HEALTH+ WELFARE

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Commentary

Seeing Ahead – Helen Disney[1]

The countries of Central and Eastern Europe can provide us with a fascinating barometer for healthcare reform. Originally based on top down, state-dominated systems, known as the Semashko system, many countries have more recently taken radical steps towards market reforms, though others are now sliding back into nostalgia for government interventions.

Multiple pressures have faced the region – painful economic and political reforms undergone in order to join the European Union have combined with the additional costs to the consumer of privatised healthcare. For some countries, like Slovakia, the price has been too high and elements of market reforms have now been reversed. For others, like the Czech Republic, some market elements, such as co-payments, are coming into the system but combined with a much harsher climate for reimbursements of medicines. Everywhere, healthcare reform is a highly sensitive topic and a political hot potato, as you will see from our Head to Head section in which an opponent and a defender of the recently proposed Czech reforms do battle.

Given our fascination with the region, the Stockholm Network's recent healthcare initiative, CEE Ahead, has been set up to specifically examine the progress of healthcare modernisation across CEE states. In 2008, we launched our CEE Ahead website with regular news flashes and updates from the region. We published a stage setting paper giving an overview of the reform process as a whole and we held our first public event in Slovenia, in association with member think tank, Joze Pucnik Institute and addressed by Slovenian MEP and Chairman of the Institute, Dr Mihael Brejc.

In this special CEE focused issue of *Gesundheit!* we look at what has been happening in various countries in the region including Slovakia, Romania, and the Czech Republic, as well as taking an in-depth look at the state of Greece's health system.

In 2009, with the chill winds of the global economic climate to consider, it remains to be seen whether harsh times will provide a greater spur to market-oriented reform. Will governments look to save public funds for other priorities, or will calls for government intervention to shore up health provision and jobs be as strong as they have been in the financial and other sectors? Just as they cannot allow high street banks to go under, one prediction is sure, no European government will allow national health systems to fail, at least not when it comes to public funding. Service quality, however, is another matter altogether.

Topic of the Month

Slovak health reform sets V4 rolling – Peter Pažitný[2]

Semashko's legacy

The ideal of providing free health care in post-socialist countries is a legacy of the Soviet health system, the foundations of which were laid after the October Revolution in 1917 by Nikolai Semashko. The Soviet Union was the first country in the world to give all its citizens the constitutional guarantee of free health care. However, in practice patients often made

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[2] Peter Pažitný is a partner at the Slovak think tank Health Policy Institute and a former Principal Advisor to the Slovakian Minister of Health.

informal payments. The goals of the universal and egalitarian health system were systematically thwarted by insufficient budgetary coverage. The result was an underfinanced and highly inefficient system offering poor quality without value added to improve the population's state of health. Central planning engendered widespread corruption, harmful motivation and huge structural imbalances.

After the Second World War, Semashko's model was exported to Eastern Bloc countries, pushing them into the twin trap of believing this was a payment-free system taking away their individual responsibility. The costs of this system were significant: a limited range of modern drugs, diagnostics and treatment. The result was a reduction in mean life expectancy. In Slovakia, between 1960 and 1990 life expectancy for men declined by 1.5 years, while life expectancy for women rose by a mere 2.7 years. Life expectancy started rising faster in the 1990s, but thus far we have failed to narrow the gap in relation to the more developed EU-15 states.

V4 lags 15 years behind the EU-15

Even though the standard of living in Central Europe is improving, the V4 countries (Slovakia, Poland, Hungary and the Czech Republic) still lag 15 years behind EU-15 countries. This backwardness can be felt on three levels – in economic performance, in expenditure on health care and in mean life expectancy.

In 2005, the V4 countries spent USD 1,221 per capita on health (in terms of purchasing power standards); this was the sum spent by the EU-15 countries in 1990. By the same token, GDP per capita in the V4 states in 2005 was USD 17,003; EU-15 countries had already achieved this level (USD 17,677) back in 1990.

A comparison of life expectancy shows the V4 lagging even further behind the EU-15. The average V4 inhabitant in 2005 could expect to live 74.5 years. The EU-15 countries reported this life expectancy as long ago as 1983. Life expectancy in the EU-15 today is 79.4 – almost five years higher than in the V4.

