

Privatization and Payments: Lessons for Poland from Chile and Colombia

Thomas Bossert, Ph.D.
Senior Political Scientist
International Health Systems Group
Harvard School of Public Health

March 2000

The information used in the article was partly supported by the Data for Decision Making Project of the Harvard School of Public Health under a Cooperative Agreement (DPE-5991-A-00-1052-00) with United States Agency for International Development and the Colombia Health Sector Reform Project on contract with the Government of Colombia and the Inter-American Development Bank (Contract Number 001/95).

The opinions expressed herein are those of the author and do not necessarily reflect the views of the U.S. Agency for International Development or the Inter-American Development Bank.

Abstract

Poland is involved in a process of health sector reform that has changed payment mechanisms and privatized many of the services. The government also anticipates introducing competitive private insurance plans in two years. This article reviews the experiences in health reform in two countries, Chile and Colombia, which have had considerable experience in similar health sector reforms, to draw lessons from their experience for health reform in Poland. This is the English version of the article submitted for publication in Polish in the journal, *Zdrowie i Zarządzanie*.

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1. Poland's Reforms

Poland has created a new social insurance mechanism that replaced the direct government payments to public providers with a universal social insurance system implemented by regional and branch insurance agencies. It also allows public funds to flow to both public and private providers through contracts between them and the insurance agencies. The public providers have gained considerable management autonomy through the Health Institutions Act and in some cases municipal governments, who are the owners of the public facilities, have transferred them to private entities for the provision of service. There are also future plans to allow competitive private insurance plans to enter the market.

The initial implementation of the Health Insurance Law has been fraught with difficulties, some of which have to do with the normal problems of implementing a complex and wide ranging reform. However, the difficulties also suggest the need to reconsider some of the policies, especially the plan to allow private insurers to enter the market.

2. Chile and Colombia

It may seem strange to use two Latin American nations, with long histories of democratic governments and capitalistic economics as a source for lessons for a Central European nation that is experiencing a transition from communist political and economic systems. However, there are significant similarities between these countries and Poland. Their economic levels are quite similar, indeed Chile's GDP per capita of US\$4,810 in 1998 was higher than Poland's US\$3,900. All three economies are based in large measure on agricultural production but have also experienced growth through emerging new technologies. All three countries also share a culture influenced by Roman Catholicism. More to the point, the Latin American countries, like Poland, had a health system dominated by public sector providers funded directly from government revenues by means of planned budgets and rigid salary scales. Like Poland, however they have found that these systems were increasingly inefficient, inequitable, and of poor quality. The private sector was seen by many patients as an increasingly attractive alternative, even though it involved significant out of pocket payments. Growth in informal gratuity payments in Poland reflect a similar market phenomenon.

Chile and Colombia underwent a considerable history in health reform, having initiated their reforms in the 1980s and early 1990s which allows us to review their experience for lessons for the implementation of reform in Poland. These experiences suggest what to avoid in payment mechanisms, warn us about risks of two-tiered systems, suggest options for transition in funding for public providers from budget to contracts and offer ideas on regulation of new mixed insurance systems

State-Run Chilean Health System 1950-1980

Prior to its reforms in the early 1980s the Chilean Health System was dominated by a National Health Service, a large single public system of providers: hospitals and primary health care clinics. (Castañeda, 1992) This system was financed by a social insurance agency for "white collar workers" (SERMENA) and by the public budget for "blue-collar" and indigent. White-collar workers were allowed some choice of private physicians. Blue collar workers and the indigent could only use public facilities unless they paid out of pocket. From its origin in the 1950s through to the early 1970s, the system had relatively high standards, relatively equal access and relatively equal per capita primary health care allocations to districts and municipalities. However, in the 1970s the system faced a significant decline brought on by political upheaval and military dictatorship which reduced public financing to the sector substantially.

Chilean Health Reform in 1980s

In the 1980's, driven by ideological commitment to market solutions, the dictatorship initiated the creation of a private insurance system with competitive private plans called ISAPREs (*Instituciones de Salud Provisional*). One of the objectives of this reform was to create a substantial market for private health providers and the ISAPRE reforms, which eventually covered around a quarter of the population, did

foster a rapid expansion of private providers to serve these private insurance beneficiaries. The new system allowed salaried employees to "opt out" of the social insurance pool and take their 7% salary contribution to private plans. The reforms also transferred primary health care facilities to the municipalities. Initially the reforms involved a fee-for-service payment to the municipal primary care providers, based on a nationally defined price list.

