3. Private Sector Policies – The Literature

This dissertation examines the privatization of health care delivery in a transition economy. It is based on the notion that the behavior and performance of physicians in Macedonia are influenced both by financial and regulatory incentives. Financial incentives are defined by provider payment incentives including the FFS and salaried systems now in place, and the capitation system proposed by the reforms. Financial incentives are also influenced by the structure of health care provision common to other low- and middle-income (LMI) countries including low pay and inadequate facilities in the public sector. Regulatory incentives are defined by the policy environment of the private health care sector – the policies and procedures established in an ad hoc manner at all levels of the Macedonian health sector. This dissertation argues that the proposed reforms of provider payment incentives are a necessary, but not sufficient, condition for successful privatization of PHC. Reform of Macedonian PHC takes place in the broader context of a transition country struggling to transform institutions of a planned economy into institutions that support a market-oriented economy. As a consequence, broader market and regulatory incentives must also be considered in designing health care reform policies.

To illuminate these embedded issues, I draw on two main bodies of the literature. In this chapter, the growing literature on privatization and policy reforms in CEE transition economies establishes a framework for understanding the existing policy environment and identifies key issues for evaluating health care privatization programs. It is worth emphasizing that social sectors, and the health sector in particular, comprise a small fraction of this literature which primarily concentrates on privatization of manufacturing enterprises. I draw on CEE experience in both industrial and social sector privatization to build a taxonomy of economic and political objectives for developing private markets in transition economies. In Chapter 5, the extensive literature on public/private health care provision in LMI and transition countries provides an understanding of the economic incentives facing private physicians. This review informs the development of the model of physician performance, presented in Chapter 6.
THE TRANSITION ECONOMY CONTEXT

Under communism, the economy was planned and controlled by a single political party. Whether localized or highly centralized, the state owned and operated enterprises under soft-budget constraints to support political goals and meet the objectives of industrial development, full employment. Kornai (1980) succinctly described this as the “shortage economy”: economic planning would set unattainable output goals for firms that became resource constrained; firms then tried to expand and hoarded the inputs that were available to them including labor, resulting in the “paradox” of concurrent general shortage and local surplus. Complicating matters, property rights were confused and diffusely held. No stakeholder in the state-owned enterprises – politicians, managers, nor workers – had sufficient incentive to improve operations (Uvalic, 1992). Inefficient state-owned enterprises (SOEs) were supported by a web of explicit and implicit subsidies. These subsidies included direct subsidies, inter-firm arrears, bad loans and credits, and artificially high prices for output all of which were partly financed by artificially low prices on agriculture and other inputs (Sachs, 1996). Under this array of perverse incentives, the systemic results followed: declining growth; low and falling productivity in all sectors; growing technology gap with the West; and low and declining standards of living and consumption (Lavigne, 1995).

Initial reform policies in CEE consisted of three major themes: stabilization, liberalization, and privatization (Ellman, 1997; World Bank, 1996a; Fischer and Gelb, 1991). Macroeconomic stabilization and trade liberalization policies have been implemented successfully in most of CEE. These actions were politically easy to enact and could be done almost “overnight” by decree, following the ‘big bang’ reform model most famously championed in Poland and Russia (Aslund, 1991; Sachs, 1991).

Other reforms, including privatization, are proving to be more difficult to implement. The World Bank reports that many reforms could take decades to complete (Ellman, 1997; World Bank, 1996a). This is more in line with the gradualist school of reforms in which political constraints are endogenous to the reform process and gaining political consensus is explicit in reform programs (Dewatripont and Roland, 1992; Roland, 1997; Vittas, 1997). The highly political nature of transition has thus forged a “new consensus” among orthodox policy advisers on the nature of the transition process itself. This view recognizes that the
constraints of institutional capacity and political power of powerful interest groups, in addition to economic goals, are central to the success of reforms (Ellman, 1997; Roland, 1997). Indeed, events in Russia during 1998 raise the question whether political resistance can be overcome by the logic of market reform. As transition economies are defined by the lack of institutions underlying a market economy, rebuilding and developing those institutions is the decades long task of the transition process. (Rapaczynski 1996; Murrel 1996; World Bank, 1996a; Fischer and Gelb, 1991; OECD 1991)