But while wealth, health spending and life expectancy are more modest than in the EU-15, our expectations and demands towards the health system are not. Indeed, in line with the increase in wealth and life expectancy, our expectations and demands of the health system are growing. Patients in the V4 expect the limited resources they put into the system to provide them with the same standard of care they see in the developed EU-15 states. Given that the strength of the economy dictates how much money can be spent on the health service – thus limiting any further substantial increase in health care spending – V4 countries are striving to find solutions that will uncover internal reserves within the system via reforms. They are focusing on:

1. Curbing excessive use of health care by introducing user charges;
2. Enhancing the efficiency of healthcare purchasing by commercialising health insurance; and
3. Increasing the safety of healthcare provision by introducing independent surveillance authorities.

User charges – the linchpin of the policy battle

The first V4 country that decided to introduce user charges was Slovakia in 2003. This resulted in a fall in the number of visits in the primary sphere by 10% and a drop in the number of prescriptions by 8%. Fears that the availability of health services would deteriorate proved to be unfounded. In December 2002, more than 32% of respondents regarded corruption and the growth of informal payments in the health sector as a serious problem (this was second in the overall order of problems). By January 2004, this was singled out as the most serious

problem by only 10% of respondents and had fallen to seventh place. Unfortunately, a new government abolished charges after taking control of the country in September 2006.

Charges were introduced in Hungary on 15 February 2007, and the results in the wake of this move were very similar to those recorded in Slovakia. There was a reduction in excessive demand (by 19-25%); an increase in savings within the system of EUR 160 million per year; an increase in providers' revenues by EUR 85 million per year (which on an individual level was equivalent to growth of 20%-50% compared to the previous level of income); and a drop in levels of corruption. However, on 1 April 2007 the government removed charges after the opposition initiated a successful referendum to have them abolished; 51% of the electorate took part, with more than 82% of them in favour of discontinuing the user charges.

In the Czech Republic, user charges were introduced on 1 January 2008. Compared to the same period one year earlier, visits to accident and emergency facilities were down by 44%, visits to outpatient specialists fell by 24%, and the number of hospitalisations dropped by 14%. According to preliminary data, there was also a dramatic fall in visits to pharmacies – the number of prescriptions plummeted by 45%, although this figure may reflect drug stockpiling by the public in December 2007. According to the health ministry, the annual protection limit (EUR 200) – designed to protect chronically ill patients from an excessive financial burden caused by the need for medication and by charges – is working well. However, the political opposition is already stating that it will abolish the user charges if it wins the coming general election in 2010.

Enhanced purchasing efficiency

Limiting access to health care through user charges, thereby increasing the value of health services to patients, is linked to the increasing demands that health insurance companies face on their resources. All V4 countries have painful experiences with soft budgetary constraints. Health sector debts at the end of 2002 were EUR 900 million in Slovakia. The Czech Republic has had to inject more than EUR 400 million into the system from the Czech Consolidation Agency, and in 2006 it significantly increased the state contribution to the system by EUR 360 million in order to settle existing debts. The Hungarian monopoly purchaser OEP was generating a deficit of EUR 1,200 million a year as of 2002; the situation was only stabilized when the government made up for the deficit every year. The debts chalked up by Polish hospitals stood at EUR 1,860 million in March 2005 despite assistance from the state.

Slovakia was the first country to place heavy restrictions on the budget with a view to preventing the waste of precious resources. In 2005, health insurance companies were transformed into joint stock companies with the possibility of making a profit. The result was they stopped recording debts. This was similar to the result with hospitals that had been turned into joint stock companies. A key role in this transformation was played by the company Veritel, which assumed creditors' receivables from hospitals and health insurance companies. It was extraordinarily effective, discharging debts worth EUR 1,100 million for just EUR 660 million. Today, it is only the non-transformed state hospitals that generate debts. As of 31 December 2007, their debts stood at approximately EUR220 million.

