS

PRESENTATION KEYNOTE SPEAKER:

"HEALTH SYSTEM REFORMS, AUSTERITY MEASURES AND OUT-OF-POCKET PAYMENTS: THE CASE OF GREECE"

Paul VINCKE

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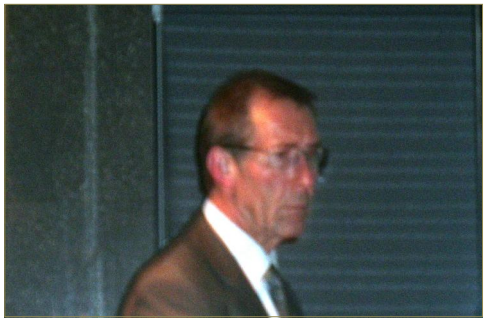

ABSTRACT:

As a consequence of many unsuccessful reforms since 1983, the Greek healthcare system suffers from inefficiencies that result in significant private sector and out-of-pocket spending on health services. The inefficiencies include a high degree of centralization in decision-making and administrative process, ineffective managerial structures, lack of planning and coordination, unequal and inefficient allocation of human and economic resources, fragmentation of coverage and an absence of a referral system, underdevelopment of needs assessment and priority-setting mechanisms, anachronistic retrospective reimbursement system, absence of health technology assessment system, quality assurance and economic evaluation processes, large accumulated deficit, high recurrent costs, inequalities in access to services, high out-of-pocket payments, regressive funding mechanisms due to high private spending, informal payments, widespread tax and social contribution evasion. Out-of-pocket payments consist of formal cost sharing arrangements (co-payments in public hospital outpatient departments, for pharmaceuticals, for dental care), direct payments (in public hospitals, at afternoon outpatient visits, at visits to primary care physicians and diagnostic centers), and informal payments (estimated to be between 14 and 17% of the total health expenditure).

When the financial crisis fully hit in 2008, the already needy public Greek healthcare system went bankrupt with an outstanding debt of nearly € 5 billion to hospitals and suppliers. And then came in the European „Troika" and the TFGR (Task force Greece), imposing measures to enforce fiscal discipline, to keep public health expenditure at 6% of the GDP, reducing pharmaceutical expenditure by 1% of the GDP, installing co-payment for all outpatient services at NHS hospitals etc., all while maintaining universal access and improving quality of care delivery. Cumulative and adverse effects of both the crisis and the austerity measures taken however show the risk of a downward spiral of creeping privatization and increasing burden of healthcare on family budgets, significantly raising the pressure on suffering public health facilities. Positive effect of it all however seems to be the growing awareness that petty bribery should be banned in both the public and private area. Although ending this practice will not solve Greece's healthcare problems, at least it can help, officials hope for a change in the cultural forces that have encouraged corruption to thrive.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusPVincke.pdf

SESSION 2: OUT-OF-POCKET PAYMENTS AND HEALTH SYSTEM REFORMS

PROJECT PRESENTATION:

"OUT-OF-POCKET PAYMENTS IN LITHUANIA: EXPERIENCE AND POLICY CHALLENGES"

Presented by:

Liubove MURAUSKIENE

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ABSTRACT:

The patient payment policy in Lithuania is primarily defined by the Constitution (declaring that the state guarantees free-of-charge health care to all citizens) as well as by the basic health legislation (e.g. health system and health insurance laws and by-laws). There is a negative list of auxiliary health care services adopted by the Ministry of Health. The services listed are subject to user charges in public health care facilities. Additional regulatory arrangements allow public providers to charge for health care services that are not in the negative list. However, these arrangements are so controversial that all of them could be considered as illegal, at least this is the current position of the Ministry of Health. The resulting patient charges are official but not entirely legal (quasi-formal). The opponents state that the patient charges that result from these arrangements should not be ignored and the Ministry of Health should make an effort to legalize these charges. There is also some evidence on informal patient payments in the country, i.e. payments outside the formal and quasi-formal payment channels.

