



# **Health Care Modernization in Central and Eastern Europe**

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# Structure and Dynamics of Hospitals





# **Rationalizing Hospital Supply**



## Current Situation

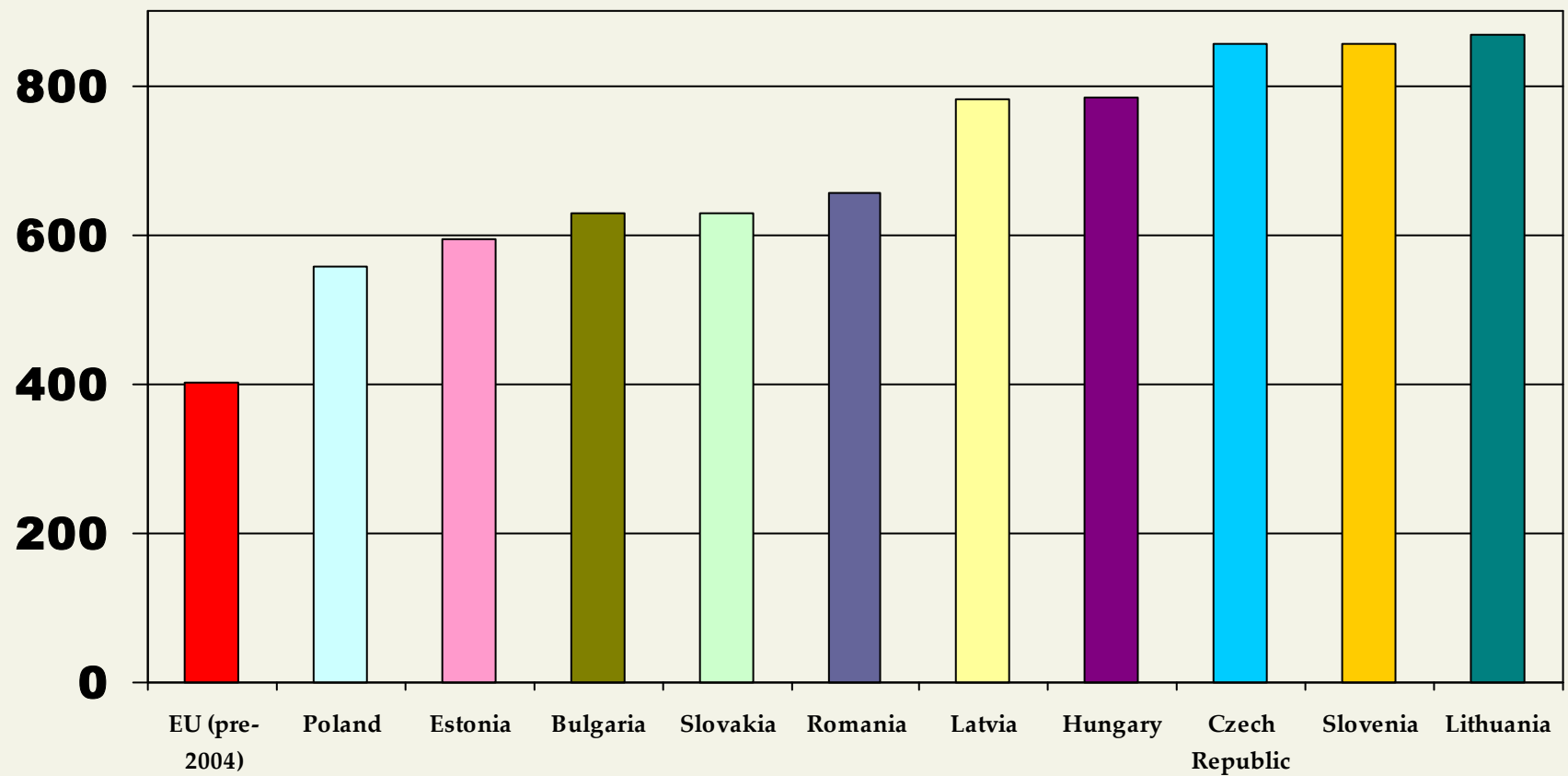
Historical trends have resulted in oversupply of hospital beds in the CEE region.

The oversupply has consequences:

- Large fixed costs
- Incentives for hospitalization

Regions with oversupply of public hospital beds are the source of largest debts in the health care system.

# Hospital Beds per 100,000 Population (2003)





## The Reform Agenda

All 10 countries have succeeded in decreasing numbers of beds since 1990.

But CEE countries have from 139% to 217% more beds per capita than the average of countries joining the EU before 2004.

One obstacle—decreasing hospital beds has been unpopular with both voters and politicians.

Rationalizing the supply of hospitals and beds remains on the reform agenda for 8 out of 10 countries in the region.

## One Example of Health Reform: Estonia

Hospital Master Plan implemented to decrease beds.

Plan included analysis of capacity requirements using demographic and epidemiologic data.

Transparent criteria used to determine location of hospitals (e.g., transport time should be ? one hour).

Long-term beds assessed separately from acute care beds.

Approximately 1,500 beds eliminated by 2003.

## Second Health Reform Example: Slovakia

Rationalizing numbers of hospitals/beds a priority

Approach included:

- Assessment of hospital resources
- Identification of a network of essential hospitals
- Creation of a master plan

Moving cautiously on closings in rural areas, but in urban areas allowing market-driven approach

## Second Health Reform Example: Slovakia

Capacity reductions accompanied by:

- Strong incentives for efficiency improvements
- More hospital autonomy and financial responsibility

Hospital Restructuring Fund supports capital investment.

## One Common Challenge: Long-term Care

Hospitals in much of the region have provided long-term social care in addition to curative care.

