Health Care Options for Polish Municipalities: The Implications of International Experience

Marc Roberts
Professor of Political Economy and Health Policy
Harvard School of Public Health
Boston, MA 02115

Thomas Bossert
Senior Research Policy Specialist
Department of Population and International Health
Harvard School of Public Health
Boston, MA 02115

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I. Introduction and Overview

The following paper, which explores the possible roles of Polish municipalities in the newly emerging health care system, is divided into four parts. The first briefly reviews features of the recent Polish health care experience. The second describes certain international trends that are likely to have an impact on the Polish situation, and hence, on the options municipalities confront. The third section is the heart of the effort. It provides an overview of various roles Polish municipalities might play in a reorganized health care system, and analyzes the advantages and disadvantages of these in light of international experience. The final section discusses practical steps the municipalities might take to secure an appropriate role for themselves.

Several conclusions emerge from this analysis. First, in all industrial nations, the problems of operating and managing health care systems are likely to become more challenging in the years ahead. This is because an increasing demand for services will collide with limited fiscal resources. As a result, Polish municipalities will face difficult choices about what role to play in the health care system. On the one hand, assuming a larger role may allow municipalities to ensure that legitimate social goals and local needs are met, particularly as there are no other sub-national units of government with democratic accountability and broad scope of responsibility. Such a greater role, however, also means that cities could confront significant financial and managerial responsibilities that may overtake their organizational capabilities. Their response, therefore, will have to be designed with some care in order to reap the benefits while avoiding some obvious pitfalls. Third, and most importantly, different localities are quite likely to devise different compromises between goals and burdens. Thus, there is good reason to allow in local governments significant discretion about the roles and responsibilities they assume within the health care system. This is clearly not a situation in which “one size fits all” will be the appropriate answer.

II. Background

Certain unique features of the Polish health care system have to be taken into account when considering options for a municipal role in that system. First, during forty years of Communist rule, many Poles viewed state institutions – including those providing health care – as not fully legitimate. A long history of partition and occupation has given rise to the widespread view that the "Polish nation" is not the same as whatever formal state authority happens to exist at any one time. Founded in violence and with a relatively small Party cadre, the Communist regime and its institutions commanded little loyalty or respect among the broad population. Thus, during that regime, there was widespread willingness to subvert its formal structures – as well as a strong desire to change them as quickly as possible.

This lack of legitimacy for formal state institutions should be of continuing concern for municipal leaders. For perfectly valid political reasons, such leaders may not want to position themselves as the defenders of the past when it comes to health care reform. On the contrary, there is every reason for such leaders to consider how taking an active role in health care can strengthen the legitimacy of local governments and signal a meaningful departure from past practice.

Second, under the communist regime, local and regional governments had relatively little autonomy, authority, or administrative capacity. Like the Napoleonic prefecture system on which it is modeled, the voivod structure represents the central government. Thus, unlike Norway, Sweden, or Germany (where "county" or "state" governments exist), Poland does not have a set of legislative and executive organizations, with a strong regional political basis, between the local scale and the national scale.[i] The problem this poses is that at least some municipalities may well be too small (in size and population) to efficiently serve as the basis for integrated health care services. In Scandinavia, for example, the countries – which are quite a bit larger than most cities – are typically responsible for hospitals, while the municipalities operate public health and outpatient services.[ii] This is one way to overcome the problems of small local communities.

The eleven recently created regional health insurance authorities (which will have elected boards)[iii] would seem to be a partial response to this dilemma, as well as a way of trying to separate and protect health care financing from the budget stringency of recent years. However, it is not clear how effectively these new arrangements will provide for democratic accountability at the regional level. In general, experience in other countries suggests that special purpose elections (like those for representatives of health care beneficiaries to the new authorities) attract less attention among the general public, and hence are more easily dominated by interest groups, than are general elections. Any relatively narrow issue, like health care, is less important than overall government policy to the voting public. Whether these new entities will be able to overcome these difficulties, and function as effective regional representative institutions, remains to be seen.[iv]

The problem of scale in providing municipal services has, of course, not gone unrecognized in Poland. Experiments with having the poviats carry out some functions have been undertaken for exactly that reason. The more recent experience with special local service zones is directed at the same problem.[v] There apparently is significant interest around the country in the creation of additional zones, which could be the focus for a municipal role in health care where municipalities are smaller in size.

The legislation creating new regional health insurance agencies does not provide for any specific role for municipalities. Instead, it envisions that the boards will create their own district offices.[vi] Nor is it clear what form the new contractual relationships between the boards and health care providers will actually will take. This is a crucial question for municipalities since the risks and opportunities of taking different roles in the health care system will be heavily influenced by how providers are paid. For example, will hospital payment be in the form of a global budget as has been widely used in the past in Scandinavia?[vii] Will it be on a per-diem basis, as in past Austrian

and German practices?[viii] Will it be on a per-admissions basis (some form of DRG's)[ix] -- a scheme many European countries are now moving toward? The same questions arise on the outpatient side where the choice between capitation (paying primary care doctors an annual fee for all individuals in their "panel" as in the U.K.)[x], fee-for-service (as in Germany and France)[xi], or simply having doctors on salary (as in some parts of Norway)[xii], has not yet been made.

Compounding the complexity of the municipality's choices is that in recent years, many of Poland's largest municipalities have assumed operating responsibility for some parts of the health care system. Under the old system, the voivod directly distributed budgets to health authorities (the ZOZ's) that in turn operated both inpatient and outpatient services. Under the Large Cities Law, the 46 largest municipalities have taken over outpatient clinics and in a few cases, some hospitals also have been municipalized, e.g., Lodz.[xiii] This experience has apparently been mixed – with some municipalities having difficulty coping with the financial and managerial burdens involved. This is a cautionary tale that municipalities need to bear in mind as they consider their own future role.

Historically, the Polish health care system was financed by centralized budgets, with services provided by salaried practitioners. This structure created a set of incentives and a set of practices in response to those incentives. These realities also must be taken into account as municipalities decide what to do next.

Given the budgetary system, most hospitals have had relatively weak administrations. Money flows were much the same from year to year – with predictable allocations down to the departmental level. There was no need for the fiscal, marketing, and strategic functions that American hospitals rely upon to operate in competitive markets. In addition, with senior appointments under the effective control of the chief physician of the voivod, patronage and influence often played a role in such decisions.[xiv] This has also been true for junior appointments where department heads have (and continue to have) great power. This means that improving the operation of the health care system will not be easy. For that system lacks much of the managerial capacity and organizational culture that is needed to provide flexible, efficient care.

In addition, under the current system, compensation has not been closely tied to either effort or productivity. As a result, incentives for efficiency and service have not been strong. In response to the decline in physician incomes in the last ten years – as governments struggled with budget problems -- a widespread system of bribes and gifts has arisen to ensure preferred access and special care – especially in the hospital setting. These so-called "envelope payments" range from substantial money payments to department heads to ensure care and/or attention, to gifts of money, liquor, or flowers to nurses and junior staff once a patient has been admitted to the hospital.[xv]

"Envelope payments" are not the only money flows that are outside government control. As doctor salaries have declined, practitioners have been motivated to do whatever they could to defend their deteriorating economic position. As a result, it is not unusual for doctors to hold more than one, supposedly full-time, appointment in order to keep up their incomes. In addition, many operate private practices after hours in order to generate added revenues.[xvi] Often, it is only through such devices (plus the "envelope payments") that physicians have been able to maintain their living standards.