Patient payments have not been studied systematically in Lithuania. This limits the use of empirical evidence in policy-making. More systematic and detailed evidence on the patient payments phenomena in Lithuania are needed to clarify who is seeking and paying for health care services, and why and how. This presentation outlines the main findings from a quantitative representative population survey on patient payments in Lithuania. The study results confirm the significant scope of the patient payment practices as well as the complexity of the issue. Overall attitudes towards informal cash payments are negative but there is a rather tolerant view on gifts-in-kind. In case of health problems, access to proper (good quality) treatment is crucial. When treatment is needed, Lithuanian patients are ready to pay irrespective of the legitimacy of the payments and despite of the significant financial burden that these payments may cause. Priorities for quality of care and protection of vulnerable groups against financial risks are important and should be addressed when discussing the design of patient payment policies in Lithuania. The lack of transparent political and organizational arrangements and the failure to communicate properly with the general public are the main challenges.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusLMurauskiene.pdf

SESSION 2: OUT-OF-POCKET PAYMENTS AND HEALTH SYSTEM REFORMS

PROJECT PRESENTATION:

"EQUITY IN OUT-OF-POCKET PAYMENTS DURING THE PERIOD OF HEALTH CARE REFORMS: EVIDENCE FROM HUNGARY"

Presented by:

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ABSTRACT:

At the beginning of 2007, health care reforms were implemented in Hungary in order to decrease public expenditures on health care. Reforms included the increase of co-payments for pharmaceuticals and the introduction of co-payments for health care services. The objective of this study is to examine the progressivity of household expenditure on health care during the reform period, separately for expenditures on pharmaceuticals and medical devices, and for formal and informal patient payments for health care services. For the analysis we use data on household expenditure from the Household Budget Survey carried out by the Central Statistical Office of Hungary. We present household expenditure as a percentage of household income across different income quintiles and we calculate Kakwani indexes as a measure of progressivity for a four years period (2005-2008): before, during and after the implementation of the health care reforms.

We find that expenditures on pharmaceuticals and medical devices are the most regressive type of expenditure (Kakwani index -0.23/-0.24), and at the same time, it represents a major part of the total household expenditure on health care (78-85 percent of total out-of-pocket household expenditure on health care). Informal payments are also regressive, while expenditures on formal payments for services are the most proportional to income. We find that expenditures on formal payments became regressive after the introduction of user fees (Kakwani index -0.1). At the same time, we observe that expenditures on informal payments became more proportional during the reform period (Kakwani index increases from -0.20/-0.18 to -0.12). To conclude, more attention should be paid on the protection of low-income social groups when increasing or introducing co-payments especially for pharmaceuticals but also for services. Also, it is important to eliminate the practice of informal payments in order to improve equity in health care financing.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusPBaji.pdf

SESSION 3: OUT-OF-POCKET PAYMENTS AS AN INCENTIVE FOR EFFICIENCY AND HEALTHY LIFE STYLE

PRESENTATION KEYNOTE SPEAKER:

"LIMITS TO LIFESTYLE SOLIDARITY"

Wim GROOT

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Council for Public Health
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The Netherlands

ABSTRACT:

There are various forms of solidarity: income solidarity; risk solidarity, including risks you cannot influence; lifestyle solidarity, risk you can influence; and generational solidarity. Solidarity can be horizontal (division of labor, loyalty and trust based on equality and reciprocity) or vertical (no reciprocity, giver-taker, income- and risk solidarity). Solidarity can also be formal or informal. This presentation looks at these forms of solidarity in the Dutch health care sector.

In 2006, the Netherlands commenced a major reform of its health care system. The main elements of the reform were: 1) replacement of the existing system of social health insurance for people with below average income and private health insurance for people with above average income by a universal health insurance with identical entitlements and contributions for all; 2) the gradual introduction of elements of managed competition in hospital markets. The main aims of the reform were to improve the so-called "public interests" in health care, which were defined as quality, access, efficiency and cost containment in health care.

