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Abbreviations

CA Central Asia
CEB Central Europe and the Baltic states
GDP Gross domestic product
LITS Life in Transition Survey
OECD Organisation for Economic Co-operation and Development
OOP payment Out-of-pocket payment
PHI Private health insurance
PPP Public-private partnership
SEE South-eastern Europe
SEMED Southern and eastern Mediterranean
THE Total health expenditure
WHO World Health Organization

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The views expressed are those of the authors and not necessarily those of the EBRD.
Introduction

For people in countries where the EBRD invests, health care has always been a high priority.

The first two *Life in Transition Surveys* (LiTS I and LiTS II), conducted jointly by the EBRD and the World Bank in 2006 and 2010, respectively, indicate the need to reform health care. In particular, LiTS II shows that a majority of respondents see health care as the highest and/or second-highest priority for additional government spending.

The surveys also identify a high level of dissatisfaction among people in the region with regard to the provision of health care services.

Furthermore, in some of these countries, analyses indicate that health infrastructure is outdated, obsolete or inefficiently managed. Regulatory frameworks for the sector often lack transparency, and standards of service are weak. While public health care services are formally free at the point of delivery in many countries, their availability is often constrained by demands for substantial unofficial payments.

In recent years, interest in the provision of health care services by the private sector has risen for a number of reasons:

- The cost of health care has soared as populations age and new and expensive technologies are introduced.
- In the aftermath of the global financial crisis, constraints on government balance sheets have made it harder to finance the rising cost of health care.
- Given these pressures, many governments increasingly perceive that providing better access to quality health care, and controlling the costs of this care, are only possible through greater involvement of the private sector. Governments see private sector alternatives such as public-private partnerships (PPPs) as generating competition, while improving efficiency and quality in service delivery.
- In less-developed countries, regulatory frameworks are often ill-equipped to deal with the rise in private sector provision that is filling the widening gap between demand and supply.

The main findings of the country health care analyses undertaken for this paper are outlined on page 3.
Methodology and key findings of country analyses

In order to assess recent developments and policy approaches to private sector participation in health care services, the authors have undertaken a country-by-country analysis of the sector (see Annex 1 on page 15).

Methodology

The main features of the methodology are as follows.

- The analysis covers all 36 countries where the EBRD invests.
- It draws on numerous sources covering health care policies and assessments.\(^2\)
- Health care services are defined as shown in footnote 1.
- The country-by-country outlines focus on the following five areas.

- **Expenditure on health care**
  This section shows how total expenditure on health care (THE) is split between public and private spending, and the percentage of private expenditure that consists of out-of-pocket payments. This data provides the first indication of whether the private sector is an important part of a country’s national health care system. The figures provided include spending on pharmaceuticals.

- **Financing**
  This section focuses on key conditions or constraints in the system of health care financing in the country.

- **Delivery**
  These points cover the key characteristics and operational constraints facing the main providers of health care services, such as clinics, hospitals, and providers of clinical support services or long-term care.

- **Key challenges and/or reform agenda**
  For each country, this section outlines broad national trends in health care reform, with the emphasis on how the sector is organised or on the conditions affecting financing or delivery.

- **Comparison with regional averages**
  These tables provide an international context for data on expenditure.

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Key findings

The results of individual country analyses are presented in Annex 1, but the overall findings and key trends are as follows.

- **There is no one-size-fits-all approach to health care provision in the EBRD region.** As expected, the analyses reveal significant differences between countries and between regions. In terms of organisation, finance and delivery, no single model of health care prevails. In many less-developed transition countries, where government provision of health care may be less efficient, the gap between supply and demand is being filled by ad hoc private provision, albeit often informal and underdeveloped. This private care is often funded by out-of-pocket (OOP) payments.

- **It appears that most governments are struggling to cope with the rapid rise in health care expenditure.** Almost without exception, governments face growing costs, as well as challenges in the quality of care and access to care, changing demographics, shifting patterns of disease, and the use of expensive new technologies. These pressures are likely to continue.

- **On average, total health expenditure in the region is lower than in OECD countries, both in absolute and relative terms as a percentage of GDP.** This reflects lower levels of income but also, perhaps, a relative underinvestment in health, a common feature of emerging markets.

- **Private sector involvement – in terms of spending at least – is significant in many countries in the EBRD region, frequently filling the gap between demand and supply by default.** However, the sector is often weak and operates below optimal levels. Importantly, this private sector expenditure involves out-of-pocket (OOP) spending, which also includes estimated informal payments. OOP payments are usually inefficient as there is no risk pooling. The significant size of the private sector may reflect, among other factors, a lack of effective health-care provision by the public sector.

- **Many of these countries are trying to decentralise health care financing and delivery in order to increase efficiency and contain costs through selective contracting and competition between providers.** To a lesser extent, some countries are recentralising their health care provision to increase control over supply and demand.

- **Government reform agendas include, to varying degrees, the use of the private sector to address rising demand and alleviate fiscal pressures on public health systems.** However, private sector firms can face significant regulatory risks, as a change in government can lead to a sudden change in the desired extent of private sector participation.

These findings are explored in more detail below.
Expenditure on health care

Total health expenditure in the EBRD region is low compared with the OECD average (about 6.7 per cent of GDP on average compared with the equivalent OECD figure of 9.3 per cent). While consistent with the region’s lower levels of income, it also points to a relative underinvestment in health. In 2014, average per capita expenditure on health in EBRD countries of operations amounted to only around 29 per cent of the OECD average at purchasing power parity.

Meanwhile, demand for health services is growing rapidly in countries where the EBRD invests and the growth in total health expenditure – public plus private – has been faster than GDP growth (see Chart 1 on page 5). Governments are reported to be struggling with issues such as cost, quality of care and access to care as they face changing demographics, shifting patterns of disease (away from infectious diseases towards a higher incidence of chronic conditions), and the use of new technologies that further increase costs.

These rising pressures are likely to continue, as suggested by the apparent correlation between GDP per capita and total health expenditure (THE) per capita (see Chart 2 on page 5). The link between GDP per capita, or income per capita, and THE per capita merits a more detailed analysis, as factors such as demographics, relative prices, technology and public policy have an impact on health care provision. Nevertheless, it is safe to say that in general, as wealth increases, demand for healthcare services sees a corresponding increase. Recent studies emphasise that this is in fact a two-way process, whereby better health care can help to increase income and wealth.

The private sector share of total spending varies in the EBRD region, but on average, exceeds the average share in OECD countries (42 per cent versus 28 per cent; see Chart 3 on page 6). This finding is consistent with that of an earlier study in low-income countries in Africa by the International Finance Corporation (IFC).

Although the private sector is already established in many countries, what is needed now is a well-functioning, truly contestable market for cost-effective, high-quality health care services.

