Costing healthcare services in Central and Eastern Europe as a management tool: Between content and context

Jonila Gabrani[1], Adriatik Gabrani[2]

[1]Institute of Public Health, Tirana, Albania;
[2]Faculty of Public Health, University of Medicine, Tirana, Albania.

Corresponding author: Jonila Gabrani M.Sc., Institute of Public Health;
Address: Rr. "Aleksander Moisiu", No. 88, Tirana, Albania;
Telephone: +355696561891; E-mail: jonila11@yahoo.com

The rising costs in healthcare

Crosswise Europe, the healthcare system is scarcely figuring out how to cover its costs. Not only are the fundraising methods not adequate, but, of even greater concern, the costs themselves are set to rise. As per World Bank figures, public expenditure on healthcare in the European Union (EU) could hop from 8% of GDP in 2000 to 14% in 2030 and it is foreseen that they will continue to grow afterwards (1). The major concern of Europe's healthcare sector is to find ways and approaches in order to balance budgets and limit spending. Unless that is carried out, the funds to pay for healthcare will soon fall short of demand. The budgetary meltdown is continuously brought on by two interdependent trends: the ageing of the population and the parallel increase in the burden of chronic diseases (1). These budgetary troubles are being aggravated by the rising cost base of medical technologies.

The cost issue in Central and Eastern Europe (CEE) is of a particular concern. The healthcare situation in the CEE countries, which had deteriorated at the beginning of transition, has clearly been improving since 1995-1996, even though it remains below the EU standards. The shift toward Bismarck's model, however, has raised new problems. After having undergone a severe adjustment at the beginning of transition, health budgets as well as prices for medical services and medicines have risen sharply in the majority of these countries (2).

The initial reforms failed to increase accountability and incentives to limit costs, i.e. the decentralization of hospital management has already begun, but this decentralization has often passed on the financial burden to the local authorities. Lastly, medicine expenditure has had a significant boost (for instance, more than 10% per year in the Czech Republic over the recent period; while in Poland, the percentage of medicine expenditure within the total health expenditure increased from 23% in 1994 to 29.5% in 1999, as against 17% in the UK and 13% in Germany) (3).

This perspective urges for a broad discussion and agreement regarding a survival strategy for Europe's healthcare systems. Policymakers have probably foreseen the forthcoming challenges to European healthcare for some time. Therefore, many countries have attempted to take action against the effects of the global financial slowdown through extensive reform of their respective healthcare sectors and systems. However, none of these efforts has yet

proved successful, despite the engagement of the best and most acclaimed thinkers on the field of healthcare systems (1).

Costing: the basic management tool towards setting strategies

Economic evaluation in general and cost-effectiveness analysis (CEA) in particular, has gained acceptance in recent years as a very important policy tool in decision-making at all levels (4-6). At a broader worldwide level, cost-effectiveness analysis turned into a more noticeable tool for policy making after the publication of the 1993 World Development Report (7) and its companion volume on Disease Control Priorities (8). Even through the CEE lens, economic appraisals are being considered as basis for decision making in health systems (9).

A wide spectrum of international datasets on costs or prices of health care services already exist (10-12). Probably, the most aspiring dataset and set of estimations is the one adapted by the Global Program on Evidence for Health Policy of the World Health Organization (WHO) (13).

This effort, named WHO-CHOICE, began in 1998 with the development of standard tools and methods. Also, this marks the first systematic attempt to assess unit costs at both patient and program level for health interventions in all countries and regions of the world. This enables to generate costs per unit that are not only consistent between different interventions within one country, but also permits for comparisons across countries with comparable determinants, such as socioeconomic factors and background epidemiology, as well as estimating the cost of scaling up interventions to different coverage levels by varying capacity utilization. One of the most important findings from this work is that costs per unit of many health-related inputs vary significantly both between and within countries. This brings to the conclusion that relying cost-effectiveness studies for a region or country on the study results of one single facility, or even a small group of facilities, is very likely to be misleading (10,13,14). The expenditures on producing the service are clear, but the actual cost of producing that service is less so.

Who will appraise what, to whom, and how?

There are various studies which indicate the actual costs of providing health care services in developing country settings. However, most of the time these are not representative nationwide, deal usually with a limited number of interventions, or use different methodologies for the calculation of costs (14).

The sound reforms will never be thoroughly scaled up unless consolidating health information systems, adapting the cost methodologies and foremost empowering healthcare human resources with the necessary trainings to appraise the economic evaluations across systems. Currently, the socio-economic status of health professionals in CEC countries remains very poor compared to the EU member states, wages are still low and training is often considered inadequate. Though there have been efforts towards continues education systems, there is a lack of competencies among economists, able to perform economic appraisals; hence, the necessary data to perform these appraisals is often unavailable, albeit traces of spare information prove their existence (15-18).