“Institutions” have received much scholarly attention the past decade and can have multiple meanings. Williamson first associated the term with firms, markets, and the contracts between them that deal with transaction costs (Williamson, 1985). North (1991) examined institutional change and its effect on economic performance. March and Olsen (1989) reinvigorated institutional analysis, defining institutions fundamentally as the embodiment of formal and informal rules in governmental administrative institutions. The transition literature tends to combine these notions, referring broadly to the institutional incapacity of CEE nations and the need for institution building including: legal and regulatory systems (e.g., Borish and Noel, 1996), courts, legal practices, and legal and managerial professionals (e.g., Murrel, 1996); and private markets, supporting financial systems, and incentives to improve efficiency (e.g., OECD, 1991).

Recent empirical work supports the importance of institutional heritage. Administrative institutions, the bureaucratic conventions and cultural norms inherited from years of communist rule have an important effect on the policy process and help determine the success of economic transition (de Melo et al., 1996). Cultural history, public attitudes toward the private sector, decision-making behavior in state agencies, and deeply-embedded corruption are neglected at the peril of reforms and obviate a blue-print approach to transition. Adequate analysis of these issues is, however, beyond the scope of this dissertation. This body of work is a point of departure for this investigation of health care privatization in a transition economy.

What characteristics of privatization in transition economies must health care reforms consider? What are the key objectives in privatization and what constraints might be faced?
This literature review identifies key features of successful privatization programs in CEE. It focuses on the role of the state in establishing legal and regulatory structures supporting a market economy, the governance of firms, and the political sustainability of reforms.

PRIVATIZATION IN CEE

The merits of private markets are often argued on philosophical grounds (Hayek, 1944; Friedman, 1962). However, the strongest policy arguments made in favor of privatization are put in economic terms (World Bank, 1996a; Johnson, 1995). Neo-classical economic reasoning for privatization is clear; placing the rights to an asset in private ownership achieves the highest possible efficiency as the owner seeks the best use of resources to meet the demands of the market. Early in transition, this argument dominated and rapid privatization was widely viewed as the only option for solving the efficiency and governance crises in the state owned enterprises (SOEs); the task of establishing and enforcing financial control of the SOEs was considered too great for CEE governments (Fischer and Gelb, 1991). More importantly, privatization was seen as essential to broader stabilization and economic growth (UNCTAD, 1994). However, this view was often based on a “mythologized” concept of markets, their benefits (Stiglitz, 1993) and, critically, how quickly markets can be established (Ellman, 1997; Kapstein, 1997; World Bank, 1996a).

What are the key lessons from the transition experience that should be considered in devising reform policies? General privatization policies in CEE are clearly important as they form the context for privatization of specific sectors of the economy, including health care. Here I review six fundamental objectives of privatization policies to improve the efficiency of both state and privately owned firms.

Objectives of privatization

The purpose of privatization is to help establish a market economy founded on private property. There is evidence that both private firms and SOEs can both operate profitably in richer transition economies (Pohl, et al., 1997; Brada, 1996). Other researchers make important distinctions between new private firms (usually small) and former SOEs (usually

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1 Privatization in Yugoslav successor states has a small presence in the published literature due its low priority during war and disintegration of Yugoslavia and also to the lack of program evaluations.
large). They argue that new startup firms in Poland and the Czech Republic have higher productivity than formerly state-owned firms and are a significant source of economic growth. (Murrel, 1996; Ellman, 1997; Johnson and Loveman, 1995). However, such studies conducted at the individual firm level do not get at the question of whether asset sales alone achieve the goal of privatization and may also be subject to significant biases. Furthermore, most observers agree that the sale of state assets to private parties is not sufficient to develop a market economy (Gray, 1996). Focusing all political efforts on the relative simple task of transferring ownership rights from the state to private hands detracts from the hard task of developing market institutions (Murrel, 1993).