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3 See WHO (2016).
4 See OECD (2013).
5 See Woolf et al. (2015).
7 See World Bank (2008).
Chart 1: Growth in GDP per capita and health expenditure per capita in countries where the EBRD invests, 1995-2014

Note: The figures represent cumulative changes in average GDP per capita and health expenditure per capita for 34 EBRD countries of operations, based on nominal US dollars. The calculations exclude Cyprus and Greece because the pattern of GDP growth as well as public and private health spending in these economies diverged significantly from other countries where the EBRD invests.

Chart 2: GDP and health expenditure per capita in EBRD countries of operations, 2014

Source: WHO and World Bank Global Health Expenditure Database.
Chart 3: Public and private health spending, 2014

Note: No data were available for Kosovo.
Health care financing

The important elements in financing health systems revolve around who pays into the system, the type of payments they make, and who collects these payments.

The mechanisms for funding health systems include taxation (direct and indirect), social insurance contributions, private insurance premiums, out-of-pocket payments and loans. Grants and donations are also considered to be funding mechanisms.

Collection agents can be public, private for-profit or even private not-for-profit entities. Public collection agents range from various levels of government (central, regional or local) to independent public bodies or social security agencies.

Chart 4 illustrates sources of funding, contribution mechanisms and collection agents.

### Chart 4: Sources of funding, contribution mechanisms and collection agents in health care financing

<table>
<thead>
<tr>
<th>Source</th>
<th>Mechanism</th>
<th>Collection agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firms, corporate entities and employers</td>
<td>Direct and indirect taxes</td>
<td>Central, regional or local government</td>
</tr>
<tr>
<td>Individuals, households and employees</td>
<td>Compulsory insurance contributions and payroll taxes</td>
<td>Independent public body or social security agency</td>
</tr>
<tr>
<td>Foreign and domestic non-governmental organisations and charities</td>
<td>Voluntary insurance premiums</td>
<td>Private not-for-profit or for-profit insurance funds</td>
</tr>
<tr>
<td>Foreign governments and companies</td>
<td>Medical savings accounts</td>
<td>Providers</td>
</tr>
<tr>
<td></td>
<td>Out-of-pocket payments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loans, grants and donations</td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Kutzin et al (2001).
Separate from the financing of health care services, the financing of public-private partnerships (PPPs) for hospital infrastructure and related facilities management services is now well established across western Europe and beyond (for example in Canada), building on the UK model of private finance initiatives. These PPP projects focus solely on hospital infrastructure (including certain support services not directly linked to health care provision) which is designed, built and maintained by a private concessionaire. The relevant ministry of health remains the sole provider of clinical services and remunerates the concessionaire with an availability payment over the lifespan of the PPP. The financing of such projects relies on a long-term PPP agreement with the health ministry that includes adequate provisions for compensation on termination of the contract, leaving the performance risk (for construction and technical availability) with the concessionaire and the lenders.

Health care delivery

The delivery of health care comprises a wide range of services as shown in Chart 5 below.

The health care delivery sector can also include segments such as health tourism and retirement communities that offer continuing care. Other areas of the health sector, such as medical equipment, pharmaceuticals (manufacturing, wholesaling, and retail pharmacies), IT firms that sell hospital information systems, and leasing companies, are beyond the scope of this paper (see footnote 1).

**Chart 5: Delivery of health care**

- **Outpatient**
  - Public health and primary care
  - Specialised clinical services
  - Hospitals
  - Long-term care facilities

- **Inpatient**
  - Vaccinations
  - Family planning
  - General practitioners
  - All clinical areas
  - Day surgery
  - Dialysis
  - Radiotherapy
  - Specialised surgical interventions
  - Acute care
  - Emergency care
  - Assisted living
  - Skilled nursing
  - Nursing homes
  - Rehabilitation
The reform agenda

To varying degrees, all countries are considering the use of the private sector to alleviate fiscal pressures and demand placed on public health systems and public policy commitments. But as noted earlier in this paper, there can be significant regulatory risks should a change of government alter the extent of private sector involvement in health care.

Factors that affect private sector participation in public health systems in the EBRD countries of operations were found to be as follows.

- **Health sector organisation** – The country overviews in Annex 1 classify trends in health sector organisation as centralising, neutral or decentralising, indicating the direction of financial organisation and control within the health system. Centralising countries are typified by a move to more state-based, top-down methods of health care financing and delivery. Countries currently in the process of centralising, for example Georgia and Hungary, are doing so after a period of decentralisation. By contrast, decentralising countries are moving to more regional and local forms of health financing and delivery.

- **Private health insurance (PHI)** – PHI plays a substitutive role when it provides financial protection to people who are either excluded from or allowed to opt out of the public health financing system. PHI plays a complementary role when it alleviates limitations in the scope and depth of benefits available through public health funding. And in cases where PHI responds to low levels of user satisfaction with the public system it plays a supplementary role.

- **Health care delivery** – The private health sector and system of delivery are described in Annex 1 as parallel, integrated or underdeveloped within the overall public health system. Private providers may be integrated (with adequate regulation and lines of financing) with the public health system or may operate in parallel (with little or no interaction). Alternatively, the private sector may be characterised as underdeveloped with no, or very few, private insurers or providers operating in the health system.

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9 See Mills (1990).
10 See WHO (2009).
Structural challenges

Assessing long-term structural challenges in the health care sector is difficult due to the lack of a widely accepted model of best practice. The multiplicity of health care models in developed market economies stems from inherent trade-offs between the three key objectives of any health care system: access to care, quality of care, and cost of care. These three can be pictured as the vertices of an imaginary triangle (also called the ‘iron triangle’ of health care; see diagram).\footnote{See Kissick (1994).} The position of a country’s health care system within this triangle depends on the government’s policy choices which are, to a large extent, political choices.

The trade-offs between multiple objectives, and the lack of an optimal model, are not unique to health care. A similar issue exists in the energy sector in the form of the ‘trilemma’ of delivering energy services that are affordable, secure and sustainable, where government involvement can be fully justified and there is no ultimate objective of private ownership.\footnote{See the EBRD Energy Sector Strategy (December 2013), http://www.ebrd.com/what-we-do/sectors-and-topics/ebrd-energy-strategy.html.}

Under such circumstances the objective should be to ensure allocative efficiency, while at the same time ensuring quality and high standards. Regardless of policy choices (in other words, where a government decides to position its country within the imaginary triangle), the most efficient way to achieve the specified objectives is to enable transparency and market-oriented behaviour in the sector, with health care service providers operating under – or as if under – competitive pressure and subject to proper monitoring and accountability. The need for such market-oriented behaviour applies across the sector, whether public or private.