The "quasi utopia" of pan-European intervention plan

Failing to develop a consistent action plan is associated to deep-rooted problems in the healthcare system. First of all, the system is both very vast and fragmented. Moreover, participants are unmanageable, looking after their self-interest whenever possible. Practitioners struggle for continued freedom of action to prescribe medications and treatment regimes. Conversely, other professionals in the health care sector seek to elevate their own status and acquire some of those rights themselves. Health care industry is striving to protect its investment. Payers are determined on spending less. In general, patients believe that their public healthcare system is not delivering all the benefits it could, despite increasing costs (1). Yet, regardless of these barriers and difficulties, almost everyone agrees that universal and egalitarian healthcare coverage is the right goal to strive for, and that a way must be discovered to deliver on that commitment by sustainable means. Healthcare systems across Europe

may be imperfect and financially unbalanced, but they are still appraised for the promise they offer—that is *"all can count on a medical safety net at an affordable cost"* (1).

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References

1. The Economist Intelligence Unit Limited; The future of healthcare in Europe; A report from the Economist Intelligence Unit by 2011. http://www.janssen-emea.com/sites/default/files/The-Future-Of-Healthcare-In-Europe.pdf.

2. World Health Organization (2009). How can health systems navigate through difficult economic times? New report documents countries' measures to respond Copenhagen, (14 September 2009) http://www.euro.who.int/en/media-centre/sections/press-releases/2009/09/how-can-health-systems-navigate-through-difficult-economic-times.

3. French Economic Mission for Enlargement report. Health care systems in Central and Eastern Europe; Federation of European Accountants; January 2010. http://www.euractiv.com/enlargement/health-care-systems-central-eastern-europe/article-110420.

4. Morris S, Devlin N, Parkin D. Economic analysis in health care. London, Wiley publishing, 2007.

5. Mauskopf J, Rutten F, Schonfeld W. Cost-Effectiveness League Tables: Valuable Guidance for Decision Makers? PharmacoEconomics 2003;-21:991-1000.

6. Drummond MF, Sculpher MJ, Torrance GW, O'Brien BJ, Stoddart GL. Methods for the Economic Evaluation of Health Care Programmes, Oxford University Press; 2005.

7. The World Bank, Logan Brenze. Selecting an Essential Package of Health Services Using Cost-Effectiveness Analysis. A manual for Professionals in Developing Countries, 1993. http://www.-hsph.harvard.edu/ihsg/publications/pdf/No-5.PDF.

8. Jamison DT, Mosley WH, Measham AR, and Bobadilla JL. eds. Disease Control Priorities in Developing Countries. New York: Oxford University Press; 1993.

9. Wenzel H, Hysa B. Economic Appraisal as a Basis for Decision Making in Health Systems; Health Systems and their evidence based. A Handbook for Teachers, Researchers and Health Professionals; 2004.

10. Adam T, Evans DB, Murray CJL. Econometric estimation of country-specific hospital costs. Cost-effectiveness and Resource Allocation, 2003;1:3. http://www.resource-allocation.com/content/1/1/3.

11. World Health Organization. Expanded Programme on Immunization: Costing guidelines. Geneva, World Health Organization, 1997 (unpublished document EPI/GEN/790/5).

12. Shepard DS, Hodgkin D, Anthony YE. Analysis of hospital costs: a manual for managers. Geneva: World Health Organization; 2000.

13. Edejer TT, ed. Making choices in health: WHO guide to cost effectiveness analysis. World Health Organization, 2003.

14. Mulligan J, Fox-Rushby J, Adam T, Johns B, Mills A. Unit Costs of Health Care Inputs in Low and Middle Income Regions, DCPP Working Paper No. 9; 2003.

15. Mulligan J, Walker D, Fox-Rushby J. Economic evaluations of non-communicable disease interventions in developing countries: A critical review of the evidence base, Cost Effectiveness and Resource Allocation; 2006.

16. Aikins M, Fox-Rushby J, D'Alessandro U, Langerock P, Cham K, New L, Bennett S, Greenwood B, Mills A. The Gambian National Impregnated Bednets Program: Costs, consequences and cost-effectiveness. Social Science and Medicine 1998;46:181-191.

17. WHO- Evidence and Information for Policy, Department of Human Resources for Health, Improving health worker performance: in search of promising practices Geneva, September 2006.

18. Gulácsi L, Orlewska E, Péntek M. Health economics and health technology assessment in Central and Eastern Europe: a dose of reality. The European Journal of Health Economics 2012;13(5):525-531.