The term privatization, using a narrow definition in developed market economies, typically denotes the transfer of public assets to private ownership. In CEE, the term has been used variously to describe different policies from limited introductions of market forces to the total transformation of formerly planned economies. In public services, it has been used to denote contracting of limited services or competition between government agencies (Mills, 1991; Mills et al., 1994; Saltman and Figueras, 1994; Vickers and Yarrow, 1991). More commonly in industrial restructuring, “privatization” identifies methods of transferring state assets to private hands. The basic models of assets sales in transition economies and technical details of the programs, such as valuation tools or the structure of voucher auctions, are discussed in other documents. Following several authors, I adopt a broad process definition of privatization, meaning the development of private markets to explicitly restructure a planned economy into a market economy (e.g., Clague, 1998; Murrel, 1996; Gray, 1996).

This is an enormously complex task; there is no one path to reform. There are however common building blocks – common institutions – that support well-functioning markets. Privatization supports markets by improving the allocation and monitoring of resources and

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2 There are no true one-on-one comparisons of private and public firms for several reasons: a) better performing firms have been privatized first; b) poorly performing SOEs have often been liquidated or looted; c) the capacity of new private firms is not subject to the overcapacity of former SOEs and is instead conditioned by market conditions at the time of start up; and, d) private owners have been in place for too short a time to effectively restructure the former SOEs (Brada, 1996).
the transparency of incentives. The degree to which these functions do improve depends on a number of factors:\(^3\)

- role of government,
- financial discipline,
- competitive markets,
- effective corporate governance,
- property rights regime, and
- political support for the reforms.

These are discussed below.

**Establishing the Long Term Government Role** One of the ironies of private sector reform in CEE is that the government need to be deeply involved in the process of developing a market economy. Where their prior role was in subsidizing firms and centralized decision-making, during transition governments now must build market institutions and eliminate supports for failing firms. These tasks are highlighted below. In the long run, the government will carry out the “traditional role” of government in a market economy; regulating to control market failures and coordinating to leverage private resources in helping meet national goals. Establishing this role can be difficult. The sale of SOEs, for example, may result in large private monopolies that are subject to only minimal governmental regulatory capacity compounded by a weakened ability to remain independent from the powerful new business interests.

The health care sector is characterized by a number of endemic market failures where the regulatory role of government is well understood. Many CEE countries are increasing the government’s role even further by following the Western Europe norm of national insurance systems. As they introduce market forces and health insurance to the health sector, CEE governments must build capacity for a number of new tasks including: regulation of insurance markets, meeting public health goals with private provision , enacting effective and

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\(^3\) Particular features and their relative importance depend on industry characteristics. For instance, not included above are foreign trade and investment that are important in allocating and monitoring resources in many industries such as pharmaceuticals. In health care provision, certainly PHC, direct foreign involvement is not
transparent quality assurance procedures, and establishing cost control measures along with new financing schemes (Saltman and Figueras, 1997). These long-term responsibilities are in addition to the tasks of transition to a market-oriented system.

**Imposing Financial Discipline** One of the central failures of the SOE system are ‘soft budget constraints’ (Kornai, 1980). Financial discipline is fundamental to firms in a market economy and, as Brada’s findings suggest, former SOEs can positively respond to it also. Other studies show that when under hard budget constraints SOEs adjust workforce levels in response to changes in revenue, more effectively collect receivables, better link investments and profits, and move from output objectives to profit maximization. (World Bank, 1996a). The credibility of “non-bailout” policies, however, is critical to maintaining financial discipline, governments must keep commitments to end subsidies (Roland, 1997; Stiglitz, 1993). If managers expect that they will continue to receive subsidies, official non-bailout policies will have little effect. Early reform experience has borne this out. Pohl et al.(1997) found that in 7 CEE countries over 1992-1995 poor lending practices were strongly associated with state-ownership, indicating that state subsidies continue. Recently, leading reform countries like Poland and Czech Republic have been rewarded with significant growth after cutting direct subsidies and reducing bad loans to SOEs. Tax breaks though, are proving harder to eliminate and are an avenue to subsidy. In Russia for example, tax subsidies to large firms have actually increased and ad hoc tax breaks in collusion with politicians have proliferated (World Bank, 1996a).