Thus, the extent of the structural challenges can be assessed by combining various indicators of outcomes – such as access, quality, cost and transparency, plus the quality of regulations that can ensure market-oriented behaviour. Such behaviour can arise either from competition ‘in the market’, in other words, between providers, or competition ‘for the market’,\footnote{For more information on competition ‘for the market’ see OECD (2007).} in other words, well-designed tendering of contracts, monitoring, and so on. The choice between these two depends on the specific circumstances of the country or region in question.
Institutional gaps can be measured by indicators such as:
- the prevalence of informal payments
- the linking of licensing and contracting to clearly defined standards or performance (for example, the use of performance-based contracts by public health insurance schemes and clear criteria for awarding operational licences)
- the presence of standards for monitoring quality and performance (including reliable safeguards against any potentially negative effects of private sector involvement, such as ‘cherry-picking’ or compromising on quality)
- the predictability of regulatory frameworks (for instance, the availability of longer-term contracts that facilitate planning and larger investments)
- the independence of regulatory authorities from purchasers and providers
- transparency in public tendering
- regional discrepancies in the quality of health care.

Market structure gaps can be determined by indicators such as:
- efficiency, quality and access, including: vacancy rates; average length of stay in hospital; waiting times; the types of services available (including the availability of modern technologies); international certifications; the level of standardisation in services; and the development of risk-sharing mechanisms
- the prevalence of good standards of corporate governance, the use of performance-linked incentive systems, and so on
- the presence of skilled and properly trained professionals such as specialist doctors, nurses, technicians, physicists and hospital managers.

Assessments of this type require extensive data and are beyond the scope of this publication. However, the Bank’s experience in the sector and analysis in this paper point to significant gaps, both in institutions and in market structures. A more precise determination of these gaps would require further analysis. The country overviews in Annex 1 are a basis on which such analysis could be built in future, examining:

- the relatively high level of non-transparency and the prevalence of informal payments
- low predictability in the regulatory systems of several countries
- significant regional disparities in the quality of care
- inefficiency in the provision of care
- deficiencies in standards.

A particular challenge in the region relates to informal provision and the related use of gratuities or bribes. Almost two-thirds of respondents in the 2010 Life in Transition Survey (LiTS) conducted by the EBRD and the World Bank indicate that they have to pay bribes in order to receive medical treatment in the public health system. This suggests a large degree of informal activity, with people often feeling powerless to obtain fair, transparent and equitable treatment and access. A lack of transparency and effective regulation that could limit monopolies in public and private provision remains a major challenge.
The findings of the 2006 and 2010 LITS included a high level of dissatisfaction among people in the region regarding the provision of health care services. In both surveys, a majority of respondents see health care as the first priority for extra government spending. In the 2010 survey results, over 36 per cent see health care as the highest priority, while 30 per cent consider it to be the second-highest priority (see Chart 6 below).

The need for additional reforms at the micro level to address inefficiencies in the national health care systems of most countries in emerging Europe have also been highlighted by the IMF. The private sector is increasingly seen as part of the solution to these inefficiencies.

Although there is a perception that private health care often serves the rich, in cases where public services are particularly underdeveloped the private sector can fill an important gap in supporting underserved populations.

A key finding of our country analyses is that the private sector, at least in terms of spending, is already quite significant in most post-communist countries where the Bank invests and even more so in the countries of the southern and eastern Mediterranean (SEMED) region, which had no legacy of a centralised, state-run system. Private spending in the EBRD region accounts for an average of 43 per cent of total health expenditure, compared with the OECD average of 27 per cent, while out-of-pocket payments account for 89 per cent of this total in the EBRD region versus 72 per cent in OECD countries.

The finding is consistent with that of a recent IFC study on the African continent, where the majority of THE is financed by private parties (mainly out of pocket) and the private sector often facilitates the provision of high-quality, advanced medical services.

Chart 6: LiTS respondents’ first and second priorities for extra government spending, 2010

Source: LITS II (2010).
References

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“Macro-Fiscal Implications of Health Care Reform in Advanced and Emerging Economies,” Fiscal Affairs Department, approved by Carlo Cottarelli, pp. 1-68.

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Medicine’s dilemmas: Infinite needs versus finite resources, Yale University Press, New Haven, CT, pp. 1-208.

J. Kutzin (2001)


OECD (2007)

OECD (2013)

M. Spence and M. Lewis (2009)

WHO (2010)

WHO (2016)
Global Health Expenditure Database (website last accessed on July 26, 2016).

“How are income and wealth linked to health and longevity?”, Urban Institute, pp. 1-22.

World Bank (2008)
Annex 1.

Health care systems by country: an overview

This Annex includes an overview of health care systems in 36 EBRD countries of operations.
Albania

Expenditure on health care, 2014

Financing

- A single insurer funds public health care: the Health Insurance Institute.
- Voluntary health insurance (supplementary to publicly funded benefits) plays a minor role and is estimated to account for less than 1 per cent of total health expenditure (THE).\(^1\)
- Private health expenditure consists exclusively of out-of-pocket (OOP) payments.

Delivery

- The private sector operates in parallel to the public health system.
- Primary care is public, while secondary and tertiary care and clinical support services are mixed (in other words, both public and private). Long-term care is currently underdeveloped.
- Albania has a small but growing private health sector, with six private hospitals.

Key challenges and/or reform agenda

- The trend in Albania has been towards greater decentralisation in the financing and organisation of health care.
- The government’s agenda for the future of health care delivery, and current reform programme, prioritise primary and emergency care and the rationalisation of the number of hospitals.\(^2,^3\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Albania</td>
<td>272</td>
<td>5.9</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>SEE average</td>
<td>643</td>
<td>7.6</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


\(^1\) See WHO (2002).
\(^2\) Ibid.
\(^3\) Author’s analysis.
Arménie

Expenditure on health care, 2014

Financing

- Un seul assureur, l’Agence de la santé publique, financer la santé publique.
- Le rôle de l'assurance santé volontaire (complémentaire) est mineur et est estimé à moins de 1% des dépenses de santé.4
- Les dépenses de santé privées sont majoritairement via les paiements hors poche.

Delivery

- Le secteur privé est sous-développé et manque d’intégration avec le système de santé public.
- La médecine primaire est publique, mais la médecine secondaire et tertiaire sont une combinaison de public et privé; les services de soutien clinique et de soins de longue durée sont également mixtes.
- Arménie a un petit secteur de santé privé: 6 hôpitaux privés, plus de 1 000 unités de soins primaires et un total d'environ 400 lits.

Key challenges and/or reform agenda

- La tendance a été vers une décentralisation plus grande dans la manière dont la santé est organisée dans le pays.
- En raison des faibles niveaux de dépenses et des défis financiers actuels, le gouvernement arménien est vu comme ayant des perspectives limitées pour la réforme du secteur.

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
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<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private Out-of-pocket expenditure</td>
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<tr>
<td>Armenia</td>
<td>162</td>
<td>4.5</td>
<td>43</td>
<td>57</td>
</tr>
<tr>
<td>EEC average</td>
<td>303</td>
<td>6.8</td>
<td>42</td>
<td>58</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
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<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

4 See WHO (2013).
5 Ibid.
Azerbaijan

Expenditure on health care, 2014

Public: 20%
Private: 80%


Financing

- Public health care is funded by a single insurer, the National Assembly.
- The role of voluntary health insurance (supplementary) is minor and is thought to account for approximately 2 per cent of THE.6
- Private health expenditure is predominantly OOP.