Example: In Romania 40% of patient days are for social care.

Countries are beginning to:

- Differentiate between long-term and acute care beds
- Establish clear policies for services provided by each
- Increase the numbers of long-term care beds  
(Examples: Hungary, Czech Republic)

# Rationalizing Hospital Care: Recommendations

Work to decrease informal payments to specialists who use but may not reimburse hospitals.

Keep the list of “direct access” specialists to a minimum.

Strengthen “gate-keeping” by general practitioners, with public campaigns to educate consumers.

# Rationalizing Hospital Care: Recommendations

Engage social health insurance funds in ensuring good decisions regarding choice of hospitalization or outpatient treatment.

Further develop ambulatory and out-patient surgery capabilities.



# **Improving Hospital Management: Management Capacity**



## The Traditional Approach

In the past, health systems in the region centralized decision-making and planning.

This decreased need for managerial skills at the hospital level.

Hospital executive positions often held by physicians with no/little management training and little appreciation for financial issues.

Appointments often political, leading to instability.

## Hospital Reforms: Decentralization, Devolution

During the 1990s, many hospital functions were decentralized in attempts to make them more responsive to community needs and control costs.

Often some authority over hospitals was transferred to provincial or municipal levels (devolution).

The form of authority and amount of autonomy given to hospitals has varied by country.

## Decentralization Requires More Managerial Skills

Good management needed to integrate hospital functions for better efficiency and quality.

Good health care delivery processes are as dependent on organizational skills as individual technical competence.

Managerial knowledge and skills are needed to ensure the success of prospective payment systems and hospital autonomy.

Some countries have instituted health management training programs but more is needed.

# Hospital Management: Recommendations

More health management educational and training programs need to be established.

Scheduling and location should consider the needs of current as well as future healthcare managers.

# Hospital Management: Recommendations

Education and training programs should include:

- Fiscal and operations management
- Strategic management
- Leadership of organizations and change efforts
- Human resources management, including team building
- Management information systems and IT concepts
- Quality improvement, efficiency and productivity analysis
- Conflict management, negotiation and communication skills

# Hospital Management: Recommendations

Health care organizations should be encouraged to share aggregate performance data for benchmarking and identification of “best practices”

Reimbursement and incentives should be aligned to reward managers for superior performance



# **Improving Hospital Management: Hospital Autonomy**



## Hospital Autonomy: Definition

At the hospital level, degree of autonomy refers to the number and types of decisions over which senior hospital managers and/or local hospital governing boards have authority.

See the “Dialogue Tool” handout for types of decisions and possible levels of decision-making authority.

Public hospitals in many countries have very complex lines of authority that may involve the ministries of finance, labor and health as well as provincial or municipal authorities.

# Hospital Autonomy

The potential: improved quality of care, reduced expenditures, better alignment of services with community needs

The evidence: experience in Australia and Sweden has shown 30% increased efficiency without changes in quality or cost increases

But in many other countries there has been limited success in achieving goals of increased autonomy.

To reap the benefits requires a number of factors in place.

# Hospital Autonomy: Factors Promoting Success

Establishing greater fiscal accountability at the hospital level

Allowing hospitals to make capital investments, including financing decisions

Establishing independent oversight boards accountable for hospital performance

Investment in healthcare management education and training

Alignment of appropriate incentives for hospital staff members who typically involve public employees and possibly labor unions

## Hospital Autonomy: Recommendations

It is not necessary to obtain consensus on only one hospital decision-making model.

Demonstration projects could test several alternatives in different locations if there is consensus that such a strategy could help determine which models are most appropriate for possible replication.

## Hospital Autonomy: Recommendations

If DRG type reimbursement payments are used, they should include the costs of capital and depreciation to ensure more reliable capital funding. This would allow hospital directors to maintain and update aging facilities.

Certificate of Need programs which operate at the national or regional level can be implemented to ensure utilization is adequate to justify capital expenditures.

Debt to revenue ceilings can be instituted to limit capital expenditures.

## Hospital Autonomy: Recommendations

Quality performance indicators should be phased in to track hospital performance over time, and to hold hospitals accountable.

Success will depend on investment in adequate healthcare management training, and the alignment of appropriate incentives for hospital staff members.



# **Role of the Private Sector in Hospital Services**



# Private Sector Involvement in Hospital Services

Multiple options are available— from outsourcing of non-core functions such as laundry to complete ownership

Benefits can include:

- More funding for capital investment
- Reduced spending on public hospitals
- Promotion of greater efficiency in health care delivery
- Improved health care quality

## Private Sector Involvement in Hospital Services

- Private ownership of hospitals not common in CEE
- More common is partial private ownership (as in Slovakia where the state retains a majority share) or non-profit ownership by community organizations

## Private Sector Involvement: Common Concerns

Private ownership, even with public financing, does not guarantee improved performance.

Competitive pressures may decrease likelihood that private providers will serve the indigent, those with poorly paying illnesses or rural populations.

The cost of contracting may negate the cost savings from private ownership.



## Private Sector Involvement: Recommendations

Market forces alone will not realize national health care goals—government must retain a critical role as regulator of markets and enforcer of regulations, especially to ensure access and quality for poor, rural, and other disadvantaged populations.

Health Ministries may already be overburdened with overseeing the public provision of health care, and may not have adequate resources to regulate the private sector. Consider the creation of autonomous regulating agencies to oversee the private sector.



## Private Sector Involvement: Recommendations

Consider cross-regional cooperation in establishing oversight and regulatory mechanisms.

Privatization introduces potential conflicts of interest and potential perverse incentives to over and under-treat. Regulation and use of contracts and subsidies could be used to share risk with the private sector while retaining public oversight.