But this pattern also makes reform of the delivery system more challenging – whether undertaken by the municipalities or by anyone else. Real financial flows (private practice income and envelope payments) are substantial and quite different from official fiscal patterns. Any attempt to reform the system will have to accommodate the incentives that these flows generate – whether by bringing them inside the system, establishing alternative incentives or leaving them undisturbed. However, any attempt to incorporate the income generated by private practice and informal payments into the formal, public financing system would create a very substantial fiscal burden since quite a lot of money would be involved. On the other hand, the existing

arrangements are a burden on the families of patients and can easily produce quite uneven care among people at different income levels and with different degrees of sophistication. Thus, there are serious reasons for not leave existing practices intact.

Moreover, the existing system does lead to a variety of counter-productive incentives. As long as primary care physicians are on salary, and inadequate salary at that, they have every reason to do as little as possible. This fact, together with the prestige structure of both the Polish medical community and the attitudes of the general population (which highly values seeing a "specialist") helps explain why the vast majority of primary care visits end in a referral.[xvii] This is true even for those conditions that could just as well be treated by the initial doctor. Moreover, the specialists who get the referral have every incentive to convince the patient to come to their private practice, and/or give the most attention to those who offer the largest "envelope payments."

Yet, for all the complexity and contradictions of the existing Polish health care system, there does not seem to be a great public outcry for reform. Municipal leaders have to consider this also in deciding what to do about their role in the newly emerging arrangements. In particular, many other urgent problems require the attention of municipal executives. The country is still struggling to decide what assets are the property of local governments and what rights of sale and disposal such property rights will convey. Whole areas are up for debate, from local taxation, to the electoral laws, to local government boundaries, to the scope of local government activities.

On the other hand, from the point of view of citizens' well-being, health care is one of the most important activities for government. While the administrative problems confronting the Polish system are substantial, there are no other obvious organizations that already exist to carry out the reform task; no insurance companies or health maintenance organizations as in the U.S. Nor are there any other sub-national organizations with effective democratic accountability. Cities, in contrast, do have an electoral base, and can be a useful vehicle for reflecting local concerns in health care decision-making, including the need to protect important social priorities like access for the poor. Given these conflicting considerations, municipalities need some strategic vision if they are to participate in health care reform in an intelligent way. Such a strategic vision needs to be informed, not only by the Polish trends we have just reviewed, but also by some larger understanding of international developments that are likely to be manifested in the Polish experience in the next several years.

III. Worldwide Trends and Problems

As Poland becomes increasingly integrated into the world economy, worldwide economic and political trends are likely to increasingly influence its health care system. In turn, these will shape the dilemmas that Polish municipalities will confront in deciding what role to play in that system.

One of these trends which is prevalent everywhere is steadily increasing health care costs.[xviii] This trend has several causes. First is the continued development of new technology. Although technology could be – and sometimes is – cost reducing, the current economic and professional rewards strongly favor the development of expensive new techniques for doing the previously unattainable.[xix] Second, the population is aging – in part due to the very success of the health care system. The so-called "failures of success" dilemma means that many individuals now live to consume substantial amounts of health care who, in earlier days, would have died sooner and less expensively. Since older people use more health care, this demographic shift significantly raises per capita health expenditures.[xx] Third, there is an increased demand for health care. This is due to increases in both income and expectations. Economically, health care is a "luxury" good -- a good whose demand rises faster than incomes. Rich countries (and rich individuals) tend to spend a higher proportion of their income on health care than their poorer counterparts.[xxi] Continued economic growth in Poland will thus tend to increase the demand for, and spending on, health care. In addition, the spread around the world of a youth-oriented, media-driven, consumption culture also tends to increase the demand for quality and quantity of life enhancing health care.

Even as the pressures for greater health care spending increase, almost everywhere the capacity of governments to finance that spending out of the public treasury is decreasing. International economic competition, in recent years, has made economic growth difficult for any nation to sustain. Each country's products have to compete with those from a host of other nations. And since price (and hence labor costs) matter in this competition, there is a restraining force on the level of employment-based taxation that can be devoted to the financing of health care. In addition, slow GDP growth means a slow growth for all public sector revenues; since broad-based taxes generate increased revenue only to the extent that the economy grows.[xxii]

International capital markets also impose fiscal discipline on governments – limiting their ability to respond to revenue shortfalls with deficit financing. The threat of international capital flight, the actions of currency speculators, and pressures from international lending institutions, all contribute to this restraint.[xxiii] As a result, Poland will have to deal with its health care financing problems in a context that significantly limits its budgetary room for maneuvering.

As industrialized nations struggle to constrain health care costs, many also have begun to confront a general trend toward decreasing social solidarity – as manifested by a shift toward the political right in many nations. This trend manifests itself as increased pressure from elites for multi-level system health care – with "safety valves" or "escape hatches." Such schemes allow the economically advantaged to enjoy services that are superior to those provided to most citizens; even if they have to spend their own funds to do so. The recent growth of private sector hospitals and supplemental insurance funds in many European nations reflects just this trend.[xxiv]

It is difficult to understand exactly why this development has occurred at this time. In part, it may be a response to slow economic growth – which can lead to disappointed expectations and selfishness. In part, it may be a response to the economic failures of Eastern European socialism, when contrasted with the economic success of England and the U.S., (not to mention the East Asian "Tigers"). But when Tony Blair, the new socialist Prime Minister of the U.K., can be hailed as the heir to Margaret Thatcher (even as many see Bill Clinton as the heir to Ronald Regan), something is clearly happening. The growth of extreme conservative leaders (from Le Pen in France to Hydar in Austria) is part of the same pattern. What all this means for Polish

politics is difficult to predict. The French, after all, have just voted for solidarity over flexibility. But any Polish municipality contemplating a role in health care cannot be sure that the national government will necessarily underwrite any and all financial commitments local governments might make. Similarly, municipalities will have to be prepared to respond to growing pressures for privatization in health care and for allowing the rich to make their own arrangements, if they take up a key role in health care delivery.

This shift to the political right can also be seen around the world in a major shift in attitudes toward the public sector. The failure of state enterprises to be competitive and efficient in both Eastern and Western Europe has lead to a widespread enthusiasm for privitization everywhere between the Irish Sea and the Urals. Direct budgetary controls are "out" and quasi-markets and various associated incentive schemes are "in."

Moreover, incentives and markets often do seem to work. Long waiting lists at Swedish county-run hospitals decreased dramatically when patients were given the right to go out-of-county for their care; and take their funding with them.[xxv] And while it is too early to fully evaluate, the British quasi-market system -- that separates purchasers from providers in the National Health Service -- also appears to have had some positive consequences. The new quasi-autonomous hospital "trusts" do seem to be more responsive to G.P. "fundholders" (who can shop on behalf of their capitated patients) than hospitals were to their patients under the previous scheme.[xxvi] There is also the U.S. experience, where fierce competition in insurance markets has lead to competitive price shopping by insurance companies and a noticeable decline in the rate of growth of health care costs.[xxvii] Clearly then, any scheme municipalities may devise will also have to respond to these trends and pressures.