Problems in Chilean Reform

The fee for service payment system for primary care resulted in an explosion in budget costs. (Casteñeda, 1992) Municipal providers quickly realized that they could gain funding by providing higher priced interventions. The delivery of services soon was significantly distorted by these perverse incentives. This occurred even though physicians were still paid salaries and did not individually benefit from the incentives, but who probably would benefit from better working conditions that higher facility budgets would provide. To control the resulting cost explosion, the government soon had to resort to impose budget ceilings on each municipality, in effect restoring historical budgeting for public sector services and ending any potential to use the payment mechanism as incentive for promoting efficiency.

At the same time the growth of private insurance schemes lead to a two tiered system. The ISAPREs offered plans that only 25-30% of the salaried employees could afford to with their 7% salary contribution. ISAPRE members on average received more than a third more funding as did public sector clients. (Larrañaga, 1997; Bitran and Almarza, 1997) The ISAPREs were probably "cream skimming" — selecting a lower risk pool of patients and leaving the more costly patients to the public system. Risk selection is well known in other competitive private insurance systems such as in the US where it has been found that 20% of the sickest patients absorb 80% of the costs. An insurance plan that can identify those costly patients, and is able to keep them from joining their plan, will be able to reduce its liabilities and increase its profits.

However, even within the private insurance system, the lack of any benchmark uniform package, and a requirement of an income-related premium of a fixed percent led to considerable inequities in benefits packages among those in the private sector. In addition, the cost escalation in the private sector appears also to have pushed up public sector costs as public facilities competed for physicians and other inputs. Despite the higher expenditures in both public and private sectors, beneficiaries expressed growing dissatisfaction with both systems. (Horowitz, 1993) Public beneficiaries were unhappy with their services even though major new investments had been made in the public sector. ISAPRE members were unhappy with the restrictions and uncertainty in the private system. At the same time, ISAPREs became one of the most profitable investments on the Chilean stock exchange. (Aedo and Larrañaga, 1994) These insurance companies and their parent conglomerates also became significant new political actors who strongly defended their lucrative status and effectively resisted the imposition of new regulations.

Lessons from Chile for Poland

A clear lesson, that has been apparent in many other countries, is the importance of avoiding a fee-for-service payment mechanism for primary health care facilities. Even though the physicians in Chilean primary care clinics had no individual financial incentive to respond to the fee for service mechanism, they rapidly increased the number of higher priced services. However, it may also be important to avoid returning to payment mechanisms similar to historic budgets. Historic budget ceilings, unlike prospective payment mechanisms, do not provide incentives for efficiency. This is important because many of the contracts between insurers and providers in Poland are based on the same hospital bed day calculations that had been used previously for budget allocations and are similar to historic budgets.

A second lesson is a caution that the private competitive insurance system that is scheduled to be implemented is likely to produce a two tiered system, with the beneficiaries of private plans having significantly higher levels of services and expenditure than the public insurance system. This outcome is particularly likely if, as anticipated, employees will be able to "opt out" of the social insurance scheme and take their contributions with them to private plans. Furthermore, the private insurance entities probably

will be able to find ways to reduce their risks — shifting the high risk and high cost cases to the public sector and making significant profits.

Chile also shows that private insurance does not necessarily bring political benefits from beneficiaries. Even the private insurance plans did not generate significant patient satisfaction because patients were unhappy with restrictions and with inequalities perceived in the private system. On the other hand, Poland should beware of the growing political power of new insurance companies and impose strong regulations early, because it will be harder to do so when they are established.

3. State Dominated Health System in Colombia

Colombia began its reforms in the early 1990s, later than in Chile. Prior to the reforms, Colombia also had a centralized public system, theoretically available for all but actually covering only 40-60%. It also had a separate social insurance system — ISS (*Instituto de Seguros Sociales*) that covered about 20% of population. Household surveys showed that 20% of the population had no access to formal health care. There was also a large and growing number of private sector providers that many patients used, even though the out of pocket payments were high. Many who were covered by the ISS also used private providers and paid out of pocket rather than use the ISS facilities. Both the public and social insurance schemes united payer and provider functions since they each had separate provider systems paid by a direct budget transfer.