The idea of leaving all health care purchasing to health insurance companies – the entity with the most information and the motivation to keep costs under control – limiting the role of the government to that of a regulator of quality and availability, was not confined to Slovakia, but has now spread to all V4 countries. Apart from the move to hard budgetary constraints,

V4 countries are also trying to decentralise the health insurance market and switch to a system of multiple insurers. Hungary attempted to go down this path earlier this year, but following the government's defeat in a public referendum it has been forced to abandon not only user charges, but also its plans to liberalise health insurance. In contrast, Poland is sticking to its plan of decentralising health insurance and allowing private insurers to enter the market in 2010-2012. According to proposals being prepared by the new Health Minister, Ewa Kopacz, there are plans to split the health insurance monopoly NFZ into several autonomous health insurance companies that will operate on a competition-based principle with a clearly defined scope of rights and obligations; in time, other private insurers would be allowed to operate on the basis of equal rights and a level playing field.

Similarly, in the Czech Republic the issues most debated in the reform of health insurance are the transformation of health insurers into joint stock companies and the transfer of teaching hospitals to universities. The idea of joint stock companies is opposed not only by the political opposition, but even by parts of the governing coalition, which disagrees with the initiative and instead wants to ensure that insurance companies remain non-profit entities. As in Slovakia and Hungary, in the Czech Republic the question of whether to permit profits is therefore one of the key reform issues. However, the reform of the insurance system in the Czech Republic should not end with the transformation into joint stock companies. The keystone should be policyholders' possibility of selecting a health plan based on their own personal preferences.

Independent regulators

The state's switch in health policy from insurer and provider to the creator of the rules of the game has resulted in the need for new independent regulatory authorities. Apart from the important role of separating the creation of the rules of the game from their enforcement, these authorities are also important in ensuring transparency and objectiveness in assessing the health market.

A sensitive issue related to regulators is their financial and political independence. A good solution is to fund the regulator from the resources of the entities supervised and not from the national budget. The greatest blow to the independence of the Slovak Health Care Surveillance Authority came from the new government, which subordinated the originally independent president of the Authority to the health minister's mandate. This is clearly not reconcilable with the concept of an independent regulatory authority. In Hungary, where the regulator can also be removed by a government minister, the situation is similar.

Unpopular reforms lead to greater responsibility

The Slovak health reform initiatives of 2002-2006, spearheaded by Minister of Health Rudolf Zajac, offer a powerful inspiration to neighbouring countries and their reform plans. These reforms have implemented instruments leading to greater patient responsibility (user charges), greater responsibility of health insurance companies for the purchasing of health care (hard budgetary constraints) and greater provider responsibility (surveillance authorities).

Hard budgetary constraints and the motivation to make a profit have resulted in Slovak health insurance companies changing their purchasing patterns: Insurers are drawing up charts of providers, they are starting to show the first real signs of selective contracting, and new products are being created for policyholders. Private insurers have increased their market share from 20% to 33% over the last three years. All this is taking place in a macro environment not at all inclined towards private

insurance companies and market competition. The new government is trying to control, centralize and manage the system through a host of meaningless measures (e.g. the order to reinvest profits), which are arguably unconstitutional and damage foreign investors.

Hungary and the Czech Republic, following Slovakia's example, have introduced user charges to make their citizens more responsible for their health and for the use of health services. In all three countries, however, these steps are unpopular, and this is exploited by populists keen to improve their political standing. In Slovakia, after three years of user charges the new government abolished them as soon as it came to power. In Hungary, a successful referendum to abolish user charges was held on March 9 2008 (just a year after their introduction), and the Hungarian government consequently discontinued charges under pressure from the opposition and the public as of 1 April 2008. According to Hungarian liberals, who introduced the charges, people believed that they could reverse the reforms and that there really is such a thing as a "free lunch". In the Czech Republic, the opposition criticizes the charges and promises to abolish them in order to build up a "free health service". But in the V4 we have already had that idea once before - from Comrade Semashko.

Think Tankers Corner

Healthcare Systems Reform: the Romanian Patient – Bogdan Lazarescu[3]

The Romanian healthcare system has all the symptoms of former communist countries' misallocations and overcapacity: low public healthcare expenditure per capita, a larger number of hospital beds per 10,000 inhabitants compared to the OECD average, a large ratio of expenditure on hospitals and pharmaceuticals. As a result of an aging population Romania has a large number of pensioners. In addition, a large subset of the population is uninsured subsistence farmers. Less than a quarter of the total population is formally registered as employees, paying contributions to the National Health Insurance Fund.