Delivery

- The private sector is underdeveloped and is not well integrated with the public health system.
- Primary care is public, while secondary and tertiary care and clinical support services are a mixture of public and private. Long-term care is public.
- Azerbaijan has a small private health sector.

Key challenges and/or reform agenda

- The trend has been towards recentralisation of health care organisation and financing.
- The current programme of reform and agenda for the future prioritise the rationalisation of health care networks and aim to increase the capacity, skills and knowledge of health professionals.7

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
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<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>471</td>
<td>6.0</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>EEC average</td>
<td>303</td>
<td>6.8</td>
<td>42</td>
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<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


6 See WHO (2010).
7 Ibid.
Belarus

Expenditure on health care, 2014

<table>
<thead>
<tr>
<th>Public: 66%</th>
<th>Private: 34%</th>
</tr>
</thead>
</table>

Financing

- Public health care is funded by a single insurer, the Ministry of Health.
- The role of voluntary health insurance (supplementary insurance) is minor.\(^8\)
- Private health expenditure is predominantly OOP.

Delivery

- The private sector is underdeveloped and is not well integrated with the public health system.
- Primary care is public, while secondary and tertiary care are mainly public. Clinical support services are mixed and long-term care is public.
- The private health sector in Azerbaijan is small.

Key challenges and/or reform agenda

- The trend has been towards the recentralisation of health care financing and organisation.
- The current programme of reform prioritises the modernisation of the country’s health system and aims to increase revenue through exports of advanced medical services.\(^9,10\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
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<th>Private expenditure (per cent)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Belarus</td>
<td>450</td>
<td>5.7</td>
<td>66</td>
<td>34</td>
</tr>
<tr>
<td>EEC average</td>
<td>303</td>
<td>6.8</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Out-of-pocket expenditure</td>
<td>Private prepaid plans</td>
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<tr>
<td>Belarus</td>
<td></td>
<td></td>
<td>93.6</td>
<td>1.3</td>
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<td>87.5</td>
<td>6.9</td>
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<td></td>
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<td></td>
<td></td>
<td>71.6</td>
<td>23.4</td>
</tr>
</tbody>
</table>


\(^8\) See WHO (2013).
Bosnia and Herzegovina

Expenditure on health care, 2014

- Public health care is funded by multiple insurers.
- The main purchasers of health services in Bosnia and Herzegovina are the Cantonal Health Insurance Fund and the Federal Health Insurance Fund.
- The role of voluntary health insurance (supplementary) is minor and is a fairly recent development. \(^1\)

**Delivery**

- The private sector is small, underdeveloped and not well integrated with the public health system.
- Primary care is mixed, while secondary and tertiary care are public. Clinical support services are mixed and long-term care is underdeveloped.
- Private health expenditure is predominantly OOP.

**Key challenges and/or reform agenda**

- The trend has been towards decentralisation of health care financing and organisation.
- The reform agenda prioritises the development of public-private partnerships (PPPs) and thus overall integration of the two sectors. \(^2\)

**Comparison with regional average figures, 2014**

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>464</td>
<td>9.6</td>
<td>71 29</td>
<td>96.9</td>
</tr>
<tr>
<td>SEE average</td>
<td>643</td>
<td>7.6</td>
<td>63 37</td>
<td>97.1</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57 43</td>
<td>88.0</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73 27</td>
<td>71.6</td>
</tr>
</tbody>
</table>


\(^1\) See WHO (2002).
\(^2\) Ibid.
Bulgaria

Expenditure on health care, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>662</td>
<td>8.4</td>
<td>55</td>
<td>45</td>
</tr>
<tr>
<td>SEE average</td>
<td>643</td>
<td>7.6</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


Financing

- Public health care is funded by a single insurer, the National Health Insurance Fund.
- The role of voluntary health insurance (supplementary) is minor and is estimated to account for approximately 1 per cent of THE.\(^{13}\)
- Private health expenditure is predominantly OOP.

Delivery

- The private sector is integrated with the public health system.
- Primary care is private, while secondary and tertiary care and clinical support services are mixed. Long-term care is underdeveloped.
- Bulgaria's private health sector is small, but the country has some privately owned hospitals.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care financing and organisation.
- The current reform programme prioritises a major reorganisation of the hospital sector, the development of e-Health and the enforcement of rules regarding hospital management and data reporting.\(^{14,15}\)

Comparison with regional average figures, 2014

**Source:** WHO Health Expenditure Database (2016).
**Croatia**

**Expenditure on health care, 2014**

![Chart showing public and private health expenditure](image)

**Financing**

- Public health care is funded by a single insurer: the Croatian Health Insurance Institute.
- The role of voluntary health insurance (supplementary) is minor and not yet fully developed.\(^{16}\)
- Private health expenditure is predominantly OOP, while prepaid plans account for a significantly larger proportion of expenditure than in regional and OECD averages.

**Delivery**

- The private sector is integrated with the public health system.
- Primary care is private, while secondary and tertiary care are mixed. Clinical support services are mixed, and long-term care is also mixed.
- A combined total of approximately 80 hospitals in the public and private sectors.

**Key challenges and/or reform agenda**

- The trend has been towards decentralisation of health care financing and organisation.
- The current reform programme focuses on achieving a cost-effective hospital sector, an agenda that particularly favours the formation of PPPs.\(^{17,18}\)

**Comparison with regional average figures, 2014**

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Croatia</td>
<td>1,050</td>
<td>7.8</td>
<td>82</td>
<td>18</td>
</tr>
<tr>
<td>CEB average</td>
<td>1,231</td>
<td>7.2</td>
<td>72</td>
<td>28</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
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<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

*Source: WHO Health Expenditure Database (2016).*

\(^{16}\) See WHO (2014).

\(^{17}\) Ibid.

\(^{18}\) See Business Monitor International (2016).
Cyprus

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: the Ministry of Finance.
- The role of voluntary health insurance (supplementary) is minor.\(^{19}\)
- Private health expenditure is predominantly via OOP payments.

Delivery

- The private sector operates in parallel to the public health system.
- Primary, secondary and tertiary care are mixed (public and private), as are clinical support services and long-term care.
- The country has a total of 3,000 hospital beds, split more or less evenly between the public sector and the large private sector.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The agenda for the future/current reform programme prioritises reorganisation of the public system as well as the introduction of the General Health Insurance System.\(^{20}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Cyprus</td>
<td>1,819</td>
<td>7.4</td>
<td>45</td>
<td>55</td>
</tr>
<tr>
<td>SEE average</td>
<td>643</td>
<td>7.6</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
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<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


\(^{19}\) See WHO (2002).

\(^{20}\) Ibid.
Egypt

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: the Health Insurance Organisation.
- The role of voluntary health insurance (supplementary) is minor.\(^\text{21}\)
- Private health expenditure is predominantly via OOP payments.