Colombian Health Reforms in 1990s

The Colombian health reforms were designed to promote "managed competition" among competitive public and private insurance plans. The insurance entities included the dominant ISS and 29 other plans that were public, private for-profit, cooperatives and non-profit plans. (Cuartas, 1998) Most of the larger for-profit plans were owned by foreign insurance companies, including Chilean firms.

The system involved the establishment of a universal social insurance scheme with two benefits packages. (Colombian Ministry of Health, 1994) One package, called the "Contributory Regime" since it was for members who had contributed a portion of their salary, covered almost all services. A universal insurance fund (FOSYGA) was created to pay insurance entities a risk adjusted premium for these services. The risk adjustment was based on the age and sex of the insurance agency's risk pool. The second package was called the "Subsidized Regime" which contained a limited package — mainly maternal and child health care — which received a risk adjusted premium initially about half the value of the premium of the "contributory regime."

Payment of the premium followed the patient to public and/or private providers who had contracts with the patient's insurance company. Patients were supposed to be offered a choice of at least two providers. Over time the government budgetary funding to public providers was scheduled to decline as funding was shifted to the insurers of the "subsidized regime".

Problems in the Colombian Reform

Colombia experienced a variety of problems with the implementation of this scheme, some of which are not particularly pertinent to Poland. They had difficulty enrolling around a third of the population that was not in formal sector employment. This is less of a problem for Poland where most of the workforce is enrolled in insurance plans.

The Colombian system does not seem to have been able to significantly increase efficiency in public facilities and to change their management practices. This was to be achieved by competition between public and private providers. However, there were significant difficulties in the transition process as payments shifted from direct public subsidies to premium payments to insurers — creating confusing signals and some "double dipping" by public facilities. The ability of the public hospitals to retain direct

subsidies and public payment of "deficits" has decreased the incentives to compete with private providers and does not appear to have produced the anticipated improvement in efficiency. Furthermore, many rural areas did not have sufficient competition among providers, reducing the incentives for improving quality and efficiency. This lack of incentives for public providers suggests the difficulty of changing organizations that have been dependent on budgets.

Other problems emerge from the design and implementation of competitive private insurance schemes, especially to reduce risk selection. As noted above, insurers have an interest in avoiding having sick patients in their risk pool. At the same time, patients who know they are sick have an interest in being covered for their health care needs. These two phenomena (risk selection and "moral hazard") combine in ways that shift the more costly patients to the plans least able to select — usually the public plans. These plans, however, will have higher costs per covered patient. Unless there is a mechanism to adjust the premium for the higher cost patients, the insurers who have selected low risk patients will get the same premium as the plans which have the higher cost patients and will profit, while the other plans may face bankruptcy. However, it is extremely difficult for regulators to design a risk-adjusted premium. The risk adjusters of age and sex explained only 3% of the variation in risk among insured in pools that were examined by a study done by Harvard School of Public Health. (Colombia Health Sector Reform Project, 1996). It is likely that insurance entities that have access to data on other factors, especially medical histories, are able to select the less costly patients. If a plan has information on who has had a heart attack, or cancer, it can try to remove these patients from the plan. There are many ways plans can do this: by not renewing at the time of re-enrollment, by increasing premiums, or by providing poor quality for high cost services and encouraging patients with these health problems to enroll in other plans. The result is that high-risk patients are shifted away from the private plans and toward either the public providers or the largest public insurer, the ISS. While the private plans may generate significant profits, the institutions caring for higher risks may face significant financial strain.

In addition, the calculations that produced the premium for the limited package of benefits in the subsidized regime were difficult to estimate and appear to have been too generous. Poor patients have been using the services much less than was estimated so that the costs of treating these patients appears to be significantly lower than the premium. (Cuartas Nieto, 1998) This high premium has been an incentive for private insurers to enroll many poor patients. While this has resulted in widespread enrollment of the poor, a benefit to the system, it also is likely not to be sustainable in the long run as these patients learn to use the services more.