At present, we find that for the entire population (18+) health care use in 2009 varied from - on average - € 47 among 5%-group with lowest health care use to € 41.500 among 5% most expensive group. Largest differences are in the use of long-term care and in hospital care. The risk equalizing insurance premium per income decile in the third decile is € 1.700 per year, higher than in the ninth and tenth decile. Other deciles are in between. About lifestyle solidarity, there are no limits to lifestyle solidarity in the Dutch health insurance system. However, the support among the public for lifestyle solidarity is not limitless, especially at a time of low economic growth. Overall, there is too much demand on solidarity in some areas. Possible solutions for sustainable solidarity include more efficiency (more strictness on entitlements, co-payments, more emphases on health outcomes), increased reciprocity (not only rights and entitlements, but also obligations and demands), increased informal solidarity.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusWGroot.pdf

SESSION 3: OUT-OF-POCKET PAYMENTS AS AN INCENTIVE FOR EFFICIENCY AND HEALTHY LIFE STYLE

PROJECT PRESENTATION:

"THE IMPACT OF OUT-OF-POCKET PAYMENTS ON PREVENTION AND HEALTH-RELATED LIFE STYLE"

Reza REZAYATMAND

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ABSTRACT:

There is ample evidence that an unhealthy lifestyle significantly contributes to the burden of disease and increases healthcare cost. A great challenge that healthcare authorities face is the fact that scare resources are being spent on the treatment of diseases that could have been prevented through individual lifestyle changes. Thus, factors that could encourage people toward a healthier lifestyle are of interest for policy. In theory, incomplete health insurance coverage could discourage individual lifestyle improvement due to ex-ante moral hazard problem. However, still there is not enough empirical evidence available to explain to what extent cost sharing can actually impact patient preventive behavior and health-related lifestyle. We aim to analyze the effect of health insurance on health-related behavior, besides the effect of other factors.

We used Dutch survey data from the first and second wave of the Survey of Health, Aging, and Retirement in Europe (SHARE) which was collected in 2004 and 2007 (i.e. before and after the introduction of the universal health insurance in the Netherlands). Daily smoking, excessive alcohol use and physical inactivity are considered as proxies for unhealthy behaviors. A comprehensive set of factors including socioeconomic, health and health insurance status is used by a logit model to predict health-related behaviors. The same set of factors is also used to study positive or negative changes in each behavior. Our findings show that having voluntary private insurance can affect daily smoking and excessive alcohol use, however, the direction and the magnitude of the effect depends on the level of household gross income. For excessive alcohol use, having voluntary insurance among people in the lowest income quintile, decreases the odds of excessive alcohol use by 35%, while in the highest quintile it increases the odds by 76%. These results can be explained by the specific insurance and cost sharing arrangement in the Netherlands. In particular, having a basic insurance, with a fixed contractual premium, is mandatory after the introduction of new insurance act in the country. Moreover, the type of insurance was determined by the level of income and it did not necessarily indicate difference in health insurance coverage. There is also only limited patient cost sharing. In fact, the out-of-pocket expenditures in the Netherlands are the lowest as a share of national health budget when compared to EU countries.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusRRezayatmand.pdf

SESSION 4: INFORMAL PATIENT PAYMENTS IN CEE COUNTRIES

PROJECT PRESENTATION:

"PATTERNS OF INFORMAL PATIENT PAYMENTS IN THREE CEE COUNTRIES"

Presented by:

Tetiana STEPURKO

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ABSTRACT:

Deeply ingrained informal patient payments admitted by both providers and consumers, and neglected by the government, seem to be a major impediment to ongoing health care reforms. Generally, extended informal patient payment in one medical field compared to others may serve as an indicator for prioritization of the health care reforms direction. In particular, informal practices are found to be more extensive in case of hospitalizations than physician visits. Although not only manner of health care provision matters, but also such structural factor as lack of patients' knowledge about service consumption peculiarities (e.g. about formal fee) is relevant in decision to pay informally. Therefore, this presentation is focused on the size and patterns of informal patient payments for the last consumption of out-patient and in-patient services in three former-socialist countries: Bulgaria, Hungary and Ukraine. Diversity of the countries' health systems and context are taken into account.