In 2005, a survey commissioned by the World Bank showed that informal payments to health care staff amounted to USD360million, more than 10% of total Romanian health care expenditure at that time. The reason for this is simple: since the Romanian public health insurance system and the governmental programmes (direct budget allocations) are supposed to cover almost all health care needs of the entire population, informal payments occur whenever the public system fails to provide just that. For example, while staying in inpatient care, patients may have to purchase pharmaceuticals or materials which are supposed to be provided free of charge by hospitals.

In addition, there is the problem of fraud: Hospitals and GPs make false statements on bed occupancy and consultations so as to be disbursed the maximum amounts available by the health insurance fund while they sell sick leaves, pharmaceuticals and medical devices on the black market.

The argument over whether the market is the perfect mechanism to counter such corruption and injustices in the health care system takes us nowhere. It is probably true that the market, through voluntary health care insurances (VHI) and 'fee for service' or user charges, is not suitable to ensure proper access to services for the less affluent. Provision is conditioned by the capacity to pay for services not covered by the public system. But how is this different from the

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current situation where there is already an informal market for health services whereby the less affluent pay the same informal fees as the better off? In fact, this situation arguably poses an even bigger threat to access for the less affluent as they are treated on an equal footing with those with higher income.

But there is something more to market than just supply and demand: it is the correlation between financial inputs and the outcome in terms of the health conditions of a population, something I would like to call accountability. While Romania's public healthcare expenditure has almost doubled since 2005 (on account of sustained economic growth, and not proportionally as a percentage of GDP) from €3billion to €6billion, there is no clear evidence about where all that money has gone when looking at improving health indicators, not to mention emerging threats to health. Since it is clear that the public system cannot cover all health care needs, the choice we have to make is between leaving the informal payments market as it is and bringing all these funds into the formal system via VHIs and user charges. Voluntary insurance and user charges would bring about a set of other policy changes the Romanian health care system so far has been lacking: attaching an average cost and a specific route to each type of care (the introduction of Diagnosis Related Groups was delayed and then made difficult to enforce due to the lack of therapeutic protocols) making the costs of care more transparent, then trying to design a system whereby the less affluent are exempt or bear a lesser co-payment burden. While the latter may well be a short to medium term policy (some studies suggest that those with VHIs tend to take advantage of it by using health care services more frequently, countering the expected benefits from redistribution towards the worse off) VHI would at least instate: i) clear rules of financial allocation; ii) fair yet performance based wages for medical staff; and iii) allow a correlation between money spent and results obtained in terms of the population health status.

So far, the Romanian Government has managed to avoid almost all World Bank lending conditions for allocating funds and loans based on results on the ground, arguing that such conditions may inhibit demand, overlooking the fact that the informal payments market has been doing this job since the early 1990s.

A succession of Romanian governments have been reluctant to introduce a mandatory accreditation system for health care providers enforcing minimum quality standards as more than half of the state owned providers would fail to meet such standards.

The major fear among policymakers is not regarding the equity of the new system but rather the fact that a large percentage of the population may see VHIs and user charges as an additional financial burden, almost like paying twice for the same service. But until politicians step up and explain the reality of the situation, some hospitals in Romania will – for routine procedures like appendicitis surgery – be reimbursed twice the amount received by other hospitals.

The Romanian health care system is in need of serious structural reform. Let us hope that governments and all public policy stakeholders alike have the courage to begin the long process that can take Romania in a market-driven direction in which care is affordable, equitable and of the highest possible standard.

Special Report

A Survey of the Greek Health Care System – Savvas Parselias[4]

What stands out when one tries to sketch the profile of the Greek health sector is the co-existence of a vast amount of private expenditure[5], a National Health Service (ESY – Ethniko Systima Ygheias), and a very low rate of uninsured - only 5 percent of the population. This high level of private expenditure, the vast majority of which consists of direct payments, in combination with a disappointing and economically inefficient public provision of health care, means that the ESY has failed to deliver on its founding principles of equity and efficiency. Reform can take two directions; towards the strengthening of the ESY and public insurance funds, or the introduction of market mechanisms and a safety net for the groups that most need it. Internationally, there are many examples of how such policies can benefit patients, but in Greece such proposals are absent from public discourse.