Delivery

- The private sector operates in parallel to the public health system.
- Primary, secondary and tertiary care are mixed (provided by the public sector as well as the private sector), clinical support services are mixed, long-term care is underdeveloped.
- Egypt’s private health sector is small; in 2007, there were 200 private hospitals in operation compared with 1,300 public hospitals.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care financing and organisation.
- The reform programme focuses on increasing expenditure on health care, biomedical research and education to 10 per cent of the country’s GDP.\(^\text{22}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Egypt</td>
<td>178</td>
<td>5.6</td>
<td>38</td>
<td>62</td>
</tr>
<tr>
<td>SEMED average</td>
<td>258</td>
<td>6.5</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
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<td>27</td>
</tr>
</tbody>
</table>


\(^{21}\) See Business Monitor International (2016).
\(^{22}\) Ibid.
**Estonia**

**Expenditure on health care, 2014**

\[ \text{PUBLIC: 79\%} \quad \text{PRIVATE: 21\%} \]

**Financing**

- Public health care is funded by a single insurer: the Estonian Health Insurance Fund.
- The role of voluntary health insurance (supplementary) is minor and is estimated to account for approximately 1 per cent of THE.\(^{23}\)
- Private health expenditure is predominantly via OOP payments (98 per cent).

**Delivery**

- The private sector is well integrated with the public health system.
- Primary care is mixed (public and private), as are secondary and tertiary care. Clinical support services and long-term care are mixed.
- The private health sector is small.

**Key challenges and/or reform agenda**

- The trend has been towards recentralisation of health care organisation and financing.
- The current reform programme focuses on achieving 100 per cent coverage for national social insurance (currently at 95 per cent).\(^{24,25}\)

**Comparison with regional average figures, 2014**

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Estonia</td>
<td>1,248</td>
<td>6.4</td>
<td>79</td>
<td>21</td>
</tr>
<tr>
<td>CEB average</td>
<td>1,231</td>
<td>7.2</td>
<td>72</td>
<td>28</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
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<td>OECD average</td>
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<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

Georgia

Expenditure on health care, 2014

- **Public**: 21%
- **Private**: 79%


**Financing**

- Public health care is funded by a single insurer: the Ministry of Economy and Sustainable Development.
- The role of voluntary health insurance (supplementary) is minor but has seen growth in the last several years.\(^{26}\)
- Private health expenditure is predominantly OOP.

**Delivery**

- The private sector is well integrated with the public health system.
- Primary care is mixed, as are secondary and tertiary care. Clinical support services are private, while long-term care is mixed.
- Georgia has a large private health sector and nearly all hospitals in the country are privately owned.

**Key challenges and/or reform agenda**

- The trend has been towards recentralisation of health care financing and organisation.
- The current reform programme focuses on re-establishing the role of the public sector as a central public purchaser.\(^{27}\)

**Comparison with regional average figures, 2014**

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Georgia</td>
<td>303</td>
<td>7.4</td>
<td>21</td>
<td>79</td>
</tr>
<tr>
<td>EEC average</td>
<td>303</td>
<td>6.8</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
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<td>OECD average</td>
<td>4,094</td>
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<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


\(^{26}\) See WHO (2009).
\(^{27}\) Ibid.
Greece

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer, the National Organisation for the Provision of Health Services (EOPYY).
- The role of voluntary health insurance (supplementary) is minor.\(^28\)
- Private health expenditure is predominantly OOP (91 per cent).

Delivery

- The private sector is well integrated with the public health system.
- Primary, secondary and tertiary care are mixed, as are clinical support services and long-term care.
- Greece has a large private health sector, including profitable hospitals, which have surged in number over the past two decades.

Key challenges and/or reform agenda

- The trend has been towards centralisation of health care organisation and financing.
- The agenda for the current reform programme is driven by the government’s agreement with the European Stability Mechanism programme (regarding a VAT increase, clawback measures and rebate cuts).\(^{29,30}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Greece</td>
<td>1,743</td>
<td>8.1</td>
<td>62</td>
<td>38</td>
</tr>
<tr>
<td>SEE average</td>
<td>643</td>
<td>7.6</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
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<tr>
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<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

Hungary

Expenditure on health care, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Hungary</td>
<td>1,037</td>
<td>7.4</td>
<td>66</td>
<td>34</td>
</tr>
<tr>
<td>CEB average</td>
<td>1,231</td>
<td>7.7</td>
<td>72</td>
<td>28</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
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<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


Financing

- Public health care is funded by a single insurer: the Health Insurance Fund.
- The role of voluntary health insurance (supplementary) is minor and is estimated to account for approximately 3 per cent of THE.\(^\text{31}\)
- Private health expenditure is predominantly via OOP payments.

Delivery

- The private sector operates in parallel to the public health system.
- Primary care is mixed, while secondary and tertiary care are primarily public. Clinical support services are mixed, and long-term care is also mixed.
- The private health sector in Hungary is small.

Key challenges and/or reform agenda

- The trend has been towards recentralisation of health care financing and organisation.
- The current reform programme prioritises reorganisation of the health care delivery system and achievement of a uniform system of insurance.\(^\text{31,32}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Hungary</td>
<td>1,037</td>
<td>7.4</td>
<td>66</td>
<td>34</td>
</tr>
<tr>
<td>CEB average</td>
<td>1,231</td>
<td>7.7</td>
<td>72</td>
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<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


See WHO (2011).

See Business Monitor International (2016).

See WHO (2011).
Jordan

Expenditure on health care, 2014

Financing

- Public health care is funded by multiple insurers.
- The role of voluntary health insurance (supplementary) is expanding.\(^3^4\)
- Private health expenditure is predominantly via OOP payments.

Delivery

- The private sector is well integrated with the public health system.
- Primary care, secondary and tertiary care, clinical support services and long-term care are all mixed.
- Jordan’s private health sector is large, with more than half of the country’s hospitals privately operated.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The current reform programme focuses on improving access to medicine, enforcing the regulations covering clinical trials and increasing the number of hospitals and insurance coverage.\(^3^5\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Out-of-pocket expenditure</td>
<td>Private prepaid plans</td>
</tr>
<tr>
<td>Jordan</td>
<td>359</td>
<td>7.5</td>
<td>70</td>
<td>30</td>
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<tr>
<td>SEMED average</td>
<td>258</td>
<td>6.5</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
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<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

Kazakhstan

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer for each oblast: the oblast health departments.
- Role of voluntary health insurance (supplementary) is minor and is estimated to account for approximately 2 per cent of THE.\textsuperscript{36}
- Private health expenditure is predominantly via OOP.

Delivery

- The private sector is well integrated with the public health system.
- Primary, secondary and tertiary care are mixed, as are clinical support services and long-term care.
- The private health sector is small but growing.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The current reform programme prioritises the remodelling of the health finance system and introduction of a mandatory insurance fund by 2017.\textsuperscript{37,38}

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>539</td>
<td>4.4</td>
<td>54</td>
<td>46</td>
</tr>
<tr>
<td>CA average</td>
<td>200</td>
<td>5.1</td>
<td>52</td>
<td>48</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
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<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

Kosovo

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: the Ministry of Health.
- The role of voluntary health insurance (supplementary) is minor.\(^{39}\)
- Health care financing is exclusively OOP.