In response to these developments, there have been changes in the health care systems of many industrial nations. As cost pressures have increased, health care managers have had to become more sophisticated. Accounting and medical records systems are becoming more complex, and increasingly are computer-based. Ideas from Total Quality Management in industry are being applied to both inpatient and outpatient services in pursuit of the twin goals of higher quality and lower cost. Increasingly, health care executives are not just well meaning former medical practitioners, but individuals with significant management training. Consequently, municipalities will have to think carefully about how to take on the task of providing such sophisticated management if they are to play a constructive role in a reformed Polish health care system.

A cautionary word is also in order however. While incentive schemes can increase efficiency and managerial discipline, they also have their own problems. Market-oriented providers tend to look aggressively to see which services generate revenues greater than their costs. And as cost constraints become more severe, providers will seek, or indeed will be forced to provide, only those services that are paid for at favorable rates. In the U.S., for example, many hospitals are increasingly trying to find ways to avoid providing care to those who are uninsured. Some physicians refuse to take those low income patients whose care is paid for (at relatively low rates) by state Medicaid programs.[xxviii] The less money there is in the health care system, the more ruthless providers become, and the more we can expect them to respond to every variation in the price signals we provide.

Given this heightened sensitivity, if the price-setting process is not sophisticated, incentives can easily be created that distort provider behavior. For example, when we pay hospitals a fixed daily rate, they tend to keep patients longer. If we pay a set amount for each admission, hospitals tend to discharge patients sooner. Thus, every payment system creates its own incentives.[xxix] Austria historically paid its hospitals by the day, and their health policy analysts now complain that Austrian lengths of stay are much too long. U.S. hospitals are paid by the admission (the so-called DRG system), and here, patients complain that they are sent home too soon. Similarly, U.S. specialists have historically been paid on a fee-for-service basis, and as a

result, U.S. patients get more tests and more surgery than those in any other country in the world.[xxx]

This suggests that whoever winds up providing care in the revised Polish system will have to be prepared to deal with the conflicts that are likely to arise between economic incentives and social goals. Being financially successful may require different behavior than doing the best for the public's health. It also suggests that municipalities need to ask themselves whether they should accept some continuing responsibility for attending to social goals as the system evolves. There always is a risk that some patients will be hurt by the transition to a market-based system.

Finally, it is important to note that around the industrialized world, municipalities have addressed these dilemmas in a variety of ways. For example, some municipalities in Germany have sought to give up ownership of their hospitals. By turning them over to independent corporations, they hope to avoid having to pay when costs go up faster than revenues. In the U.S., some municipal hospitals, like those in Philadelphia, have simply been closed. In San Diego, the county hospital was sold to the local medical school. Selling hospitals is just what the Mayor of New York wants to do with that city's very large public hospital system. For these cities, as central governments seek to control their own health care spending, the risk of being caught between diminished funding and rising expectations seems too great to bear.

In other cases, municipalities have sought to isolate public hospitals from some of the bureaucratic constraints and political pressures that being fully a part of the public sector implies. On the one hand, these changes are designed to increase managerial flexibility. In Vienna, for example, a quasi-autonomous entity now runs the city's hospitals, with substantially more budgetary and procedural freedom than its predecessor, which was simply a city department.[xxxi] Such arrangements, under the control of an independent board, can insure more professional management. In many countries, including the U.S., patronage, inefficiency, and even simply corruption can all too easily occur when health care institutions are operated in a way that is too closely connected to local politics.

At the same time, efforts to insulate public sector health care from political processes can do harm as well as good. Freed of political accountability, providers can become a "wolf in sheep's clothing" -- a market-responsive profit maximizer with little concern for public purposes. At least one municipality in the U.S., Deming, New Mexico, turned its hospital over to an independent corporation and now wants it back because the new operator was so socially irresponsible.[xxxii]

These are some of the worldwide trends that allow us to partially foretell what some of the pressures are likely to be like in the Polish system in the years to come. How might Polish municipalities respond to the problems and opportunities these pressures are creating?

IV. Alternative Roles for Polish Municipalities in Health Care

Given all the fiscal risks and administrative difficulties just reviewed, one option for cities is to take only a *minor role* in the health care system. This could involve one or more components. First, around the world, many public health functions are carried out by local authorities. These range from restaurant inspection to water and sewer services to disease vector (rodent and insect) control. Municipal governments are often perceived as having the detailed local knowledge and the on-going relationships with citizens that facilitate carrying out of these activities.

There are also more narrowly defined clinical activities that, in many municipalities, for various historical reasons, are carried out in public health facilities. Such functions include vaccination, clinics for the treatment of sexually transmitted diseases, and control and treatment of selected infectious diseases. In some municipalities, one or more of the following are also done by local government: ambulance services, school health clinics, or family planning services.

As a part of this public health role, municipalities can also play a major role in health promotion and disease prevention. Municipalities have an advantage in performing this function because of their varied multiple areas of responsibility and authority. Effective preventative efforts often involve just such a mix of different functions. For example, efforts to lower alcohol abuse can include law enforcement to prevent drunk driving; education about alcohol abuse, which includes using the schools; and taxes, to raise prices to discourage consumption. And cities are well positioned to carry out just such multi-faceted campaigns. Moreover, compared to the national government, they are better able to respond to variations in local culture, attitudes, disease patterns, and health risks.

Whether various Polish municipalities will choose to undertake some of these functions will, no doubt, depend in part on funding patterns, as well as on the role taken by the voivods. But, assuming that funding is available, many local governments around the world carry out these functions successfully – and find that doing so meets with the approval of local citizens. They are not especially difficult technically or complex managerially, and can provide clearly visible benefits.

A second, less traditional role municipalities could play is to focus on various regulatory and information functions. Let us suppose for a moment that new regional health insurance funds do create a somewhat competitive system in which the “money follows the patient,” and various providers strive to attract patients to their services. Citizens then will confront much wider and more confusing choices than they do today – where most individuals now simply utilize the closest public facility and/or the one in the ZOZ in which they live. Could municipalities then play some role in order to help these new markets function more effectively? Could or should they undertake any regulatory, information, or enforcement functions?

One role would be to produce simple guides to the available local practitioners, their training, location, hours, fees, specialization, etc. More extensive reporting – on performance, quality, complaints or disciplinary actions –might be possible for the more sophisticated municipalities. Beyond information, there are also regulatory possibilities. Should all clinics meet certain standards? Should any advertising be regulated for content? The new insurance agencies might well carry out some regulatory functions, but they also might leave some role open to municipalities.

Insofar as municipalities have the technical capacity, there is something to be said for such activities. As markets develop, consumers will be relatively inexperienced with choice in health care. They might well appreciate a reliable source of information as well as some regulatory protection. Do note, however, that such a role does run the risk of putting local governments into conflict with physicians and other providers -- who are likely to prefer not to be regulated. Also,

it would be hard for local governments to act as credible sources of information and regulation if they also act as providers in the system.

Some local leaders might want to play a more extensive role in health care than suggested by the options already discussed. Perhaps they see an opportunity to make a contribution to citizen's well-being, a contribution that could also have political value. Perhaps local leaders also want to increase the functional responsibilities of local elected governments as part of the task of building up local democratic institutions. Functions left to the voivod, after all, are left in the hands of appointed officials with only very indirect channels of local political accountability. Moreover, the scope of local government activities is not unrelated to a local political leader's base of political support.