An X-ray of the Greek health care system

In 1983 the newly elected social democratic government established the Greek National Health Service which would be free at the point of use. Initial plans included the unification of the numerous insurance funds, the membership of which depended on occupation, in order to achieve concerted action and create a monopsony. The measure faced the resistance of the members of those funds which provided the most comprehensive benefits and doctors, and was, consequently, abandoned[6]. Instead, the expansion of the hospital sector was to become the centre of gravity of government efforts. Non-profit hospitals were nationalised and the establishment of new private hospitals or the expansion of existing ones was prohibited. Socio-political pressures prevailed throughout the years and shaped the current system, which can be best described as a sequence of inertia, and minor reforms– heavily influenced by interest groups.

The current health system includes around 30 social insurance funds that cover around 95 percent of the population. Membership of the funds depends on occupation, and there is no freedom of choice. The ESY provides public hospitals, public primary health centres and rural posts, which accept any person who seeks treatment; even non-citizens and the uninsured. At the same time, IKA, the largest insurance fund, which covers around 50 percent of the population, provides 242 urban primary health centres and a few hospitals to its beneficiaries[7].

Private health providers are an integral part of the health care system. Following the ban on the expansion and creation of private hospitals, entrepreneurs shifted their focus to diagnostic centres and laboratories, a sector in which private initiative has thrived. After 2000, when the ban on private hospitals was lifted, private hospitals started emerging, today accounting for 16 percent of total hospital admissions[8]. At the same time, hundreds of private practices operate throughout the country. Private health providers are either contracted by insurance funds or accept direct payments from patients. Public insurance funds do not have a common policy when it comes to contracting private providers and payments may be on a fee-for-service or a capitation basis.

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[5] According to the World Health Organisation, general government expenditure accounts for only 42.8 percent of total expenditure, the lowest among EU member states. Of the remaining 58 percent around 2 percent is spent on private insurance and the rest on formal or informal direct payments.

[6] Mossialos, Allin, Davaki, 'Analysing the Greek health system: A tale of fragmentation and inertia'. *Health Economics* 14: S151-168.

[7] Ibid.

[8] Siskou O, et al., 'Private health expenditure in the Greek health care system: Where truth ends and the myth begins', *Health Policy* (2008), doi:10.1016/j.healthpol.2008.03.016

The issue of equity

The ESY was founded on the principle of equity. The first article of the law proclaimed that all citizens, regardless of their economic and social status or location of residence, have equal rights to high quality social and health care, and treatment[9]. Even though the ESY and the public insurance funds are heavily subsidised by the state budget through taxation (30.4% of total health expenditure[10]), it is extremely doubtful whether equity has been achieved.

First, freedom of choice is not uniform among members of different public insurance funds. As mentioned above, there is no common policy regarding the contracting of services to the private sector. The inequities are more apparent in the primary care sector, where IKA beneficiaries have limited access to private contracted doctors.

Even within the ESY there are cases where there is rationing taking place in the form of informal payments. An amount of money is given to doctors voluntarily to express gratitude for the services provided, or in order to jump the queue, and/or to secure more attention. Although it is extremely difficult to record the amount of such payments, a household budget survey has estimated that informal under-the-table payments in public hospitals amounts to 2.9% of total household payments for health care.[11] Moreover, doctors refer patients to their private practices for extra consultation and attention. It needs to be noted that ESY doctors are salaried civil servants who have no right to run private practices outside the ESY framework.

To sum up, the patients who have the option of avoiding ESY treatment, either through their insurance funds' contracts with private providers or through private medical insurance or by direct payments are considered to be better off.

The issue of efficiency

While Greek households spent large amounts on private health care, few cost containment mechanisms are in place. As mentioned above, the insurance funds may contract private doctors to provide primary health care. Nevertheless, the system of primary health care is disorganised and leaves great scope for mismanagement of funds. There is no system of referral, as the role of family doctors is nonexistent and only 2% of doctors are general practitioners. This alone enhances freedom of choice and access to specialists, but in combination with the absence of computerised medical records systems, it has proven to be an enemy of public funds. In some cases private doctors have been reported to receive fees for consultations that never took place. Moreover, doctors may prescribe unnecessary tests and refer patients to specific private laboratories and diagnostic centres with which they are 'cooperating' and receive a fee per referral.