The data are collected in nation-wide surveys carried out simultaneously in these countries in 2011. About 800 effective face-to-face structured interviews per country were conducted in the summer of 2011. The results of the cross-country comparison suggest that one prevalent type of patient payment exist in countries with more transparent regulations (e.g. in Bulgaria mostly formal and in Hungary mostly informal payments), in contrast to Ukraine where informal payments are a wide-spread supplement to also widespread quasi-formal payments. Also, relatively higher prevalence of informal patient payments is noticed in Hungary and Ukraine than in Bulgaria. Informal patient payments are relatively less often reported by Bulgarians (4% and 14% for out- and in-patient service respectively), followed by Hungarians (10% and 44% respectively) and Ukrainians (26% and 41%). Internists (in Bulgaria and Hungary) and gynecologists (in Ukraine) are on the top among the out-patient physicians who are paid informally by patients. In case of hospitalization, childbirth and surgery (emergency or planned) in contrast to procedures (emergency or planned) require considerable under-the-table payments. Solicited informal payments can be seen as an indicator of major financial troubles in the health care system, while patient-initiated informal payments can be related to unmet patients' expectations of better service quality.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusTStepurko.pdf

SESSION 4: INFORMAL PATIENT PAYMENTS IN CEE COUNTRIES

PROJECT PRESENTATION:

"INFORMAL PAYMENTS FOR HEALTH CARE IN BULGARIA – THEIR SIGNIFICANCE AFTER 10 YEARS OF CO-PAYMENTS"

Presented by:

Elka ATANASOVA

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ABSTRACT:

During the last 20 years, a growing number of studies have addressed the problem of informal patient payments and demonstrated their spread in countries with various economic developments. Not only low- and middle-income countries face this phenomenon but there is evidence that it also appears in some high-income countries in Europe. Bulgaria, as a former-socialist country, is no exception to this phenomenon. Informal patient payments were observed in the Bulgarian health care system before and after the introduction of social health insurance in 2000. Notably, the social insurance implementation was accompanied with the introduction of official co-payments for health care services. Informal patient payments present a challenge for policy-making because they adversely affect the efficiency of health care provision and aggravate the equity in access to health care services.

A nationally representative survey took place in July 2010 among health care consumers in Bulgaria (1003 respondents). Data show that about 76% of the users report out-of-pocket payments for visits and around 13% report informal payments for visits. The average amount paid informally per year for outpatient visits is 92 BGL (about 46 euro). Two-thirds (66.5%) of the users paid for hospitalization and one-thirds (32.9%) paid informal payments. The average amount paid informally for inpatient services is nearly twice higher (198 BGL, about 100 euro) than for outpatient services.

Overall, it can be concluded that the results of our study confirm the existence of informal patient payments in Bulgaria at present and this evidence underlines their significance after 10 years of co-payments. This means that a policy of co-payment to replace rather than supplement the informal payments has not been fully efficiency. Dynamics of informal payments obviously shows that in the transition period (in the 1990s) cash payments become more frequent and magnitude of both gratitude cash payments and value of gifts increased. Increase awareness among consumers related with the pitfalls in the legislation will be necessary to reduce the existence of informal payments. Information about official user fees and free-of-charge services has to be available and easily accessible to patients.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusEAtanasova.pdf

SESSION 4: INFORMAL PATIENT PAYMENTS IN CEE COUNTRIES

PROJECT PRESENTATION:

"THE ROLE OF INFORMAL PATIENT PAYMENTS IN THE DELIVERY OF MATERNITY CARE IN SERBIA"

Presented by:

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ABSTRACT:

The organization and delivery of adequate maternal care is one of the major problems in Central and Eastern European countries (CEE). In many of those countries, mothers report low level of satisfaction with obstetric care. In our study, we examine the characteristics of maternity care in Serbia focusing on process-related indicators regarding the accessibility of maternity care, the quality of care received, patient payments for maternity care and policy regulations. For this purpose, we use data collected through three sources: questionnaires filled in by mothers who delivered in one of the maternity wards in Serbia in the period 2000-2008, research publications and official guidelines.