In that connection, it is worth noting that if a municipality is concerned about taking a role in prevention, there is an argument for also taking a role in the delivery system. The best preventative efforts combine "primary prevention" – efforts to prevent individuals from getting sick, like getting young people to not smoke – with "secondary prevention" – efforts to prevent disease from getting worse or recurring, like getting people to give up smoking after a heart attack. Obviously, secondary prevention often relies on the delivery system. But so too does primary prevention – as in vaccinations, annual checkups, and efforts by doctors to get overweight patients to lose weight. So a full spectrum prevention effort, at minimum, requires close coordination between health care and public health activities.

In situations where local officials do want to play a larger role in health care, municipalities face two broad alternative roles. These are the *wholesale/intermediary* function and the *provider* function. We will discuss the *provider* option first, because that will allow us to develop some categories and distinctions useful for the rest of the analysis.

Municipalities in Poland that are considering acting as a provider of health care can see a wide variety of examples as to how that role is undertaken by cities around the world. We propose to discuss this experience in terms of four dimensions: 1) managerial control, 2) fiscal independence, 3) market share, and 4) scope of services.

Around the world, municipal health services are organized in ways that range from those that are simply a part of municipal government; to intermediary cases where cities exercise some, but limited, control of their health care providers; to situations where cities have given up operational control almost completely. Examples of direct government operation are to be found today in Norway and Sweden, where local hospitals and clinics are run by municipal and county governments.[xxxiii] This is exactly what the Large Cities Law could lead to in Poland. In the U.S., many municipalities and county governments have directly provided outpatient care – not to everyone, but only to the poorest segments of society -- through clinics staffed by county employees.[xxxiv]

However, there is an international trend away from having health care facilities be simply a part of local government. As mentioned earlier, the Vienna municipal hospitals were transformed from being a part of local government to being a quasi-autonomous agency with more budgetary flexibility. Actually, in Austria, hospitals are not generally operated by localities, but by regional, (i.e., state), governments. Vienna is so large that it is both a city and a state, and so it does operate its own hospitals. Many city hospitals in the U.S. also were transformed in the 1980s from municipal departments to entities with some independence – including those in Boston and New York. The new British system of hospital trusts also affords semi-independence to former National Health Service hospitals. The new trusts are subject to global controls on financial performance and capital investment – while retaining substantial internal managerial discretion. The trend toward greater autonomy for local health agencies is easy to understand. As long as they are a regular part of local government, health care agencies become entangled in the purchasing, personal, and budgetary control systems of the governments that run them. These can be very cumbersome – making it difficult to make decisions, hire and fire personnel, and in

general, manage effectively. One way to understand the movement for organizational reform is that it is seeking a position for health care that is analogous to the legal position of some state-owned enterprises in Western Europe.

Ironically, these same institutions can also become subject to pressures to provide exactly the kind of political patronage such controls were designed to prevent. For example, a study of Boston City Hospital revealed it had higher costs than any other comparable hospital in the city. This was because of a large number of non-clinical employees (cleaners, gardeners, laundry workers, etc) – the result of efforts by managers to provide employment to friends of local political figures.[xxxv]

Thus, if Polish municipalities want to take on the role of operating health care institutions, they would be well advised to pay careful attention to the design of the relevant management structures – where the Viennese, British, and American experiences can all provide some guidance. Some degree of separation from local government seems worth exploring. While there are no detailed studies, talks with experienced managers suggests the greater flexibility of such arrangements can make possible both greater efficiency and lower cost. One option would be to make the executives of each institution responsible to a Board of Directors. This might be composed of representatives of patients, employees, and the general government. Such a board would, in turn, have to approve major budgetary, programmatic, and personnel decisions.

This has long been the position of municipal hospitals in Germany, for example. In some cases, hospitals are even governed by their own special purpose political bodies – rather like the new regional health insurance agencies being established in Poland. Tampa General Hospital, in the U.S., is run by such an entity (the Hillsboro County Hospital Authority).[xxxvi] On the other hand, the existing pattern of patronage in Polish health care organizations also implies that there can be risks from allowing them too much independence.

Creating the right balance between independence and accountability will not be easy. To deliver good service, health care managers will have to be broadly knowledgeable about both clinical issues and techniques for providing services efficiently. They will have need to be supported by a reasonably sophisticated cost accounting and management information system that allows the analysis of resource commitments and outputs in some detail. And there will have to be personnel systems and policies that provide for merit-based hiring, promotion, and rewards. And all of this is surely easier to write about than it is to deliver in practice.

The ultimate step for a municipality is to move its health care activities totally outside the scope of government. Many German local governments in recent years have done this to avoid any fiscal responsibility for hospital losses – turning their facilities over to independent corporations.[xxxvii] In the U.S., Richmond, Virginia did the same with its local hospital.[xxxviii] Florida acted similarly with a major teaching hospital, Shands Hospital, at the University of Florida in Gainesville.[xxxix] That institution now has its own board of directors and a distinct legal status separate from state purchasing and personnel systems. It is also financially independent.

Perhaps the clearest example of fully independent health care organizations, which are nonetheless closely connected to local government, are the numerous examples in the U.S. of local governments supporting independent outpatient clinics that in turn provide services to target populations. Examples here include the neighborhood health centers in Boston, Denver, and San Diego. Such clinics get reimbursed from a variety of public and private insurance schemes – and also get funds directly from local governments on a contract basis. Each of these organizations typically has its own board of directors and complete managerial and fiscal autonomy.[xl] At the same time, these clinics have a deep dependence on fiscal and programmatic aid from local government.

The second dimension along which municipal health care systems vary, is fiscal responsibility. This can vary from the city assuming complete fiscal responsibility to various forms of shared obligation to a complete lack of fiscal connection. Moreover, fiscal responsibility itself has two

different dimensions – operating costs, and capital costs. And responsibility for one does not necessarily imply responsibility for the other. While the fiscal characteristics of a city's health care activities are often determined in parallel to its degree of managerial control, the two, in principle, and sometimes in practice, can vary independently. For example, many quasi-autonomous municipal health agencies in the U.S. remain the ultimate fiscal responsibility of local governments. With regard to operating costs, such governments have to make up any difference between expenditures and revenues, where revenues include payments from a variety of private, state, and national reimbursement systems.[xli] And while local government hospital's capital costs are typically financed by issuing bonds -- the same approach used by most private hospitals -- often the city itself is the ultimate guarantor of these bonds.[xlii]

A very different example is provided by Norway, where county governments directly operate the hospitals. In practice, those governments are not really responsible for hospital operating losses. Instead, habitually, the national government makes up such shortfalls – albeit only after some service cutbacks and confrontational behavior by hospital managers.[xliii] And as in most of Scandinavia, construction funds come from the central government directly. A similar pattern emerged in the U.S. last year when the national government arranged various ad hoc grants and programs, totaling nearly $500 million, to prevent Los Angeles County Hospital, and the county itself, from going bankrupt.[xliv]

An even more exaggerated pattern of lower level fiscal non-responsibility, is seen in Argentina. The local governments habitually run out of money before the end of the year and hold up the provincial and national governments for special subsidies to allow services to continue. This is especially common for those municipalities that directly operate substantial clinic and hospital services, since health care costs are likely to create serious fiscal difficulties.[xlv] (The extent of local government health activities varies widely.) Indeed, the provinces, which have their own elected governors and legislators, often play exactly the same game with the national government.[xlvi]

A critical aspect of any shared financial relationships is *which unit* of government is responsible for any annual shortfall. In Sweden and Denmark, the national government gives the local governments block grants for health care based on each area's population and its socio-demographic characteristics. But local governments also contribute and have to make up the difference when problems arise.[xlvii] Unless political and institutional traditions mean that national governments will act in the event of a serious local fiscal crises, this is a very risky position for a municipality.