Delivery

- The private sector is not well integrated with the public health system and operates largely in parallel.
- Primary, secondary and tertiary care are mixed, clinical support services are also mixed, and long term care is underdeveloped.
- The private health sector in Kosovo is small.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The agenda for the future/current reform programme focuses on the formation of PPPs, reorganisation and further improving the insurance system.\(^{40}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Kosovo</td>
<td>194</td>
<td>5.0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>SEE average</td>
<td>643</td>
<td>7.6</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
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</tr>
<tr>
<td>Public prepaid plans</td>
<td></td>
<td></td>
<td>Out-of-pocket expenditure</td>
<td>Private prepaid plans</td>
</tr>
<tr>
<td>Kosovo</td>
<td>100</td>
<td>N/A</td>
<td>97.1</td>
<td>2.4</td>
</tr>
<tr>
<td>SEE average</td>
<td></td>
<td></td>
<td>88.0</td>
<td>9.9</td>
</tr>
<tr>
<td>EBRD average</td>
<td></td>
<td></td>
<td>71.6</td>
<td>23.4</td>
</tr>
</tbody>
</table>

\(^{39}\) See World Bank, Kosovo Health Project (2016).
\(^{40}\) Ibid.

Source: Kosovo Health Project, World Bank (2016).
Kyrgyz Republic

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: the Mandatory Health Insurance Fund.
- The role of voluntary health insurance (supplementary) is minor. \(^{41}\)
- Private health expenditure is predominantly via OOP.

Delivery

- The private sector is not well integrated with the public health system
- Primary, secondary and tertiary care are mixed, as are clinical support services. Long-term care is underdeveloped.
- The private health sector is small.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The agenda for the future and current reform programme prioritise the development of PPPs and the improvement of core health services.\(^ {42}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>----------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------</td>
<td>----------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Kyrgyz Republic</td>
<td>82</td>
<td>6.5</td>
<td>56 44</td>
<td>89.8 N/A</td>
</tr>
<tr>
<td>CA average</td>
<td>200</td>
<td>5.1</td>
<td>52 48</td>
<td>93.8 3.2</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57 43</td>
<td>88.0 9.9</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73 27</td>
<td>71.6 23.4</td>
</tr>
</tbody>
</table>


\(^{41}\) See WHO (2011).
Latvia

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: the Ministry of Health.
- The role of voluntary health insurance (supplementary) is minor.\textsuperscript{43}
- Private health expenditure is predominantly OOP.

Delivery

- The private sector operates in parallel to the public health system
- Primary, secondary and tertiary care is mixed, as are clinical support services and long term care.
- Latvia’s private health sector is small.

Key challenges and/or reform agenda

- The trend has been towards recentralisation of health care organisation and financing.
- The agenda for the future/current reform programme includes improving diagnostics, introducing e-Health and tackling issues related to finance.\textsuperscript{44,45}

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Latvia</td>
<td>921</td>
<td>5.9</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>CEB average</td>
<td>1,231</td>
<td>7.2</td>
<td>72</td>
<td>28</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

Lithuania

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: the National Health Insurance Fund.
- The role of voluntary health insurance (supplementary) is minor.\textsuperscript{46}
- Private health expenditure is predominantly OOP.

Delivery

- The private sector is expanding and becoming better integrated with the public health system.
- Primary, secondary and tertiary care are mixed; clinical support services and long-term care are also mixed.
- The private health sector of Lithuania is small.

Key challenges and/or reform agenda

- The trend has been towards recentralisation of health care organisation and financing.
- The agenda for the future/current reform programme prioritises structural reorganisation and improved budgeting and cost-sharing.\textsuperscript{47,48}

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Lithuania</td>
<td>1,063</td>
<td>6.6</td>
<td>68</td>
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<tr>
<td>CEB average</td>
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</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

FYR Macedonia

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: the Health Insurance Fund.
- The role of voluntary health insurance (supplementary) is underdeveloped.\(^{49}\)
- Private health expenditure is exclusively OOP.

Delivery

- The private sector operates in parallel to the public health system.
- Primary, secondary and tertiary care are mixed, clinical support services and long-term care are also mixed.
- The private health sector is small.

Key challenges and/or reform agenda

- The trend has been toward decentralisation of health care organisation and financing.
- The current reform programme includes improving education, expanding elderly-care homes and establishing a new financial model.\(^{50}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
<td>Out-of-pocket expenditure</td>
</tr>
<tr>
<td>FYR Macedonia</td>
<td>354</td>
<td>63</td>
<td>37</td>
<td>100</td>
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<td>SEE average</td>
<td>643</td>
<td>63</td>
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<td>97.1</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>57</td>
<td>43</td>
<td>88.0</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>73</td>
<td>27</td>
<td>71.6</td>
</tr>
</tbody>
</table>

Moldova

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: the National Health Insurance Company.
- The role of voluntary health insurance (supplementary) is minor.\(^1\)
- Private health expenditure is predominantly via OOP payments.

Delivery

- The private sector is well integrated with the public health system.
- Primary, secondary and tertiary care are mixed; clinical support services and long-term care are also mixed.
- The private health sector is growing; the number of public hospitals is declining while the private sector continues to expand.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The agenda for the future/current reform programme includes improving education, expanding the elderly care home network and establishing a new financial model.\(^2\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private Prepaid plans</td>
</tr>
<tr>
<td>Moldova</td>
<td>229</td>
<td>10.3</td>
<td>51</td>
<td>49</td>
</tr>
<tr>
<td>EEC average</td>
<td>303</td>
<td>6.8</td>
<td>42</td>
<td>58</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

Mongolia

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: Social Health Insurance.
- The role of voluntary health insurance (supplementary) is minor.
- Private health expenditure is predominantly via OOP.

Delivery

- The private sector is well integrated with the public health system.
- Primary care is mixed. Secondary and tertiary care are mixed, as are clinical support services and long-term care.
- The private health sector is growing.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The agenda for the future/current reform programme prioritises development of e-health, improving cost-effectiveness and further support for private sector involvement.

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Mongolia</td>
<td>195</td>
<td>4.7</td>
<td>55</td>
<td>45</td>
</tr>
<tr>
<td>CA average</td>
<td>200</td>
<td>5.1</td>
<td>52</td>
<td>48</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

Montenegro

Expenditure on health care, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Montenegro</td>
<td>458</td>
<td>6.4</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>SEE average</td>
<td>643</td>
<td>7.6</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


Financing

- Public health care is funded by a single insurer: the Health Insurance Fund.
- The role of voluntary health insurance (supplementary) is minor.\(^{55}\)
- Private health expenditure is exclusively OOP.