Our results show that although macro-indicators related to maternity care in Serbia are comparable to the European averages, women who delivered in one of the Serbian maternity wards are unsatisfied with the treatment. The women in our study emphasize the discrepancy between official guidelines and hospital guidelines regarding standard services, the existence of direct official co-payments for standard services that should be available free of charge, the lack of transparency in the treatment received, the barriers to the presence of the father during birth, as well as the absence of family members - isolation of the women, and a lack of motivation and compassion by health care workers. The existence of informal patient payments as well as so called "special connections" make the position of Serbian women in maternity wards even more vulnerable. Problems in communication with medical staff are also present.

The current situation in maternity wards in Serbia raises concerns about equity but also about equality. Equal access to medical procedures but also services that cater to individual preferences should be the norm in every maternity ward.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusJArsenijevic.pdf

SESSION 4: INFORMAL PATIENT PAYMENTS IN CEE COUNTRIES

PRESENTATION KEYNOTE SPEAKER:

"CURRENT ATTEMPTS TO ELIMINATE INFORMAL PAYMENTS IN HUNGARY"

Peter GAAL

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ABSTRACT:

Although in Hungary there was a well sequenced and comprehensive health reform, this did not provide clear and realistic entitlements. Efficiency gains realized as a result of payment reforms and delivery system restructuring were taken away from the health sector (fiscal stabilization of the state budget). Public financing of health care has remained inadequate, unstable and erratic (long periods of austerity were coupled with short periods of increased spending).

In particular, attempts to formalize informal payments failed because they did not address the root cause of these payments. Measures of the government of 2006-2010 include: introduction of user charges for all patient-doctor encounters in outpatient care in 2007 (abolished later in 2008 as a result of a national referendum), as well as quite high user charge for the free choice of hospital and medical doctors. Both measures failed. Formal user charges add to the burden of informal payments if the causes of informal payments (real or perceived shortage) are not tackled. User charges for free choice is not a bad idea, but has been implemented badly. Patient payments had become the revenue of the hospital not the medical doctor (patients and doctors had no interest to shift from IP to formal OOP), and also, patient payments had to be deducted from NHIFA payment (hospitals has no interest to collect user charges, because they did not receive more money).

How should the policy modified in order to succeed? Suitable strategies include: (1) much more moderate charges in addition to NHIFA payment not as its replacement; (2) substantial part of the revenue should go directly to the medical doctor, who treat the patient; (3) payment should be subject to no (or at least light) taxation; (4) medical doctors, who treat "ordinary" patients should also receive some additional payment (from the NHIFA), in order to avoid any negative consequences on access to care (requires some additional public money). This is what the current health government in Hungary is considering, but tampering with out-of-pocket payments in health care in Hungary is a highly political issue, which requires increased public spending (or at least the reinvestment of efficiency gains).

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SESSION 5: WILLINGNESS AND ABILITY TO PAY FOR HEALTH CARE SERVICES

PROJECT PRESENTATION:

"POVERTY EFFECTS OF OUT-OF-POCKET PAYMENTS IN THE RUSSIAN FEDERATION"

Presented by:

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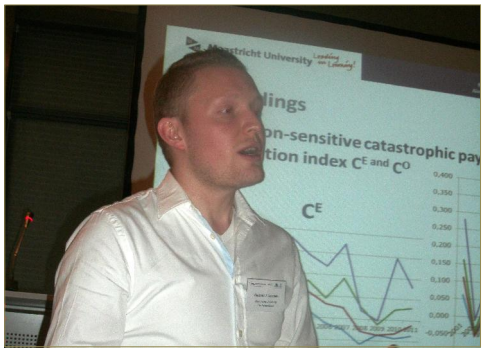

ABSTRACT:

In Russia, the fairness in access and financing is one of the problems that is yet to be tackled; therefore, background information on the exposure to catastrophic and impoverishing OOP health payments is needed. And whilst there are a number of studies addressing the changes in poverty levels in the Russian populations, none of them actually mention the exposure of Russian healthcare users to catastrophic or impoverishing payments for healthcare. Being a considerable expenditure, such healthcare spending could directly affect households irrespectively of the amount paid. To explore this hypothesis, we answer the following questions: which households are exposed to catastrophic and impoverishing expenditure for healthcare services, and whether there are Russian household that had to forego utilization of healthcare services during the past 11 years (2001-2011).

