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Healthcare in Central Europe:Transiting to Catch-Up

In spite of such positive developments, considerable work still remains to be done. The systems predating EU accession were characterized by significant inefficiencies, with gaps in areas like primary care accompanied by over-supply in others (not least, in terms of specialist physicians, hospital beds and staff).

Meanwhile, the growth of private hospitals and practices (pioneered by Poland and Hungary, and followed by the Czechs) has catalysed new structural imbalances.

The key issue remains one of financing. In spite of greater budgets, needs continue to overwhelm availability. All central European countries have introduced cost-containment mechanisms, beginning with competitive tendering via health funds (both private and public) and the decentralisation of hospital management.

Further along the road are proposals for setting up a gate keeping system, introducing diagnosis related group (DRG) payments for hospitals and reducing the number of specialists. The single biggest challenge, however, concerns the cost of pharmaceuticals, whose share in total health expenditure in the region is about two times mo re than in the EU.

Given below is an overview of the healthcare system in each of the four surveyed central European countries.

Czech Republic

Reforms to the centralised Czech Semasko healthcare system began in earnest in 1990, with the aim of developing a German-inspired social insurance model.

This was accompanied by the emergence of a variety of insurers, who finance healthcare providers on the basis of a fee-for-service reimbursement, and also compete for members.

Most physicians have private practices and work under contract with insurance funds to offer a basic package of services.

In early 2003, ownership of public hospitals was transferred to regional authorities. The Health Ministry is however responsible for

legislation, medical research, the licensing of drugs and operation of university hospitals.

Privatisation has been the key means to decentralize healthcare delivery, above all at the primary level. The Czech Republic has a small but growing number of private clinics and small hospitals.

Various surveys indicate three out of four Czechs favouring the growth in private healthcare provision.

The Drug and Technology Control Institute, an institution of the Ministry of Health, was set up to assesses the cost-benefits of medical technology. The Deputy Minister for Health Insurance has direct responsibility for information technology.

In recent years, facilities such as the Institute of Clinical and Experimental Medicine in Prague, two (national government-managed) Teaching Hospitals at Bulovka and Motol, the Central Military Hospital Prague and the Masaryk Institute of Oncology have reached Western European standards. Czech hospitals have also shown they are second to none in some trailblazing medical applications. In November 2005, the country saw performance of its first robot-assisted surgery at the Na Homolce Hospital and the Military Hospital in Prague.

In 2002, the Czech Republic had a total of about 165 hospitals. While the national government owned only 19, they accounted for almost 30% of total beds, owing to their size. In addition, the country had 82 hospitals administered by regions and cities or municipalities. 64 private hospitals accounted for just over 10% of total bed capacity.

Hungary

Healthcare reforms in Hungary have focused principally on cost containment and structural decentralisation. Purchasing and spending falls under the purview of the National Health Insurance Fund, which is financed by the National Tax Office and whose annual budget is determined by the National Assembly (Parliament). The Fund is, however, under tight government control after removal of a self-governing system in 1998, to contain spiralling expenditure.

Reimbursement for acute care and rehabilitation is based on diagnostic-related groups (DRGs). In 1987, the government established an Information Centre for Health Care (Gyoginfok) with responsibilty for managing the country's DRG system. Gyoginfok is the key institution in the design and administration of provider payment methods.

Since 1993, DRG-based reimbursement applies across Hungary. DRGs do not, however, apply to certain high-cost medical interventions such as bone marrow transplantation, which are reimbursed on a case basis. Reimbursement for chronic care is based on patient-days adjusted to the complexity of the case.

The responsibility for service provision in Hungary has been transferred to local governments, which own the bulk of the country's health care facilities, including hospitals, clinics and operating theatres of most primary care physicians. They are however permitted to outsource service delivery to private providers.