Delivery

- The private sector is well integrated within the public health system.
- Primary care is public while secondary and tertiary care are mixed. Clinical support services are mixed but long-term care is public.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The current reform programme prioritises increasing private sector participation through PPPs.\(^{56,57}\)

Comparison with regional average figures, 2014

\(^{56}\) Ibid.
\(^{57}\) Author’s analysis.
Morocco

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: the national health insurance agency ANAM.
- The role of voluntary health insurance (supplementary) is relatively substantial.\(^{58}\)
- Private health financing is predominantly via OOP.

Delivery

- The private sector is well integrated with the public health system.
- Primary, secondary and tertiary care are mixed, clinical support services are also mixed, and long-term care is underdeveloped.
- Morocco has a relatively substantial private health sector — the private sector accounts for 20 per cent of total bed capacity and two-thirds of primary care services.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The current reform programme prioritises improved access to health care, modernisation of medical equipment and increased private sector participation.\(^{59}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Morocco</td>
<td>190</td>
<td>5.9</td>
<td>34</td>
<td>66</td>
</tr>
<tr>
<td>SEMED average</td>
<td>258</td>
<td>6.5</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

Source: WHO Global Health Expenditure Database (2016).\(^{58}\) Source: WHO Health Expenditure Database (2016).\(^{59}\)
Poland

Expenditure on health care, 2014

Financing

- In Poland, public health care is funded by a single insurer: the national health fund NFZ.
- The role of voluntary health insurance (supplementary) is minor.60
- Private health expenditure is predominantly OOP.

Delivery

- The private sector is well integrated within the public health system
- Primary, secondary and tertiary care are mixed, clinical support services are mixed and long-term care are also mixed.
- Poland’s private health sector is substantial.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The current reform programme focuses on the implementation of a managed-care model and significant price cuts in the health sector.61,62

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Poland</td>
<td>910</td>
<td>6.4</td>
<td>71</td>
<td>29</td>
</tr>
<tr>
<td>CEB average</td>
<td>1,231</td>
<td>7.2</td>
<td>72</td>
<td>28</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

Private - OUT OF POCKET: 80.8%
Private - PREPAID PLANS: 13.7%
Private - OTHER: 5.4%


See WHO (2011).
See Business Monitor International (2016).
Romania

Expenditure on health care, 2014

**Financing**

- Public health care is funded by a single insurer, the Ministry of Health.\(^6\)
- The role of voluntary health insurance (supplementary) is minor.
- The private health system uses mainly OOP payments.

**Delivery**

- The private sector is well integrated within the public health system.
- Primary care is private and secondary and tertiary care are mixed; clinical support services and long-term care are mixed.
- Romania’s private health sector is substantial.

**Key challenges and/or reform agenda**

- The trend has been towards decentralisation of health care organisation and financing.
- The current reform programme prioritises the legalisation of informal payments to doctors and aims to increases the wages of public health care professionals by 25 per cent.\(^6\)

**Comparison with regional average figures, 2014**

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Romania</td>
<td>557</td>
<td>5.6</td>
<td>80</td>
<td>20</td>
</tr>
<tr>
<td>SEE average</td>
<td>643</td>
<td>7.6</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
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</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


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\(^6\) See WHO (2008).
\(^6\) Ibid.
Russia

Expenditure on health care, 2014

Financing

- Public health care is funded by multiple insurers. This includes a Federal Health Insurance Fund as well as Regional Mandatory Health Insurance Funds.
- The role of voluntary health insurance (supplementary) is substantial.\(^{65}\)
- Private health expenditure is predominantly OOP.\(^{65}\)

Delivery

- The private sector is well integrated within the public health system.
- Primary, secondary and tertiary care are mixed; clinical support services and long-term care are also mixed.
- Russia’s private health sector is substantial.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The current reform programme is focused on closing many public hospitals, which is shifting expenditure from state providers to private sector providers.\(^{66,67}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Russia</td>
<td>893</td>
<td>7.1</td>
<td>52</td>
<td>48</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

The health care sector in EBRD countries of operations

Serbia

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer: the Republican Health Insurance Fund, HIF.
- The role of voluntary health insurance (supplementary) is minor.\(^{68}\)
- Private health expenditure is predominantly via OOP payments.

Delivery

- The private sector is not well integrated within the public health system.
- Primary, secondary and tertiary care are mixed. Clinical support services are mixed, and long-term care is underdeveloped.
- The country’s private health sector is small but expanding.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The current reform programme includes improvements to primary care and education, increased access to health care and the enforcement of accountability within the health sector.\(^{69}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Serbia</td>
<td>633</td>
<td>10.4</td>
<td>62</td>
<td>38</td>
</tr>
<tr>
<td>SEE average</td>
<td>643</td>
<td>7.6</td>
<td>63</td>
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<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


\(^{68}\) See Business Monitor International (2016).
\(^{69}\) Ibid.
Slovak Republic

Expenditure on health care, 2014

Public: 73%
Private: 27%
Out of pocket: 82%
Other: 18%


Financing

- Public health care is funded by multiple mandatory health insurers providing statutory cover (public and private).
- The role of voluntary health insurance (supplementary) is minor.\(^70\)
- Private health expenditure is predominantly OOP.

Delivery

- The private sector is well integrated within the public health system.
- Primary, secondary and tertiary care are mixed. Clinical support services and long-term care are also mixed.
- The country’s private health sector is relatively large.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The current reform programme includes construction of a 945-bed PPP hospital, expansion of voluntary health insurance coverage and the nationalisation of all health insurers.\(^71,72\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
<th>Private prepaid plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
<td>Out-of-pocket expenditure</td>
</tr>
<tr>
<td>Slovak Republic</td>
<td>1,455</td>
<td>8.1</td>
<td>73</td>
<td>27</td>
<td>82</td>
</tr>
<tr>
<td>CEB average</td>
<td>643</td>
<td>7.6</td>
<td>63</td>
<td>37</td>
<td>97.1</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
<td>88.0</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
<td>71.6</td>
</tr>
</tbody>
</table>

Slovenia

Expenditure on health care, 2014

Financing

- A single insurer, the Health Insurance Institute of Slovenia, funds public health care.
- The role of voluntary health insurance (supplementary) is substantial.\(^74\)
- Private health expenditure is via OOP and private prepaid plans. Private prepaid plans account for a relatively large part of private health expenditure compared with the average for the EBRD region.

Delivery

- The private sector is well integrated within the public health system.
- Primary, secondary and tertiary care are mixed. Clinical support services and long-term care are also mixed.
- Slovenia’s private health sector is small.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The current reform programme prioritises the improvement of financial stability.\(^74,75\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Slovenia</td>
<td>2,161</td>
<td>9.2</td>
<td>72</td>
<td>28</td>
</tr>
<tr>
<td>CEB average</td>
<td>1,231</td>
<td>7.2</td>
<td>72</td>
<td>28</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

\(^73\) See WHO (2016).  
\(^74\) See Business Monitor International (2016).  
\(^75\) See WHO (2016).
Tajikistan

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer, the Ministry of Finance.
- The role of voluntary health insurance (supplementary) is almost non-existent.\(^{76}\)
- Private health expenditure is predominantly via OOP payments.