During the last 11 years, health-related payments as the share of the total household consumption grew from 4% to 5.3%, with the highest share among households belonging to the first and second income quintiles. At the same time, the number of households where at least one member had to forego healthcare services utilization (due to the lack of financial resources), overall, reduced over the decade. A similar trend was observes for utilization of pharmaceuticals. Dental care turned as the least affordable type of services, and the number of households that forewent these services remained steady within 9%-12% interval. Poorer household have a greater tendency to fall into catastrophic payments and overall incidence of catastrophic payments increased over the decade for all households. The incidence of impoverishing healthcare payments declined. Households residing in the rural area, households with larger number of children (especially with a single parent) are more vulnerable to experience impoverishing effect healthcare-related expenditure. Residing in the urban area living as an extended household with highly-educated family members, as well as having pensioners in the household, on the contrary, cushines the healthcare expenditure-related poverty spells. Our results confirm that an increase of healthcare expenditure affects all households and policy measures require address poverty alleviation and implementation of targeted and mean-testing healthcare provision.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusVSGordeev.pdf

SESSION 5: WILLINGNESS AND ABILITY TO PAY FOR HEALTH CARE SERVICES

PROJECT PRESENTATION:

"PATIENT PAYMENTS IN ROMANIA: BETWEEN WILLINGNESS AND BURDEN"

Presented by:

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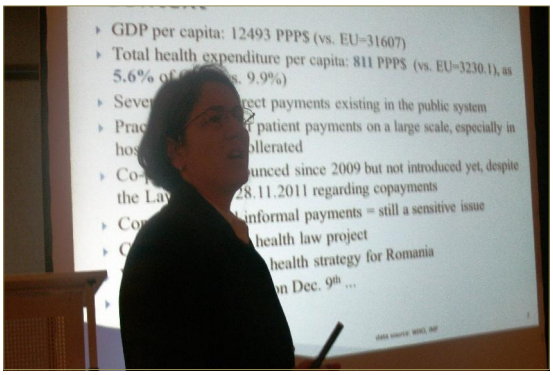

ABSTRACT:

Direct patient payments are still a quite sensitive issue in Romania, after five communist decades living under the slogan of "free health care" guaranteed by the all-powerful state, while the unofficial payments were blooming and health status was considerably deteriorating. Although several health reforms have been implemented since 1990, "under the table" payments and corruption have increased in the health sector, making it a vulnerable one. Current context for introducing co-payments: increasing poverty, multiple effects of economic crisis, recent political events, a controversial health law project, low level of salaries for the medical personnel working in public facilities, existing official charges for patients within the public sector concomitant with unofficial ones, inapplicable Law for copayments (no.220/28.11.2011).

The purpose is to study cross-disciplinary the attitudes and patterns of practice towards formal and informal payments, in order to document appropriate interventions. The main findings of the quantitative research show that 63% of respondents used healthcare, 55-72% of outpatient / hospital services who paid, paid informally; 26,5% users not paying at all for ambulatory care received, while only 6% did not pay at all for hospital services; 22-35% even had to borrow in order to cover direct payments; 29% did not visit a MD and 9% referred to hospital did not go because could not afford to pay; 62% of outpatient and 48-52% of hospital users were satisfied with the quality of services received; 58% respondents paid cash informally, while 61.5% gave gifts in kind.

Emergency care, health services for children, severely disabled and poor should be exempted from co-payments. Level of formal and informal charges paid depends mostly on the intensity of use, number of chronic patients per household, disease type and severity (high correlation coefficients), less by attitudes of patients. Transforming informal into official payments is not realistic without cost containment, decrease corruption and loss, discourage overuse of hospital care, develop outpatient services, charge moderate official fees, encourage private insurance, paying for performance from public funds, evidence-based decisions.