One of the primary aims of physician payment reforms in CEE is to improve incentives for efficiency and quality in care provision and to control overall spending (Saltman and Figueras, 1997). Many reformers are moving from a system of salaried, state-employed physicians to one emphasizing contractual relations with practitioners who are paid by capitation, fee-for-service arrangements, or a mix of these systems often supplemented with a salary component. Romania and Poland, are cases in point in that they have several demonstration projects with different mixes of payment plans (Saltman and Figueras, 1997).
The focus of reforms is currently on physician payment. Capital financing of clinics, however, is also an important concern, especially in countries with underfunded public clinics and severe budget problems. As policies shift from state subsidies to market-oriented financing banks will play a central role in pooling, allocating, and monitoring resources. The extent of a banking role in funding CEE health care capital investment is uncertain. Nonetheless, if private resources are increasingly relied on to improve the quality of care, private actors will eventually turn to banks for financing. However, banking systems across CEE are in very poor shape and are saddled with large non-performing loans dictated by former governments (Borish, 1996; World Bank, 1996a; Lavigne, 1995). Compounding problems of insolvency, banks have little experience allocating funds in a risk-filled environment, having previously been mere recorders of transactions (Stiglitz, 1992).

**Building Competitive Markets** Competitive (or contestable) product and factor markets are necessary for incentives for efficiency and quality improvements (Brada, 1996; Stiglitz, 1992; Vickers and Yarrow, 1991). In CEE there is evidence that private firms can outperform SOEs in conditions of highly competitive markets (Vickers and Yarrow, 1991). This only emphasizes the credibility of non-bailout policies and ensuring equivalent expectations of non-bailout for private and public sector managers. Another important issue is freeing the paternalistic labor market policies lingering from the communist era including fixed wage structures, restrictive hiring and firing policies, and disincentives to employment must be changed to improve labor mobility and efficiency. (Borish, 1996; World Bank, 1996a).

A central tenet of the case for privatizing is that competition will improve quality of care and patient satisfaction as providers work to keep patients (Preker and Feachem, 1995; World Bank, 1993). Lowering barriers to entry and exit enhance competition and allow the private sector to experiment with organizations and relationships that are most effective (Borish and Noel, 1996; Vickers and Yarrow, 1991). This may be important in CEE where the dominant organizational form was large, state-run clinics and will allow private providers to develop effective models of group practices.
Encouraging effective corporate governance  Resolving corporate principal-agent problems is made more difficult in CEE as there are few effective mechanisms for monitoring and enforcement (Brada, 1996; Gray, 1996; World Bank, 1996a). In early years of transition, direct monitoring is likely to be most important and managerial capacity grows and stock markets develop which can also evaluate managers’ performance. An extensive study of CEE firms supports this, showing that those with more concentrated ownership, especially by banks, is associated with more extensive restructuring (Pohl, 1997). While there is little that governments can do directly to advance these private sector developments, government action in three areas help improve governance.

Three strategies or policies would lead to better governance. One would be to make it possible for owners to change managers by freeing rigid labor laws from the previous era (Borish and Noel, 1996). A second important role for government is establishing effective bankruptcy laws and enforcement mechanisms that facilitate closure of inefficient firms and build creditor confidence. Finally, governments need to depoliticize industry. Some authors argue that the main governance problem in CEE is not managerial discretion but “political discretion” and the continuing influence of the government over private decision-making (Boycko et al, 1995). Such influence includes political favors, kickbacks, and favorable regulatory action. This problem is especially difficult with weak central governments that can’t control powerful bureaucrats and enterprise managers seeking favors (Shliefer and Vishny, 1993).