Around the world, there are many forms of mixed fiscal responsibility – of sharing between local and federal governments. In Finland, that burden used to be shared, but the Hiltuner Reforms shifted the counties to capitated payments from the national government – and made them fully responsible for any cost overrun.[xlviii] This was done exactly to impose fiscal discipline and limit national government financial risk. Another example of shared fiscal responsibility is the U.S. Medicaid system, which pays for the care of various specified categories of low income citizens. Medicaid costs are shared by the states and the federal government. Both are responsible for an overrun in roughly equal shares, depending on the state's income level.[xlix] And for the same reasons that lead to changes in Finland, fiscal conservatives in the U.S. have advocated shifting funding from the current formula to block grants since that would make the states fully responsible for all cost overruns.

In both the German and Austrian "dual," financing systems capital and operating costs are handled quite separately. In Germany, operating costs come from the insurance funds. Capital costs come from the "lander" – the state governments – and are quite tightly controlled.[l] Such controls help explain the relatively low costs in Germany and Scandinavia because this is one way of controlling the diffusion of cost-increasing new technology. As a result, high tech devices in Germany (e.g., radiation therapy machines) tend to be used more intensively than their U.S. counterparts.[li]

Now, much of the cost impact of high technology is not from the cost of the machine itself, but from the cost of the people who operate it. Studies in the U.S. suggest that for a CT scanner, the machine cost is only 10% to 20% of the overall cost to the system. But that only reinforces the point that controlling capital investment is a good way to control system costs. This is why in the U.S. for many years there were regulatory limits (again, at the state level) on health care capital investment. These "Certificate of Need" Laws have, however, been largely repealed in recent years in the face of our enthusiasm for market solutions.[lii] In contrast to this, England allows new hospital trusts to borrow for capital purposes – but only up to external financing limits set by government. And they are supposed to pay interest to government as a return on the capital they were given when they were established.[liii]

One clear lesson from international experience is that some cells of the matrix of fiscal and managerial control are much more attractive than others, at least to local governments. High control and low fiscal responsibility is obviously easier to deal with than low control and high fiscal responsibility. The latter is a position to be strenuously avoided – especially at a time when money is in short supply everywhere in the public sector. And yet, that is exactly the situation that could prevail in Poland in the next several years.

Cities that want to operate health care facilities will also have to consider what scope of services they want to provide. The Vienna municipal system, for example, provides a very broad array of both acute and long-term (nursing home) care – and its hospitals also operate large outpatient clinics.[liv] Swedish county governments and Finnish municipalities are responsible for an even broader array of health and social services – although some of these are provided by independent practitioners on a contract basis.[lv]

The scope of services Polish municipalities seek to provide might well vary with the size of the city. Smaller cities may not have a sufficient population to support the most specialized, high technology care. Many particular medical conditions are quite unusual in a population sense and yet, to be properly treated, the care team should see quite a few cases in order to develop and maintain expertise. This leads many nations to have regional or even national centers to care for specific conditions. Indeed, the smallest rural areas may be too small to even support basic hospital services, or the more specialized forms of outpatient care. It is for this reason, for example, that smaller Finnish municipalities combine to operate a single board of health to which the communities all elect members based on their relative sizes.[lvi] Again, for Poland, the question of using the poviets or local service zones might be an answer here. What we do know is that outpatient care and long-term care are less technically demanding and can be effectively provided to smaller populations than more elaborate inpatient activities. Municipalities with smaller populations, less extensive managerial capacities or more modest ambitions might well want to focus their efforts on those kinds of care. On the other hand, the largest municipalities might well want, and be able, to offer more comprehensive services.

Even within the outpatient sector, municipalities might want to focus their activities on those areas or functions of particular social concern in order to ensure effective access for all. This would mean leaving most health care to someone else, but keeping some specialized activities. Pre-natal and maternity care, well-child care, control of infectious diseases, supportive care for the old and disabled (physically and mentally); these are all activities that might be given special priority by a public system concerned about solidarity and social justice.

In that context, municipalities that limit themselves to outpatient care will confront the fact that much of that care is now provided in the outpatient clinics of hospitals. If those hospitals remain on the voivods' budgets, there will be a continuing temptation for locally financed clinics to refer patients, and hence transfer costs, to those hospital-based services. In the process, both the efficiency and continuity of care could be diminished. Thus, municipalities that do limit themselves to non-hospital care might want to consider whether they should also assume

responsibility for the budgets, and the functions, of at least some of the hospital-based outpatient specialty services that are provided within their boundaries.

Finally, municipal systems will vary in their market share. In the U.S., most municipal hospitals in large cities are only one of many in their market and hence, are only 10% or less of health care volume. At the other end of the spectrum, the Scandinavian local government systems and Vienna system have very high market shares.[lvii] In the U.S., public hospitals in smaller communities may be the "only game in town" and have a monopoly except for those who travel for care elsewhere. When it comes to outpatient care, fewer municipalities have a monopoly position. Many European countries rely for some of their outpatient care on independent practitioners who are paid on a fee-for-service basis, even if that payment comes via local governments as in Sweden. Yet, the municipalities also operate some of their own clinics. A similar role of local government, as one of several competitive providers, is developing in California. Under the new form of the state's Medicaid program – called Medical -- the larger counties that operate their own clinics and hospitals are competing for patients with various private health maintenance organizations.[lviii]

When it comes to market share, international experience provides mixed signals to Polish municipalities. One the one hand, having a monopoly makes the system easier to operate – because there is no competition for patients and revenues. On the other hand, it also would focus all complaints for poor service on local governments.

And with the history of private practice by state doctors in Poland, establishing a public monopoly of all outpatient services would not be easy to do. Moreover, the British and Swedish experience suggests that it is not easy to make a monopoly system really efficient and customer friendly. Thus, municipalities might want to allow themselves to be one-among-several providers. Cities that do try to establish a comprehensive system should also consider ways to get providers to compete. For example, by creating competition among ZOZ's or even individual clinics. By tying money to patients, and allowing patients to choose where to get their care, quasi-market arrangements might avoid some of the efficiency-destroying properties of a purely monopolistic system.