LINK TO PRESENTATION SLIDES:

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SESSION 5: WILLINGNESS AND ABILITY TO PAY FOR HEALTH CARE SERVICES

PROJECT PRESENTATION:

"ELICITING WILLINGNESS TO PAY FOR PHYSICIAN SERVICES IN SIX CEE COUNTRIES"

Presented by:

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ABSTRACT:

Patient charges for health care services are implemented in developed countries to reduce unnecessary service use. Although service use in Central and Eastern Europe (CEE) is high, patient charges for services are not common. Moreover, there is no evidence on their potential effects in these countries. We provide evidence on the potential impact of patient charges on the consumption of specialized physician services in six CEE countries: Bulgaria, Hungary, Lithuania, Poland, Romania, and Ukraine. We apply a semi-parametric survival analysis to the stated willingness and ability to pay (WATP) in order to identify potential demand pools, i.e. shares of population willing and able to pay a certain fee in case they need a service, and calculate price, income and age semi-elasticities. Data are collected through a survey held in 2010 among representative samples of about 1000 respondents in a country.

Our results suggest that median WATP in the studied countries ranges from 5.15 EUR to 12.2 EUR and the country ranking by WATP follows exactly the ranking by income level. Low service charges, up to 2.5 EUR in Bulgaria, Hungary, Lithuania and Romania, and up to 5 EUR in Poland should not cause many people to drop out of the demand pool. The lower payment interval should be studied in more detail for Ukraine, however. Official service charges together with exemption/reduction criteria are argued to be beneficial as an alternative to informal payments. Conducting demand analysis based on stated preference data might be a useful tool for designing patient payment policies, especially if new calibrating techniques are incorporated.

Given the low resource costs in CEE, the WTP in the six countries is substantial and in some of them, may be even comparable to the actual costs of services. Hence, there is a potential for introducing (or increasing) the formal charges for out-patient physician visits, especially taking into account the homogeneity of the WTP estimates. However, formal patient charges should be accompanied with improvements in quality and access otherwise informal payments will continue to exist creating a double financial burden for consumers.

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SESSION 5: WILLINGNESS AND ABILITY TO PAY FOR HEALTH CARE SERVICES

PROJECT PRESENTATION:

"PAYING INFORMALLY FOR PUBLIC HEALTH CARE IN ALBANIA: SCARCE RESOURCES OR GOVERNANCE FAILURE?"

Presented by:

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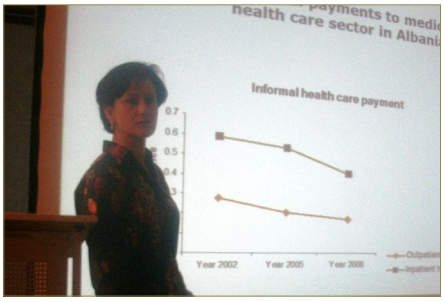

ABSTRACT:

The causes and origins of informal patient payments are usually grouped in (i) the cultural model, (ii) the economic model, and (iii) the governance model. The cultural model considers informal payments to be a particular type of behavior of care seekers to express their gratitude in the form of gifts rooted in values and traditions. The economic model links informal payments to the increased demand for health care, inadequate budget, as well as ineffective investment policies. The governance model links these payments to the lack of control and accountability in the health care sector, weak rule of law and weak corruption control. While previous studies have identified possible causes for informal payments, they have been mainly based on descriptive analysis of the data. This study employs a new approach to look at such causes by exploring the demand-side factors (i.e. patient's characteristics) and supply-side factors (i.e. provider's characteristics) and looking at the way they influence the probability of paying and the amount paid informally. Tobit and Heckman selection model are used to determine the amount paid informally while propensity score matching is used to investigate how characteristics of patients paying informally have changed over years.

Drawing a clear distinction between different causal models may be a difficult task as they may also be interrelated to each other. Considering that cultural factors were also mentioned in previous studies, we expected such model to play a stronger role in determining informal payments in Albania. Contrary to this, we find that this is not the case. While cultural factors can be broadly considered as enabling the existence of informal payments, they cannot justify the widespread and the high amounts paid (especially in inpatient care). The widespread of payments in outpatient and inpatient care, the relative exploitation of certain groups of patients (e.g. rural patients visiting hospitals in Tirana) provide evidence in favor of the governance-related issues. The influence of economic-related issues would be a reason for the amounts paid informally to resemble 'fee-for-service' payments (e.g. varying based on the type and intensity of service delivered). The different amounts paid for outpatient and inpatient care, and the positive influence of education, income on payments in inpatient services support the existence of these economic–related issues.