Public hospitals' and public insurance funds' budgets are practically demand-led, as any deficits are dealt with retrospectively by government subsidies. Hence, there are no incentives to improve efficiency on the micro level. Moreover, doctors are employed in hospitals according to beds available and are allocated equally to the hospital departments disregarding actual needs. This leads to inefficiencies, as 60.1% of hospital departments reach occupancy rates of up to 100%, whereas 34.4% reach rates of fewer than 50%.[12]

The way forward

The Greek health system is not efficient, and leaves much room for wasting public money. Government subsidies have been keeping the

[9] Law 1397/83.

[10] Figure refers to year 2000. Mossialos, Allin, Davaki…

[11] Siskou O, et al…

[12] Mossialos, Allin, Davaki…

system alive up until now, but an ageing population and fiscal pressures mean that reform is urgent. There can be two main trajectories for reform. First, try to strengthen the NHS, and increase efficiency through command and control mechanisms, and second, introduce market mechanisms. The first option is the one that seems to be preferred by consecutive governments since 1983. The current conservative Greek government this year merged the largest insurance fund IKA with four smaller ones[13]; a policy that brings to mind the initial plans of the 1983 socialist government for a unified insurance fund. Nevertheless, command and control mechanisms have largely proven to be unsuccessful, as they have been heavily influenced by interest groups, and have rarely managed to achieve the declared goals.

Introducing market mechanisms in the Greek health system could, on the other hand, increase freedom of choice for patients, and deliver higher quality of services, and a better management of funds. Competition, where it currently exists, has proven to be beneficial. Cooperation between private health providers and some public insurance funds has offered beneficiaries significant freedom of choice, and a higher quality of services, as a consequence of competition, and shifted some pressure away from the ESY. At a first stage, giving citizens the freedom to choose an insurance fund would give the funds incentives to provide the best services with less money. At the same time, high private expenditure in direct payments could be spent on risk-spreading insurance schemes, further improving the system. There are many more examples of how market mechanisms may benefit the health sector.

The fact is that the Greek health system has – at great financial cost – failed to provide high quality health care to all citizens. There have been many attempts to save the current system, but they have failed. It is time that new market-based ideas were introduced in the public discourse, and brought to the top of the political agenda.

[13] http://www.in.gr/NEWS/article.asp?lngEntityID=92399 Accessed 31 July 2008. In Greek.

Head2Head

Health reform in the Czech Republic: Should hospitals and health insurers be privatized?

Health reform is a hot topic in CEE countries. Across the region there is an often intense argument between those who wish to reform the system through privatisation and a greater role for the market versus those who wish to preserve a pronounced public presence. Who's right and who's wrong? In this edition of Head2Head our two distinguished contributors take sides.

Jiří Schlanger[14]

Last year the Ministry of Health of the Czech Republic proposed health care reforms focusing on changes in ownership of hospitals and health insurance companies. Trade unions strongly opposed them, arguing that reforms should, rather, concentrate on relations inside the Czech health care system and regulation of market behaviour, with the aim of securing maximum accessibility and quality within the public health insurance system. While this 2008 initiative has so far been stalled, the Czech Government (and new Health Minister) has vowed to continue promoting reforms in the healthcare. The following is an outline of some of the main problems with last year's initiative.

The authors of the government-proposed reforms were misinforming the public on the potential benefits of the proposed reforms. In 2005, World Bank experts pronounced their support for the Czech health insurance system. They described it as the most valuable part of the Czech healthcare system and stated that the existing problems resulted from regulation of healthcare insurance caused by political interference in the system. In 2007, a study by the Czech affiliate of Transparency International looked at Czech healthcare and health care resources and the negative effects of corruption. An independent professional

[14] Dr Schlanger is the President of the Trade Union of the Health Service and Social Care of the Czech Republic.

Lucie Bryndova[15]

The question posed above is a misleading one. A key point of the Czech healthcare reform is not whether public ownership at the level of central government, regional autonomies or municipalities is better than that of private businessmen. Hospitals, as well as health insurers, can provide quality services under any of the above mentioned ownership models. Rather, it is a question of efficiency. To achieve this, these health care entities need to have a legal form that allows for their efficient management, responsible ownership and oversight from a public regulatory body.

Unfortunately, this is not the case in the Czech Republic at present.