The alternative major role municipalities might play in health care is as an *intermediary* or *wholesaler*. For example, a municipality could try to act as a managed care intermediary in the way that many U.S. HMOs operate. This would involve accepting capitated contracts from the regional insurance authority in return for providing (or buying) services for some (or all) of its citizens. Depending on what services it operated directly, the city could then contract with various independent providers for some (or all) of the care for those in its plan. This is one way to understand the Swedish countries' role. They directly provide hospital care and some outpatient services and pay independent physicians on a fee-for-service basis for the bulk of outpatient care – while being responsible for everyone who lives in their geographical area. Moreover, much of their funding comes in the form of capitated payments (age and sex adjusted) from the national government.[lix] There have also been efforts to create similar payor/provider separations in Finland. There, the subsidies that used to go directly to health care providers now go to municipal governments, who in turn pool them via regional agencies to pay for health care; along with some of their own funds.[lx]

It is worth noting that the wholesaler/intermediary role involves the municipality mastering somewhat different skills from the direct provider role. As an intermediary, the municipalities will have to become skilled at writing, negotiating, and monitoring the implementation of contracts – not in the actual operation of facilities. However, if they choose the intermediary role, they will have to confront the question of who do they contract with? Is it the ZOZ's? Or those agencies without their hospital component? And if a ZOZ gets into financial trouble, who is responsible? Are they still units of local government, and a municipal responsibility? Or are they truly on their own?

This question, in turn, raises the issue of how a municipal intermediary will deal with the effects of patient choice, and a "money follows the patients'" contracting system. As several Swedish countries discovered, such a scheme is likely to produce both winners and losers -- as patients and resources flow to some and away from others. Then the county was faced with whether or not to let some provider institutions shrink – or disappear -- even as others grew. Experience all around the world suggests that the prospect of closing a hospital or clinic can generate enormous political pressure. Employees, patients, and local political leaders all argue for keeping the facility open and urge that there be special subsidies to do just that. Thus, a city trying to use incentives to enhance efficiency should be prepared to deal with the complaints and problems effective incentives will produce.[lxi]

It is far from clear whether or not an intermediary role will be available to the municipalities. The new regional insurance authorities may well see the task of system organization and contracting as their own. On the other hand, they may be overwhelmed and welcome the change to pass some of the burden of dealing with actual providers on to local governments. And when it comes to fulfilling such a function, the municipalities do have the significant advantage of being both local in scope and politically accountable. They also are closer to the people and have some more general administrative experience and capacity, as well as more experience with health care than some newly created organizations.

We have learned from the U.S. experience that for an intermediary to be able to bring about cost savings, several conditions must be met. First, the buyer of care must represent enough individuals to be a real force in the marketplace. Second, there must be more than one seller, so that a buyer can demand price concessions, and back that up with the credible threat to go elsewhere if the seller does not offer lower prices. Third, the intermediary does need a good deal of sophistication about the medical care process – to know what care is worth buying and at what cost.[lxii] Thus, the intermediary role is likely to be most attractive to larger cities with substantial technical capacity and whose health care systems are extensive enough to offer a number of alternative providers for the city to choose among.

V. Making Choices and Making Choices Possible

There are two clear implications from our discussion thus far. First, municipalities could, in theory, play a wide variety of roles in the Polish health care system – at least if the experience of other industrialized nations is any guide. Second, the decision about what role to play is not an obvious one. A municipality's managerial capacities, its experience with health care, public satisfaction with the existing system, the decisions of the new regional insurance authorities; all of these are likely to vary from place to place. And all are relevant to the choices to be made by a responsible municipal executive.

Our role is to provide municipality leaders with information about options, about their advantages and disadvantages. In considering these choices therefore, we believe there are a few cautionary points to bear in mind:

- Municipalities should be cautious about assuming the ultimate fiscal risk for the health care system in their area unless they have reliable mechanisms for raising the needed revenue – for example, reliable inter-governmental transfers, and/or effective local taxing authority.

- Poland's health care system is far from optimal and substantial opportunities for rationalization and cost saving exist. But these can only be realized if the existing compensation, payment and patronage practices are reformed.

- Achieving cost savings will require substantial managerial sophistication, administrative leadership and political will. Transitional costs, in the form of unhappiness and disruption will be substantial. Gains, in the form of better service and efficiency, will take some time to materialize.

- There are social and political gains and losses from both action and inaction. Even if existing institutions lack legitimacy, their employees and managers will not necessarily embrace change.

- Smaller municipalities may be too small to act on their own and need to use local service zones as a basis for assembling a large enough population to organize an efficient system.

There are also a set of considerations that should encourage municipalities to take a more active role in the health care system. Doing so will not be easy, but cities do have some major advantages that should not be overlooked.

- The Pilot Cities Program and the Law of Large Cities have given some local governments substantial experience with health care. They know many of the problems and have begun to develop the personnel and systems to overcome these. Even if they don't have all the skills they might like, there are no other entities in the system with more skill. There are no insurance companies, health plans, or hospital chains that can do a better job.

- With a broad scope of functional responsibilities, cities are well equipped to undertake multi-focal prevention programs. Furthermore, if prevention activities are to be integrated with curative health care, cities are the entity in the best position to effectively manage that full set of functions. But doing this integration means undertaking either the provider or the intermediary role.

- Cities are the only subnational entity with real democrative accountability. This makes them especially well-positioned to respond to variations in local attitudes, values, and problems. Because they are accountable, they are also best able to set priorities inside the health care system in the way that reflects citizens' preferences.

- Cities are in a position to defend a broad set of social values – beyond just efficiency – as the system develops. They can act as a counter-weight to revenue-seeking providers to ensure that emerging markets and quasi-markets do not get off track. They can seek to make sure that the least articulate, aggressive, and sophisticated, the most ill and disabled, are not left behind by entrepreneurial medical managers.

- Cities have to realize that there are alternatives to just taking over and operating the existing system. By allowing the developing private market to provide some services, municipalities can try to direct the resources now flowing through envelope payments and private practices, thereby supplementing public funds. By encouraging competition, and quasi-market arrangements that involve at least semiautonomous providers, they can produce improved efficiency without the burden of direct management. The challenge is to be creative and to allow and learn from the experiments and variety that will result.

One clear common goal for all municipalities does stand out however. They all have an interest in being able to shape their own role as the health care system changes. They all have reason to think hard about the existing legal framework – and to work for its reform to create the room for maneuver they might like to have in the future. Even municipalities that do not now expect to immediately take a major role in health care have every reason to support such changes. First, they will serve as a precedent for recognizing the autonomy and capacity of local government as other issues arise in the years ahead. Allowing for experimentation will also teach all municipalities about what approaches work well and badly -- knowledge that will benefit all. Finally, assuring flexibility now will allow cautious municipalities greater options in the future should they then want to undertake a larger role.

VI. National Decisions About Local Government Roles

Of course, the municipalities do not come to the health policy debate in Poland in a vacuum. Instead, their arguments and analyses will have to be couched, not just in terms of their own interests – but in terms of the national decisions that will have to be made about what role to allow local governments. And from a national perspective, there are various advantages and disadvantages to allowing (or requiring) some decentralization of health care decision-making.

- The broader the area over which money is raised, the easier it is to redistribute from richer to poorer areas. Purely local financing reinforces local economic inequality – as the whole debate in the U.S. about local versus state funding for primary education illustrates.[lxiii]

- Centralized control over capital investment makes planning and rational capacity expansion easier. On the other hand, it risks embedding health care decision-making in processes of political coalition building and favoritism.

- Regionalization of financing and provision can solve some boundary problems. For example, if urban centers have sophisticated facilities, then residents of rural areas will find it appropriate to utilize these. But if urban areas receive no funding for such "cross-over" treatment, they are likely to resist providing such care. Within a regional system however, care responsibilities and resource flows can be balanced appropriately. However, if the regions are too large, they can become too distant from local concerns. One possible way to balance these concerns is to build on the poviets' experience of the special service zones.