LINK TO PRESENTATION SLIDES:

http://www.assprocee2007.com/SeminarASSPROCEE2007DEC34VilniusSTomini.pdf

SESSION 6: DISCUSSION OF EU POLICY BRIEF

EU POLICY BRIEF TITLED:

"FORMAL AND INFORMAL OUT-OF-POCKET PAYMENTS FOR HEALTH CARE SERVICES IN CENTRAL AND EASTERN EUROPEAN COUNTRIES WHAT ARE THE ACTUAL PATIENTS' CONTRIBUTIONS?"

Presented by:

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ABSTRACT:

The issue of patient payments is especially relevant to Central and Eastern European (CEE) countries. Despite the common economic and political arrangements during the communist period, the CEE countries have proceeded on their own road of transition. However, the sharp economic decline after the collapse of the communism affected their health care systems in a similar manner. Most important, it limited the health care resources and provoked major health care system reforms. Health care funding was partly shifted to patients by applying or increasing charges for pharmaceuticals and dental care, but also for other services in the basic package, and due to the development of the private health care sector. Thus, out-of-pocket payments have become a common feature of health care delivery, which is a major contrast to the free-of-charge service provision during the Soviet times.

This policy brief presents the key findings of the project related to policy projections. In particular, the scale of formal and informal patient payments for health care services in six Central and Eastern European countries - Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine is estimated. Project results show that informal patient payments continue to exist in CEE countries. Informal patient payments for services pour additional resources into the health care systems, which are ranging from 0.1% to 0.5% of GDP depending on the country. In terms of expenditure, the share of informal patient payments is equal to 0.5-6.7% of total health expenditure (lowest in Poland and highest in Romania and Ukraine). Informal patient payments present a considerable problem in the health care sector because they negatively affect the overall functioning of the health care system. In case of informal patient payments, the providers of health care services are compensated individually, irrespective of the value of health care provision to the society. The role of health policy and priorities set by policy-makers are undermined by the existence of these payments. A mixture of strategies on the demand and supply side is proposed as a plausible solution to informal patient payments.

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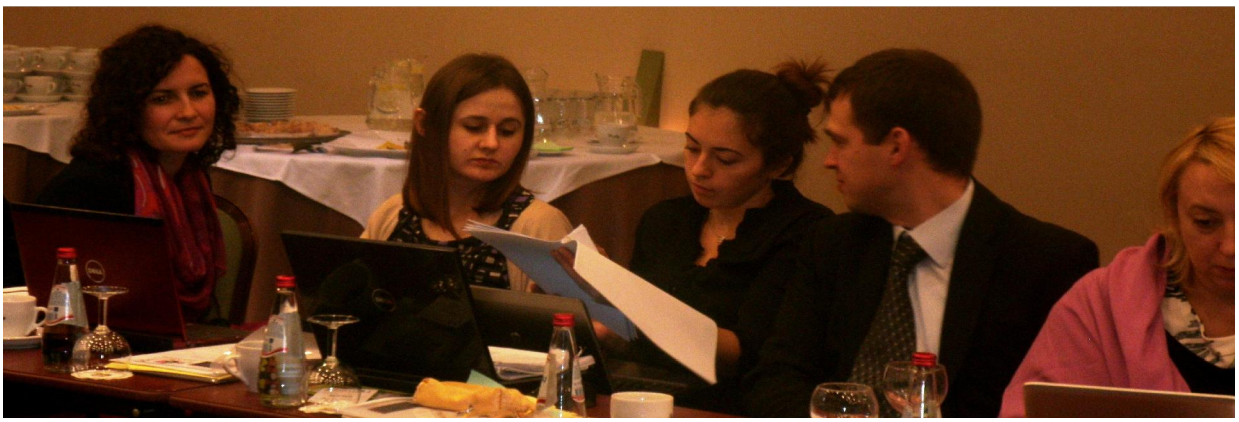

THE INFORMAL DISCUSSIONS








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