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The recent health reform in Croatia: True reforms or just a fundraising exercise?

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ABSTRACT

Croatia's most recent reform of the healthcare system was implemented in 2008. The aim of the reform was to enhance financial stability of the system by introducing additional sources of financing, as well as increase the efficiency of the system by reducing sick pay transfers to households, rationalising spending on pharmaceuticals, restructuring hospitals etc. This paper attempts to assess the success of the 2008 healthcare system reform in reaching financial stability and sustainability, and to evaluate the effects of the reform on equity in funding the system. It takes into account the fact that the reform coincided with a severe economic crisis and decline in the overall living standard of Croatian citizens. The paper shows that the reform ended up being expansionary and thus impaired the necessary fiscal adjustment. Finally, it is argued that in circumstances of declining disposable incomes, increased co-payments aimed at the financial stabilisation of the health system made health services less affordable and could have had detrimental effects on equity in the utilisation of health care.

1. Introduction

This paper represents an attempt to assess the economic consequences of the healthcare reform that was enacted in Croatia in 2008. The reform was initiated in response to a series of healthcare reforms that had taken place in a relatively short period of time, but were largely unsuccessful in fulfilling their main goal – the financial stabilisation of the healthcare system. The 2008 reform was similar to the previous reforms in a sense that it also leaned much more towards increasing revenues than containing expenditures. However, it differed from the reforms implemented in 2002, 2005 and 2006 in that it was more comprehensive and rigorous and, therefore, might have had better chances to meet its goals.

In the first section, the paper gives a short overview of the Croatian healthcare system prior to 2008. The second section lays out the main elements of the reform. In two of the sections that follow, the paper presents the results of the evaluation of the reform's effects on the financial stability and sustainability of the healthcare system as well as on equity in funding the healthcare system. The last section summarises the findings and gives recommendations for further reform steps, accordingly.

2. Croatian healthcare system prior to 2008

A number of studies on the main characteristics of the healthcare system just before the beginning of the most recent reform argued that the effectiveness of the Croatian system, as measured by metrics such as life expectancy at birth and infant mortality rate for instance, was satisfactory considering the level of Croatian income and health expenditures per capita [1–4]. However, the studies also pointed out a number of weaknesses with respect to organisation, financing and spending within the public healthcare system [5–9].

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Constant deficits of the healthcare system were caused by both insufficient revenues and a lack of control over expenditures, brought about by inefficiencies in both the demand and supply sides of the system. The main cost drivers were excessive consumption of health services and pharmaceuticals, generous sick leave programme, complex structure of health institutions, as well as hospital and primary care mechanisms that did not promote efficiency, contributing to the constant growth of health expenditures. The deficits they created in the system were not so obvious since the financial imbalances were reflected either in a rising stock of payment arrears or in one-off measures like massive hospital loss assumptions by the state, which occurred almost on a yearly basis [10].

In the period leading up to the 2008 reform, the World Bank and independent economists proposed different measures aimed at resolving the accumulated problems in the healthcare system. In addressing financial stability, the World Bank recommended raising more funds from private sources by increasing co-payments and stimulating funding through private health insurance [3]. National economists and health economists emphasised the need to diversify sources of financing towards less reliance on payroll taxes but, unlike the World Bank, they also recommended apportioning a larger part of general tax revenues to health system financing [11,12]. In either case, the recommendations did not envisage any increase in total health spending and instead proposed changes in the composition of health revenues with a view to establishing a stable financing base, lowering the tax wedge and limiting the excessive demand for health services.

3. Main elements of the recent healthcare reform

In 2008, the former Ministry of Health and Social Care announced a new health reform and started to communicate its main elements to various groups of stakeholders. The launch of the reform coincided with the outbreak of economic crisis so it was promoted and perceived as part of the Government's antirecessionary package. However, in many respects, the health reform just added fuel to the fire. Due to relatively unfavourable initial fiscal and current account positions, the appropriate response to Croatia's cyclical downturn was fiscal consolidation rather than discretionary fiscal relaxation. The health reform, which was expansionary by its nature since it required more money from general taxation, made fiscal consolidation almost impossible.

The goals and basic elements of the reform could be discerned from the presentations available online on the web site of the Ministry of Health and Social Care but, unfortunately, there was no well-elaborated strategic document to back the reform. Still, based on public communication, it is safe to conclude that the reform that started in 2008 was quite ambitious and comprehensive and that it intended to address many of the deficiencies of the health system. The reform encompassed a wide set of measures aimed at the financial stabilisation of the system by introducing new and additional sources of financing, exercising better control over the main cost drivers and initiating some other operational improvements (see Table 1) [10–14].

Measures aimed at assuring abundant and diversified financing were the most evident part of the reform. Unlike all previous health reforms, which were less courageous in shifting a higher proportion of health financing to the citizens, the recent reform increased obligatory out-of-pocket health financing. According to some unofficial and unpublished *ex ante* assessments, additional financial resources for the healthcare system brought about by the reform were expected to reach some HRK 5 billion. Out of that amount, 25% would be paid out-of-pocket and through a new levy on revenues from insurance against car accident liability, whereas 75% would be covered by the state budget. According to the actual data for 2009, the reform resulted in some HRK 4.4 billion revenues that would not have been collected otherwise. The distribution of additional burden differed, however, from the projected one since the rise in revenues was distributed equally between the out-of-pocket payments (together with the revenues from the new levy) and the state budget [13].

The scope of the population exempt from paying co-payments was considerably reduced and co-payments were increased to a certain extent. For a majority of services, the insured were required to pay 20% of the full price of medical care but no less than the prescribed minimum amount whereas before the reform, co-payment rates ranged from 15% (applied to the most common types of medical care) to 50% of the full price. Since having supplementary health insurance was the only way to avoid paying co-payments, the number of persons who bought supplementary health insurance went up, which caused an unprecedented rise in supplementary health insurance revenues. Supplementary health insurance revenues amounted to around HRK 500 million in 2008, and soared to HRK 1.650 million in 2009 [13]. At the same time, supplementary health insurance premiums that had previously been set at a flat-rate amount of HRK 50 per month for all insured persons were now set at different rates, ranging from HRK 50 per month for pensioners with net pensions below HRK 5.108 per month, to HRK 130 per month for insured persons with net wage or income above HRK 5.108 per month [16].

Another revenue enhancing measure was the broadening of the scope of persons liable to pay compulsory health insurance; apart from employed persons, a 3% health insurance contribution became obligatory for pensioners whose pensions exceeded the average net wage. Persons whose pensions fell below the average net wage also became liable for paying a 1% health insurance contribution; however, this contribution was supposed to be covered by the state budget.

In addition to the broader size of population liable to compulsory health contributions and increased out-of-pocket payments, the reform also envisaged additional health financing from a newly introduced levy on revenues from insurance against car accident liability, which was specifically earmarked for health from general taxation. With the beginning of 2009, it became obligatory for the Government to allocate a defined amount of money raised through taxes to health financing, pertaining to the mandatory health insurance and supplementary health insurance of certain groups of citizens (pensioners with pensions