- Decentralization in general may enhance both responsiveness and accountability. Smaller areas may effectively respond to patient concerns and public opinion, and to variations in local conditions and problems.

In most industrial countries, these considerations have led national governments to give local governments a significant role in health care. Do note, however, that those local governments may actually be regional – for that is the best way to understand the Scandinavian systems.

In fact, around the world, four patterns are distinguishable:

- **Mandated**, local government role – Norway, Sweden, Finland, and Denmark *require* all local governments to play a major role in health care.

- **Optional** systems allow local governments to have substantial discretion, both in what role to play in health care, and how to play it. This is the U.S. situation.

- **Constrained** systems allow some limited role for local governments, but give them relatively limited discretion. Instead, their role as provider is tightly constrained by the national health care system. Germany, Austria, and Canada have this system.

- **Excluded** in some countries, local governments have little involvement in health care. Instead, there is a purely national system. The U.K. and Australia are examples, as was the Polish system until recently.

In effect, we hope Polish municipalities will consider urging their government to create what we have called an ***optional system*** in which a variety of roles for local governments will be possible. Under such a scheme, municipal governments would be neither required nor forbidden to fulfill certain functions. And they would have substantial discretion as to how to carry out those health functions that they do choose to undertake.

VII. Next Steps For The Municipal Associations

In the months ahead, the new Polish Parliament is likely to have to grapple with the ambiguities and inconsistencies in the major health reform legislation passed last year. It is both legitimate and desirable for Polish municipalities – and their representative associations – to play a significant role in this process. Local governments have much at stake in how the reform effort progresses, and substantial experience with how the health care system operates, which it is useful to all to have them share.

To develop their own strategy, the associations should analyze their political situation, their own power and develop sufficient consensus within and among the associations so that they can have a reasonable chance to change the laws and regulations. This means that they need to know what they want, and how to go about getting it. Developing this strategy will be difficult since there are many divisions within the associations – those among rural, suburban, and the larger urban centers being the most evident. There is the added problem that health issues are not terribly salient to the associations – since there are so many other fundamental issues of local governance still to be addressed.

As they proceed, the associations should look at their task as both *technical* and political. The technical task is one of identifying the best options. The *political* task involves identifying what it would take to influence the process that is establishing the laws and regulations governing the health sector.

The following steps constitute one way the municipal associations might proceed:

- Attempt to reach consensus among the Municipal Associations on what are viable and acceptable options that all (or most) can agree to support:
- Decide whether to agree on one or several options. We think it likely they should choose to favor several options for both technical and political reasons.
- Decide how making a range of options available can overcome internal differences among the various kinds of municipalities.
- Review the laws and regulations (especially the Insurance and Institutions Laws) to establish what needs to be changed and what opportunities there are to change them.
- Develop a political map of the key stakeholders in the system to determine who are the important players, what positions they are likely to take, and what an overall coalition of supporters (and opposition) might look like.
- Develop linkages with other key stakeholders in order to make that coalition a reality.
- Develop a strategy for mobilizing the supporters and neutralizing the opponents in order to achieve the desired legal and regulatory changes.
- Develop a lobbying strategy through existing contacts between associations and other stakeholders to influence the parliamentary deliberations.
- Develop a media campaign to rally support at both the popular and legislative levels.

We do know from the experience of health care reform in the U.S., the U.K., Germany, and elsewhere, that success depends on a delicate mixture of both technical and political competence. The Clinton Plan in the U.S. went down to defeat both due to tactical failures by its

proponents, and because they failed to convince the public that it would ameliorate the problems the public perceived in the current system. This suggests the need for the municipalities to reach their position based on a careful analysis of public attitudes and expectations, and on a critical understanding of why what they propose will actually make the system better. Simply defending municipalities' institutional interests is unlikely to be a cause around which the necessary broad-based coalition can be mobilized.

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[i] For a basic review of Western European health core systems see O.E.C.D. The Reform of Health Care Systems: A Review of Seventeen OECD Countries, Health Policy Studies, No. 5, Paris 1994.

ii Scandinavian local governments compensate outpatient physicians in a variety of ways. Some are salaried employees, others work on a fee-for-service or capitated basis. See Saltman, R.B. and Figueras, J., Health Affairs, "Analyzing the Evidence on European Health Care Reform," March/April 1998, pp. 95-96.

iii Ustawa z dnia 6 lutego r.o. powszechnym ubezpieczeniu, see articles 74-77.

iv Roberts, M.J., Public Policy, "Organizing Water Pollution Control: The Scope and Structure of River Basin Agencies, Vol. XIX, No. 1, Winter 1971, pp. 88-112. A review of American experience with regional authorities in the environmental arena.

v Woldarczyk, C. With Chmaj, A., Harvard-Jagiellonian Consortium for Health, "Local Government Versus Health Issues: Initial Reports, Subproject: Democracy and Self-Government," p. 25.

vi See esp Art, pg. 89, 99, 100, not 3 supra.

vii See Note 1, supra, chapters 9, 10, 17, and 19.

viii White, J., Competing Solutions, Brookings Institute, 1995, pp. 78-79, 85 for Germany. For Austria, see ibid chapters.

ix Op cit, pp. 44-45, Roberts, M.J. with Clyde, A., Your Money or Your Life, Doubleday, 1993, pp. 57-58. The U.S. system of DRGs is actually quite complex since it includes allowances for other conditions.

x Robinson, R., and Le Grand J., "Contracting and The Purchaser-Provider Split," and Smee, C.H., "Self-Governing Trusts and G.P. Fundholders: The British Experience," in Saltman, R.B., and von Otter, C., eds., Implementing Planned Markets in Health Care, Open University Press, 1995. Also, Robinson, R., and Le Grand, J., eds, Evaluating The NHS Reforms, Kings Fund Institute, 1994.

xi For Germany, see White, op.cit, pp. 79-84. For France, see OECD, The Reform of Health Care, Health Policy Studies, No. 2, Paris, 1992, Chapter 4 and White, pp. 106-108.

xii See OECD, The Reform of Health Care Systems, 1994, p. 246.

xiii _____ of Large Cities, Nov. 24, 1995, Articles 2 and 3.

xiv Engelstad, M., "Background Paper on The Polish Health Care System," World Bank Flagship Course, Module 2, curriculum materials, August 1997.

xv Ibid. Also, Poland, Health System Reform, The World Bank, 1992, p. 43.

xvi Dobrodzick, A.G., "Health Care Reform in The Republic of Poland – Second Opinion," Thesis for the American College of the Healthcare Executives, Alberta, Canada, 1992, pp. 21-24.

xvii Thorne, S., "Too Many Specialists, Not Enough GPs, Poland Seeks Change," in Canadian Medical Association Journal, Vol. 148, pp. 624-626, 1993.

xviii Saltman and Figuera, p. 90, Exhibit 1.

xix Roberts with Clyde, pp. 27-33.

xx OECD, New Directions in Health Care Policy, Health Policy Studies, No. 7, Paris, 1995, pp. 13-15.

xxi Ibid, pp. 21-23. Also Jönsson, B., "Making Sense of Health Care Reform," in OECD, Health Care Reform: The Will to Change, Health Policy Studies, No. 8, Paris, 1996, pp. 32-34.

xxii Depending on the details of its structure, a progressive income tax could generate reviews that rise somewhat more rapidly than GDP, but in general, the elasticity of tax revenue with regard to economic growth is close to one, i.e., a given percent change in GDP produces an equal percent change in tax collections.