Overall, nevertheless, private participation in the delivery of services remains limited, for example, compared to the Czech Republic. The only significant private presence is in primary care, where 85% of Hungarian physicians work as independent contractors. Specialist care is still largely provided by medical staff on hospital payrolls. On the hospital side, the only private presence is in a few hospitals earlier owned by the Church (although some have been returned to the Church or charities).

One recent development of interest is training in public health and health services management. The government has supported the setting up of a School of Public Health at Debrecen and a Health Services Management Training Centre at Semmelweis University.

Both schools offer Master of Science training curricula for medical graduates and other professionals, with the latter recently expanding its offer to continuing education programmes for hospital managers. In recent years, management qualifications have been made mandatory for hospital managers in Hungary.

Hungary had 182 hospitals in 2002, excluding those run by the Ministry of Justice.

Poland

Poland has one of central Europe's longest and most far reaching legacies of healthcare reform, followed (ironically) by considerable back-tracking and politics in the early 2000s.

In the 1970s, Poland created integrated networks for healthcare and social services in each district across the country – in the shape of ZOZs (Zespól Opieki Zdrowotnej), or integrated healthcare management units. Follow- on efforts in the 1080s sought greater decentralisation, beginning with an increase in power for the ZOZs, a bolstering of the primary care infrastructure and the launch in 1999 of compulsory health insurance and sickness funds.

In 2002, however, a change of government saw the abolishing of the sickness funds and their replacement by a centralized National Health Fund (NHF). The NHF was however deemed to be unconstitutional by the Polish High Court, and a new Law on Health Care Services Financed from Public Sources was passed in August 2004 to accommodate the court ruling.

At present, Poland has a mixed public-private financing system for healthcare. The public system accounts for the bulk of financing and consists of mandatory universal health insurance contributions (based on income).

These are supplemented by budgetary allocations from the national and local governments. Private financing includes formal insurance plans as well as co-payments and out-of-pocket spending.

The NHF finances health services for insured persons from social contributions. It contracts with service providers for the supply of health services. Reimbursement is based on a classification system (with more than 1,000 categories of hospital services and procedures). Physicians are financed by the NHF on the basis of a capitation system (patient list) – which is split into three age groups (below 6, 7–64 and 65+).

The management of healthcare is shared between the Ministry of Health and territorial self-government administrations which operate country hospitals and primary care centers. The Ministry is responsible for national health policy, major capital investments and medical science as well as education.

Its operational responsibility is however limited only to health care institutions which it directly finances. University hospitals (and the so-called medical Academies) are semiautonomous but remain accountable to the Ministry of Health.

In 2003, Poland had 732 public hospitals, and 72 private hospitals (including those run by religious orders or NGOs).

Slovenia

The run-up to independence in Slovenia was accompanied by growing financial problems in funding its communist-era inspired healthcare services. The country sought to couple such challenges with a broader push to modernise its healthcare and social welfare structure.

In 1992 (one year after becoming a sovereign nation), it adopted new healthcare legislation accompanied by sweeping structural reforms. These essentially replaced Ministry of Health funding (via general taxation), with a new public health insurance agency funded from employee payrolls.

The reforms also separated compulsory and voluntary insurance schemes, and provided for the possibility of optional supplemental insurance, via the private sector.

Alongside, parts of the public health service network were privatised, with provision for free choice of physicians and gatekeeping functions in primary health care. Provider contracting processes were also formalised and restructured.

Statutory insurance now accounts for over 80% of funding, while tax-based financing has seen a sharp drop in its share to below 5%. Supplemental insurance contributes the balance. At the present moment, Slovenia's priority is on converging legislation with the EU, fine tuning resource allocation to increase incentives for cost-effective care, and improving health information systems.

An electronic health insurance card is meant to register all prescriptions electronically and is seen as a means to reduce irrational consumption. IT is also crucial to the hospital payment system, moving steadily towards a sophisticated case-mix payment model.

According to latest figures, Slovenia has 26 hospitals. These include nine regional and three local general hospitals as well as the Clinical Centre in Ljubljana, which is an academic facility. In addition, there are about a dozen specialised hospitals.

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