Defining and Enforcing Property Rights  The property rights regime, the foundation of privatization, is especially weak in CEE. It suffers from two basic problems: 1) definition and protection of property rights and, 2) establishing ownership rights prior to sale. Definition and enforcement of property rights rely on legal constructs which must be established, in many cases, from first principles (Rapaczynski, 1996). Distinctions such as cash flow rights, control rights, or split rights were not even recognized in most of CEE (World Bank, 1996). Once rights are defined, protection mechanisms must be developed quickly for privatization to succeed. Current legal systems are complex and arbitrary, raising transaction costs for basic procedures so high that only the worst violations of private property are pursued legally (Rapaczynski, 1996). Governments must establish legal
definitions of property rights, privatization procedures, rules for post-privatization sales between private parties, and clear legal protection of private property. Enforcement mechanisms must also be established. But here the government role is limited; enforcement in practice infrequently requires initiation of legal proceedings. Property rights are enforced only on the margin in developed market economies. Instead, private self-enforcement is relied on; with mechanisms based on professional reputation or multi-lateral arrangements overseen by trade groups (Rapaczynski, 1996; Rubin, 1993). In health care, the analogs are medical trade groups and professional physician associations.

The second major problem arises from the “confused” property rights inherited from the communist era (Uvalic, 1992; Winiecki, 1990). The state, enterprise management, workers, and citizens all had various claims to state assets in varying degrees from country to country. To solve some of the legal problems these claims pose, many laws on privatization have effectively re-nationalized assets to enable subsequent sale. However, the political problem remains—these multiple claims to state property have greatly complicated privatization and heightened the political sensitivity of the process (Uvalic, 1992; Winiecki, 1990; Lavigne, 1995). One problem that can be anticipated is if municipal governments are not involved in the sale of “nationally-owned” municipal-level health care facilities.

**Gaining Political Support for Privatization** Policy reform is an inherently political process as it seeks to alter the distribution of goods among different groups. Privatization is especially politically charged due to the very clear distributional consequences of transferring state assets to profit-seeking private parties. Thus, tension between the goals of economic efficiency and distributional equity often drives the design and implementation of CEE privatization policies. It is also central to gaining the social and political consensus required to sustain long-term reforms (Fischer and Gelb, 1991). Faced with often politically powerful groups, most reformers seek to maintain or achieve political support by selling assets at near give-away prices. Britain in the 1980’s, for example, sold public shares in state monopolies at deep discounts to boost political acceptance of the program (McAuley, 1993).

A similar model has emerged in CEE though the group gaining from the process is largely firm insiders; state assets are sold at low or no cost to managers or to management/employee
teams with management as the dominant partner (Lavigne, 1995; Boycko et al., 1995; Mosley et al., 1991). While CEE enterprise managers are inexperienced at operating in a market economy, they are adept at manipulating the state planning system (Lieberman et al., 1995). Where they are strong enough, they have effectively directed the course of asset sales and have generally maintained control of SOEs, particularly against potential outside investors (Frydman and Rapaczynski, 1993). In Bulgaria, for example, managers blocked privatization policies until 1995 and have slowed their implementation since. In the interim, extensive “spontaneous privatization” stripped assets and cash from state firms to such a point that the condition of SOEs became a serious macroeconomic problem in 1996 (World Bank, 1996a).

Social sectors have seen very little in the way of widespread asset sales or other forms of privatization. One exception is the Czech Republic’s health sector where a vast majority of both outpatient and inpatient facilities have been transferred to private sector ownership (Massaro et al., 1994; Chermak, 1995; Cheska, 1993). Clinic values were set at book value and were transferred by direct sale or open bids. Building on this transparency, new owners accepted extensive obligations to provide certain types of care (usually preventive or high cost) and to care for patients regardless of insurance status (Chermak, 1995).

One clear lesson from privatizing reforms is that forceful leadership within the government is crucial in overcoming bureaucratic interests. Ministerial branches of national governments had a great deal of control over SOEs and often ostensibly “owned” enterprises with strong ties to enterprise managers. Thus, individual bureaucrats perhaps have the most to lose in privatization, and in many countries have not relinquished control (Gordon, 1998; Lieberman et al., 1995; Boycko et al., 1995). Strong central leadership was important in the Czech Republic and Poland, even in the first round of asset sales in Russia, to maintain and defend the programs against entrenched interests of bureaucracies (Ewing et al., 1996; Lieberman and Rahuja, 1995). The importance of central leadership in CEE is echoed by the experience of the privatization programs in Mexico and Chile where strong central government action was able to push privatization programs (Przeworski, 1988; Bartlett, 1992).