[xxiii] See Flemming, J., "Public Sector Deficits and Macroeconomic Stability in Developing Economies" in *Budget Deficits and Debt: Issues and Options*, Federal Reserve Bank of Kansas City, 1995.

[xxiv] The Western European country with the largest private insurance sector is the Netherlands. See "The Reform of The Health System in The Netherlands," Chapter 2 in *The Reform of Health Care*, OECD, Health Policy Studies, No. 2, 1992.

[xxv] Anell, A., "Implementing Planned Markets in Health Services: The Swedish Case," pp. 207-226, in Saltman and von Otter, eds, op. cit.

[xxvi] See Gladstone D., and Goldsmith, M., "Health Care Reform in The UK: Working for Patients," pp. 71-84 in Seedhouse, D., ed. *Reforming Health Care*, Wiley, 1996. Newdick, C., "Resource Allocation in The National Health Service," *American Journal of Law and Medicine*, pp. 291-318, No.s 2 and 3, 1997, and Maynard, A., and Bloor, K., "Introducing a Market to The United Kingdom's Health Service," *New England Journal of Medicine*, Feb. 29, 1996, pp. 604-607.

[xxvii] White, pp. 128-149.

[xxviii] Ivewacheck, P.W., Hughes, D.E., and Stoddard, J.J., "Children's Access to Primary Care: Differences by Race, Income, and Insurance Status," *Pediatrics*, Vol. 97, pp. 26-32, 1996 and Gruber, J., "Health Insurance for Poor Woman and Children in The United States, Lessons from The Past Decade," National Bureau of Economic Research Working Paper, #5831, Nov. 1996.

[xxix] See Hsiao, W.C., "Financial Incentives," and "Diagnostic Approaches to Assessing Strengths, Weaknesses, and Change to Health Systems," World Bank Flagship Course on Health Sector Reform, Module 2, Background Paper, Oct. 1997, Tables 2 and 3, pp. 51-52.

[xxx] Battista, R.M., et al, "Lessons from The Eight Countries," in *Health Policy*, Vol. 30, 1994, pp. 402-406. Anderson, G.F., "In Search of Value: An International Comparison of Cost, Access, and Outcomes," in *Health Affairs*, Nov/Dec, 1997, pp. 163-171. -

[xxxi] See Koeck, C.M., and Nevgaad, "Competitive Hospital Markets Based on Quality: The Case of Vienna," in Saltman and an Otter, eds, pp. 227-236.

[xxxii] Personal communication with Maureen Baker, Chief Executive, New Mexico Hospital and Health System Association, Sept. 15th, 1997.

[xxxiii] The Reform of Health Care Systems, op. cit. Also Weiner, J.P., "Primary Care in The United States and Four Northwest European Countries: Comparing The "Corporated" with The "Socialized,"" Milbank Memorial Fund Quarterly, Vol. 65, No. 3, 1987, pp. 426-61.

[xxxiv] Williaims, S.J., and Torrens, P.R., eds, *Introduction to Health Services*, Wiley, 1980, pp. 116-120, and Wilson, F.A. and Newhauser, D., *Health Services in the United States*, Ballinger, first edition revised and enlarged, 1976, pp. 203-07.

[xxxv] Personal communication with Judith Kurland, former Commissioner of Health and Hospitals, Boston, Massachusetts.

[xxxvi] Independent health and hospital agencies, with their own supervisory boards, are more common in the south and west of the United States. In the north and east, these agencies are more likely to report directly to a state or local government chief executive. Where they exist, such boards are either directly elected or appointed – sometimes by a variety of other local government bodies.

[xxxvii] Personal communication with professor Karl Lauterbach, University of Cologne.

[xxxviii] The hospital now characterizes itself as: "A private hospital with a public mission." Personal communication with Susan Edgeman-Levitan, President, The Picker Institute for Patient Centered Care, Boston, MA.

[xxxix] See "Hospital Wields Political Power," *The Gainseville Sun*, April 20, 1996, and "UF Sets Out On New Health Path," *The Gainseville Sun*, June 23, 1996.

[xl] See Wilson and Neuhausen, op. cit., pp. 211-213. Williams and Torrens, op.cit., pp. 113-115.

[xli] See "Fiscal Indicators and Uncompensated Care Trends," Annual Report, Shands Hospital, Gainseville, Florida, and sources in Note 40 supra.

[xlii] In some states, hospital bonds are actually issued by an independent public agency designed for that purpose. For example, in Massachusetts, there is the Health and Education Financing Authority which is an which is an agency of state government. In such cases, repayment of the bonds is guaranteed by a private (i.e., commercial) insurance carrier.

[xliii] Personal communication.

[xliv] The funds largely come from the Federal Emergency Management Agency, and are nominally to deal with the vulnerability of the current facility to earthquake damage. Personal communication with Bruce Bronzan, Associate Dean, University of California, San Francisco Medical School.

[xlv] Personal communication, Enrice Ballinger, Institute for Local Government, Ministry of Interior, Argentina.

[xlvi] *Argentina: A Growing Nation*, Ministry of Economics and Public Services, Buenos Aires, 1994, pp. 9-12, 186-193.

[xlvii] *Reform of Health Care Systems.*

[xlviii] Brommels, *Contracting and Political Boards,"* pp. 92-93.

[xlix] Roberts with Clyde, op. cit., pp. 49-54.

[l] White, op. cit., p. 84 and *The Reform of Health Care,* pp. 61-62.

[li] Lauterbach, op. cit.

[lii] For a description of the early implementation of these laws, see Gordan, R., Howel, J., Alexander, D., "Problems in Health Care: Is government Regulation Helpful?" in Gordan, R., (ed), *Issues in Health Care Regulation*, McGraw Hill, 1980, pp. 6-20.

[liii] See notes 10, 26 supra.

[liv] See Koeck and Neugaad, op. cit.

[lv] Kokko, S., *Short Overview of The Finnish Health Care System*," Helsinki, March 3, 1998.

[lvi] Brommels, op. cit.

[lvii] Currently, the public system in Vienna has a market share of 75%. Personal communication with Christian Koeck.

[lviii] Personal communication with Commissioner of Health, San Diego County.

[lix] Brommels, op. cit., *The Reform of Health Care Systems*, Chapter 19. Also Annell, A., "Implementing Planned Markets in Health Services: The Swedish Case," pp. 209-226 in Saltman and van Otter, eds.

[lx] Notes 5, 6, 57, supra.

[lxi] See for example, "Closing Doctors Hospital" teaching case, University of Toronto, 1981, and "Hospital Closing in Worcester, Mass." teaching case, Harvard School of Public Health, 1983. In both situations, local political leaders responding to citizen pressure attempted to convince regional authorities to maintain inefficient hospitals – with some success.

[lxii] Bruce Bonzan, op.cit., reporting on efforts in five U.S. cities to establish public sector purchasing cooperatives.

[lxiii] See, for example, "New York Times" magazine, April 20, 1998, p. 42.