Delivery

- The private sector is not well integrated within the public health system.
- Primary, secondary and tertiary care are mixed. Clinical support services are mixed, and long-term care is underdeveloped.
- The private health sector is small and includes no major general hospitals.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The agenda for the future/current reform programme prioritises the improvement of health care quality and financial stability.\(^{77}\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>76</td>
<td>6.9</td>
<td>29</td>
<td>71</td>
</tr>
<tr>
<td>CA average</td>
<td>200</td>
<td>5.1</td>
<td>52</td>
<td>48</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
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<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


\(^{76}\) See WHO (2016).
\(^{77}\) Ibid.
THE HEALTH CARE SECTOR IN EBRD COUNTRIES OF OPERATIONS

Tunisia

Expenditure on health care, 2014

Financing

• Public health care is funded by a single insurer: the national health insurance fund CNAM.
• The role of voluntary health insurance (supplementary) is minor.\(^7\)\(^8\)
• Private health expenditure is predominantly OOP.

Delivery

• The private sector is well integrated within the public health system.
• Primary, secondary and tertiary care are mixed. Clinical support services are mixed, and long-term care is underdeveloped.
• Tunisia has a relatively significant private health sector. A large share of the revenue of private providers derives from international patients.

Key challenges and/or reform agenda

• The trend has been towards decentralisation of health care organisation and financing.
• The agenda for the future or current reform programme prioritises the development of the pharmaceutical sector.\(^7\)\(^9\)\(^\)\(^0\)

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Tunisia</td>
<td>305</td>
<td>7.0</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>SEMED average</td>
<td>258</td>
<td>6.5</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


\(^8\) See IHS Global Insight (2015).
\(^9\) See WHO (2010).
Turkey

Expenditure on health care, 2014

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>Total health expenditure (THE) per capita in US$</th>
<th>THE as a percentage of GDP</th>
<th>THE (per cent)</th>
<th>Private expenditure (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Turkey</td>
<td>568</td>
<td>5.4</td>
<td>77</td>
<td>23</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>OECD average</td>
<td>4,094</td>
<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Out-of-pocket expenditure</th>
<th>Private prepaid plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turkey</td>
<td>78.7</td>
<td>N/A</td>
</tr>
<tr>
<td>EBRD average</td>
<td>88.0</td>
<td>9.9</td>
</tr>
<tr>
<td>OECD average</td>
<td>71.6</td>
<td>23.4</td>
</tr>
</tbody>
</table>


Financing

- Public health care is funded by a single insurer, the Social Security Institution.
- The role of voluntary health insurance (supplementary) is minor.\(^81\)
- Private health expenditure is predominantly OOP.

Delivery

- The private sector is well integrated within the public health system.
- Primary, secondary and tertiary care are mixed. Clinical support services and long-term care are also mixed.
- The country has a large private health sector, with a number of large hospital networks.

Key challenges and/or reform agenda

- The trend has been towards the centralisation of health care organisation and financing.
- The reform agenda prioritises the introduction of zones in which health care is tax-free and a new system of referrals.\(^82,83\)

Comparison with regional average figures, 2014


\(^81\) See WHO (2011).
\(^82\) See Business Monitor International (2016).
\(^83\) See WHO (2011).
Turkmenistan

Expenditure on health care, 2014

**Financing**
- A single insurer, the Ministry of Economy and Finance, funds public health care.
- The role of voluntary health insurance (supplementary) is minor.\(^8^4\)
- Private health expenditure is exclusively OOP.

**Delivery**
- The private sector is underdeveloped and not well integrated with the public health system.
- Primary care is public and secondary and tertiary care are primarily public. Clinical support services are mixed, and long-term care is underdeveloped.
- Turkmenistan has a small private health sector, with one small private hospital.

**Key challenges and/or reform agenda**
- The trend has been towards decentralisation of health care organisation and financing.
- The reform agenda prioritises the re-establishment of medical centres in less urbanised areas and improvements in the quality of health care by reintroducing qualified doctors in medical facilities outside urban areas.\(^8^5\)

### Comparison with regional average figures, 2014

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<thead>
<tr>
<th>Country/region</th>
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<th>THE as a percentage of GDP</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>187</td>
<td>2.1</td>
<td>65</td>
<td>35</td>
</tr>
<tr>
<td>CA average</td>
<td>200</td>
<td>5.1</td>
<td>52</td>
<td>48</td>
</tr>
<tr>
<td>EBRD average</td>
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<td>6.7</td>
<td>57</td>
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<td>9.3</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


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\(^8^4\) See WHO (2000).
\(^8^5\) Ibid.
Ukraine

Expenditure on health care, 2014

- Public health care is funded by a single insurer: the Ministry of Health.
- Role of voluntary health insurance (supplementary) is minor.86
- Private health expenditure is predominantly OOP.

Delivery

- The private sector is underdeveloped and not well integrated with the public health system.
- Primary, secondary and tertiary care are mixed. Clinical support services are mixed and long-term care is public.
- The private health sector is small, consisting mostly of clinics and specialised facilities.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing, although many aspects of the semashko health care system still exist.
- The reform agenda has been halted due to the ongoing conflict in eastern Ukraine and political instability.87,88

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
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<th>THE (per cent)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Out-of-pocket expenditure</td>
<td>Private prepaid plans</td>
</tr>
<tr>
<td>Ukraine</td>
<td>203</td>
<td>7.1</td>
<td>51</td>
<td>49</td>
</tr>
<tr>
<td>EEC average</td>
<td>303</td>
<td>6.8</td>
<td>42</td>
<td>58</td>
</tr>
<tr>
<td>EBRD average</td>
<td>636</td>
<td>6.7</td>
<td>57</td>
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<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>


87 See Business Monitor International (2016).
Uzbekistan

Expenditure on health care, 2014

Financing

- Public health care is funded by a single insurer.
- The role of voluntary health insurance (supplementary) is minor.\textsuperscript{89}
- Private health expenditure is predominantly OOP.

Delivery

- The private sector operates in parallel to the public health system.
- Primary, secondary and tertiary care are mixed, as are clinical support services. Long-term care is underdeveloped.
- Uzbekistan’s private health sector is small.

Key challenges and/or reform agenda

- The trend has been towards decentralisation of health care organisation and financing.
- The reform agenda is likely to consist of shifting costs towards patients.\textsuperscript{90,91}

Comparison with regional average figures, 2014

<table>
<thead>
<tr>
<th>Country/region</th>
<th>Total health expenditure (THE) per capita in US$</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public</td>
<td>Private Out-of-pocket expenditure</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>124</td>
<td>5.8</td>
<td>53</td>
<td>47</td>
</tr>
<tr>
<td>CA average</td>
<td>200</td>
<td>5.1</td>
<td>52</td>
<td>48</td>
</tr>
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<td>6.7</td>
<td>57</td>
<td>43</td>
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