These health care entities need a legal form that would allow them to have a real owner - someone who is responsible for and interested in their economic and social performance and long-term development, and will not use them only for short-term economic or political purposes. Hence, the proposed Czech healthcare reform is, not in the first instance, about ownership, but about legal form. Confusing the question of legal status with that of ownership is one of the biggest misunderstandings dominating current political debates in the Czech Republic.

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platform – Czech Healthcare Forum – as well as the OECD have identified the key problems in Czech health care.

Briefly summed up these are as follows: lack of motivation for effective treatment; big differences in quality and accessibility of care; different payments for the same treatment; lack of information about quality for decision-making purposes etc. But the Government's suggested reforms did not seek to solve these problems. Instead they would eliminate health care as a public service and, above all, act as a transfer of property. Privatization of health-insurance companies was being prepared; teaching hospitals were to be changed into joint-stock companies (with the majority of tradable securities belonging to the State and non-tradable minority to universities) which would later be privatized. Regulated healthcare was being prepared for patients, limiting the free choice of physicians, with the result being the provision of the cheapest care possible. Any money saved by citizens on the cost of health insurance would partly become profit for private owners and would have disappeared from the public health care system altogether.

There are 10 health insurance companies in a country with 10 million inhabitants. The biggest one (General Health Insurance Company serving 65 % of population) was not to be privatised. The others, some of them rather influential in different sectors/regions, were to be privatised.

The government wanted to distribute the proceeds from the selling of these health insurance companies to the public. But it did not tell people that they would receive only a small one-time amount, while the changes made would limit care irreversibly and make it more

Formerly, all hospitals in the Czech Republic used to have the legal status of a budgetary organisation. This legal status is a legacy of the past and has little to do with anything under current business codes or legislation. A budgetary organisation does not have standard accounting procedures; the management and scrutiny of its economic performance is very difficult since auditing practices often do not correspond to those more commonly used; and the ultimate responsibility for decision and hospital performance is not clearly specified either.

Apart from teaching hospitals, most hospitals are run by the regions with only a minority run by local municipalities, the Church or private industry. Six years ago the Regions gained control of hospitals from the central Czech Government. At the time hospitals were in very dire financial straits. Soon after this the regions started to turn their hospitals into joint-stock companies. Bearing in mind the total number of hospital beds in the Czech Republic per population is still 40% above the OECD average, some regions (i.e. Central Bohemia) sold several smaller – and for the purposes of regional healthcare – redundant hospitals to private owners.

As a cost-cutting measure other regions rent hospital management; a practice common also in other European countries. The vast majority of regional hospitals remain the property of the regions. But official statistics on in-patient care facilities do not reflect this ownership structure, instead falling under the two categories of simply "public" and "private" only the obsolete legal forms of hospitals are monitored. Hence, budgetary organizations are viewed as "public" and joint-stock companies as "private" ones, irrespective of ownerships by public entities such as regions and municipalities.

expensive. Vertical monopolies are emerging already and last year's reform initiative would further have supported them. One owner would have operated a health insurance company, in-patient and out-patient facilities, pharmacies etc, providing the cheapest possible care with no other choice available.

Not only the official political Opposition but also smaller political parties, trade unions and employers, universities, patients' and other citizens' organizations opposed these reforms. Trade Unions are aware of the changes the Czech healthcare system needs. But the government's proposed reform would only have resulted in a dangerous experiment bringing about not improvements but a deterioration of the situation for both patients and healthcare workers.

Regarding teaching hospitals, the claim that the Czech Government intends to sell them to private parties is false. There was a plan to transform them from the legal form of budgetary organisations into joint-stock companies. The aim was to provide them with a well functioning legal environment, clearly defined responsibilities of owners as well as management and transparent accounting. The second step then involved transferring one third of shares to Universities with medical schools, the aim being to allow Universities to have direct influence on the hospitals' performance. Universities are public schools. Can we call this intention a "privatisation"? The answer is no. Nevertheless, these plans are, due to political sensitivity, put on hold for the moment.