A second important problem in Colombia has been the high cost of administration and publicity imposed by private competition among insurers. A study of two private insurance plans showed that these costs equaled between 15 and 25% of the premium. These costs are similar to those found in the US and are much higher than administrative costs in systems without competitive insurance plans. If an objective of competition is to increase efficiency, it will have to increase the efficiency of the use of inputs at a greater rate than these additional costs — a difficult task.

Lessons for Poland

As Poland shifts to contracting between insurers and public providers it needs to develop contracting mechanisms that require competitive incentives and encourages competition between public and private providers in order to obtain the anticipated efficiency benefits and quality improvements from the new system. Public providers who are guaranteed budgetary support through insurance contracts will not have incentives to improve their efficiency or quality.

Poland should reconsider the opening of insurance to private plans. If private plans are able to select patients with low risk for health problems, they will be able to reduce costs and profit from the premiums, leaving the rest of the system with higher cost patients. The Colombian case, as in the US and other competitive insurance markets, shows that it is extremely difficult to create a risk adjusted premium that significantly reduces incentives for risk selection.

Competitive insurance markets will also likely increase the administrative and publicity costs of the system, making it harder to contain costs and increase efficiency.

4. Regulating Mixed Markets

Both Chile and Colombia faced the need to establish institutions to regulate the private insurance market. Although both had long established Ministries of Health, these institutions did not have adequate capacity to regulate markets. (Bossert et al. 1998) They were established mainly to finance and operate public facilities. As such they lacked appropriate information and skills in analyzing markets, analyzing risks, monitoring incentives, designing regulations, and following the political process of changing laws and regulations. To perform these tasks the Ministry has high requirements for information and analytical skills and needs a strong enforcement capacity. Without a strong regulatory body, both public and private sectors will take advantage of their unfair market advantages unless regulators are highly skilled and have appropriate powers to level playing field. The experience of regulators in Colombia, Chile and the US to keep ahead of entrepreneurial insurance companies suggests the multiple difficulties. Adequate use of sophisticated regulation is necessary to adjust incentives and provide administrative rules to reduce risk selection, assure that insurance plans remain solvent, encourage the creation of competitive markets and to assure that public health objectives are also achieved.

In order to respond to this need, both Chile and Colombia created separate regulatory agencies, called *Superintendencias*. These entities developed some of the skills necessary for monitoring the insurance entities but in both countries, they lacked effective information systems, sufficient analytical skills in market analysis, were unable to develop appropriate new regulations, and often lacked enforcement capacity.

If Poland is to develop a competitive private insurance market it will have to develop the appropriate regulatory institutions. It will need extensive information on many detailed aspects of the markets; it will require highly skilled analysts, strong political skills and strong enforcement capacity.

5. Conclusions

This brief review of Chile and Colombia suggests several general conclusions for Poland. Poland should carefully reconsider the problems of introducing competitive private insurance plans. It will be difficult to avoid the creation of a two tiered system in which the private beneficiaries have access to more and better care. Furthermore, it is difficult to avoid risk selection by private insurers, who could gain significant profits, while leaving the higher cost risks on the public insurers. Finally, competition among insurers is likely to increase the administrative and publicity costs and to add these costs to the system at a time that priority should be given to reducing costs.

Secondly, Chile and Colombia suggest the need for contracts between insurers and providers to have carefully designed payment mechanisms. Poland should avoid historic or planned budgeting (like paying for a specified number of bed days) which do not have incentives for efficiency. Poland should also avoid simple fee-for-service payments without mechanisms, such as DRGs, for providing incentives to restrict costs.

Thirdly, as a mixed public and private market emerges among providers, and especially if the competitive insurance market is created in the future, then Poland must develop a strong regulatory capacity. Strong regulation in health markets is necessary to assure a level playing field for competition and to develop appropriate incentive systems to assure quality, equity of access and efficiency.

Finally, the introduction of a private system does not necessarily translate into broader public support for the new health system. In both Chile and Colombia public opinion has expressed dissatisfaction with both public and private systems. However, the creation of new insurance organizations, with important financial links to other interest groups, does create new political forces that may pose obstacles to future regulation.

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