My last point concerns health insurers. They are not even budgetary organisations like the above mentioned hospitals. Actually, their public ownership can be questioned. They neither belong to a private party nor to the government, nor to their policyholders (ie the people). Who do they belong to? That is the question that the Czech healthcare reform wants to resolve once and for all. Today, since they have no actual owner, there is nobody to insist on their prosperity and efficiency, whereas many parties have incentives to take advantage of them. Many of the members of boards of trustees are even appointed by the government or directly by political parties, without having any personal liability. As soon as health insurers have a legal status more appropriate for such important financial institutions – that is, they become joint-stock companies - it will then be the responsibility of the government to find skilful, high-quality and credible owners for them and make these organisations responsible and accountable for everything they do.

New Initiatives and Publications

CEE Ahead – A vision for sustainable health care

CEE Ahead is an independent, non-partisan initiative promoting high quality healthcare solutions for Central and Eastern Europe (CEE). The Stockholm Network acts as the initiative's secretariat. Partners involved in the project seek to create a better understanding of best practice in healthcare from around the world.
How can a more competitive market be created without sacrificing social solidarity? How can CEE countries attract greater investment in their health systems? Is there a way to allow patients to take more control of their own treatment and care? How can new innovation and respect for intellectual property rights be encouraged?
http://www.stockholm-network.org/Conferences-and-Programmes/Health-and-Welfare/CEE-Ahead

Health Care Reform in Central and Eastern Europe: Setting the Stage for Discussion - Stockholm Network research team

This paper examines the transformation and reforms of Central and Eastern European (CEE) health care systems following the collapse of the Soviet Union in the early 1990s. Taking the examples of Poland, Hungary, the Czech Republic, Slovenia and Romania it sketches the major success stories but also examines the missed opportunities and major backlashes against these reforms.
http://www.stockholm-network.org/downloads/publications/CEE_Discussion_Paper.pdf

What price for a year of life? The Threshold Discussion in Health Technology Assessment – Stockholm Network research team

This paper by the Stockholm Network researc team looks at the sensitive issue of how cost constraints in health care are handled. We often read that the role of institutions like NICE in Britain consists in checking whether a medical treatment provides 'value for money'. But what precisely does 'value for money' mean? What is an 'appropriate' relation of costs and benefits? This paper, the fourth piece in a topical series on HTA, analyses how this question is answered in a selection of countries. It also explains why in some health systems, this issue is more sensitive than in others.
http://www.stockholm-network.org/downloads/publications/HTA_4.pdf

The Health Quality Agenda – David Torstensson and Gulya Isyanova

In *The Health Quality Agenda* the Stockholm Network has taken a fresh look at the issue of health care spending.

This paper attempts to re-evaluate the way health care expenditure is understood. As such, it pertains to a much wider understanding of health and health care than is normally taken into account by policymakers. In particular, it examines consumer spending on a novel basket of health and wellbeing goods, which relate to this wider understanding of health.

This paper demonstrates that in categories ranging from sport and fitness expenditure to alternative medicine, cosmetic surgery and healthy eating, consumers are sending a clear message. Our desire for health and wellbeing is growing in a hitherto unprecedented manner and, based on observed trends, demand for better health is expected to keep on growing.

Indeed, no longer a fringe industry, the global health and wellbeing sector was last year estimated to be worth a staggering $1trillion.

This paper concludes that greater purchasing power and economies of scale can be replicated within private care. Using appropriate combinations of government regulation and the power of consumer choice and competition is the best way to create a health care market which will allocate economic resources most efficiently and also drive up standards.

http://www.stockholm-network.org/downloads/publications/The_Health_Quality_Agenda.pdf

***Courting Confusion? Where is Canada`s Intellectual Property Policy Heading? –* David Torstensson and Meir P. Pugatch**

In this paper the Stockholm Network`s David Torstensson and Dr Meir P. Pugatch discuss and analyse the pharmaceutical IP environment in Canada. The paper describes the changes that led Canada – which until the 1990s was an "outlier" among developed countries in terms of the level of protection provided to pharmaceutical IPRs – to go ahead and strengthen its pharmaceutical IP environment, making it much more aligned with the environments of other developed countries such as the US, the EU Member States and Japan. Still, the paper suggests that this shift has not yet been completed and that Canada is still undergoing some significant internal debates about the future of its pharmaceutical IP landscape, not least in the context of its judicial system.
http://www.stockholm-network.org/downloads/publications/Courting_Confusion.pdf