Reform in Europe... where are the opportunities?

Healthcare Europa estimates that countries with a total population of 215m are serious about structural reform which will favour private operators and insurers in Europe over the next decade.

Here we look at what is happening across Europe. The follow on article looks at reform trajectory in no less than 20 European countries and at where it creates opportunities for the private sector.

Often, people claim that Beveridge systems, where healthcare is delivered by an NHS, (as in Spain, Italy, Poland and the UK) are converging with Bismarckian systems (Germany, France, Netherlands) where individuals pay into a statutory insurer and can then chose doctors and hospitals. There is truth in this. NHS systems are giving the public a wider choice and are increasingly looking to private providers to cut queues or provide services. Meanwhile, Bismarckian systems in France and Germany are trying to lessen patient choice and to promote the role of the family doctor as gatekeeper.

There is a simpler truth. All European governments are wrestling with same big issues. For the public sector these are: How do we ensure that staff work hard for the allotted number of hours? How do we set up meaningful pricing and accounting systems? How do we cut acute hospital beds? How do we build ambulatory outpatient services? How do we build effective gatekeeping primary care structures?

For the private sector these are: How do we avoid private players maximising profits at the expense of quality?

For the care of the elderly these are: How do we keep costs down given the grey population explosion of the next 30 years? How do we avoid expensive acute episodes (accidents and falls)? How do get individuals and families to pay their share of costs? How do we control the cost of care homes beds? Put it another way: all healthcare ministries across Europe are keen to identify ways of cutting costs and reducing the power of incumbent professions. The left favours solutions within the public sector, whilst the right looks to creating more of a free market including the private sector or (in France) to a controlled expansion of private providers.

But healthcare reform is such an emotive issue that only governments with majorities or a strong national consensus can really hope to make serious structural reforms.

Electorates across Europe will not agree to the privatisation of hospitals, are strongly opposed to hospital closures and oppose any increase in out of pocket payment or restrictions in the basic care package. They want unlimited, free-at-point-of-service healthcare and will only grudgingly accept the idea that they should pay for care in homes or homecare. This remains the case in countries

such as Romania, Bulgaria and Greece which face huge problems and have very poor public healthcare services.

In these countries an honest, “tough love” policy would be to explain to the electorate that they can have a smaller range of basic services free of charge and will then have to pay extra. But citizens prefer to hold on to an illusory larger thing which is actually worth very little, rather than have a small thing which is worth having.

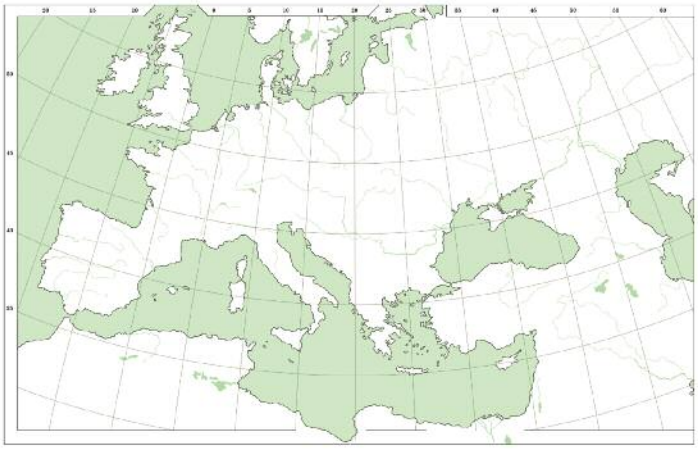
In the face of such resistance in countries like Bulgaria, Romania and possibly Hungary, there is no clear reform path – simply gibbering incoherence.

Often, looming healthcare deficits do not seem to have moved governments away from immobility, even though voters have responded to the crisis by electing the right in a string of elections in the UK, Sweden, Hungary, Poland, Czech Rep, Slovakia and Bulgaria.

National healthcare reform is also next to impossible where responsibility has been delegated to individual regions. Germany has been in a messy stalemate for years, whilst in Sweden, Switzerland, Italy and Spain healthcare is decided by around 20 elected regional/cantonal or county assemblies in each country. The Czech regions are all ruled by the left, although the central government is rightist, making coherent healthcare reform difficult.

Some of these regions are free market reform pioneers such as Madrid, Valencia (Spain), Stockholm, Halland (Sweden) and Lombardy (Italy).

The recession has led to some cuts in public healthcare expenditure, but, in general, it has not been badly hit compared to other sectors, including care. Where cuts have been made, they have been visited mainly on pharmaceutical expenditure and the amount



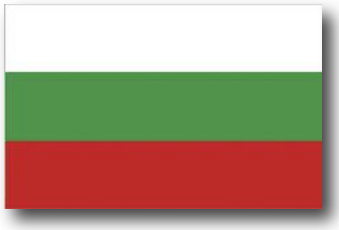
spent on private sector healthcare. Over the last year, the private healthcare sector has proved to be a major victim of the recession in PIIGS countries, facing longer delays in payment and cut budgets.

To some extent, reform is defined by the government in power. The left is only in power in Portugal, Norway, Spain and Greece. Apart from Norway, these are all lame dog governments which lack credibility.

They continue to not make any changes which would give private providers and insurers a wider role. Note, however, that they sometimes have been prepared to take radical action – in Spain public sector nurses and doctors saw their pay cut by 5%, for example.

There are, however, strongly reformist governments which are trying to create more of a market in healthcare services and to liberalise whole sectors. Here the main examples are France, Poland, Slovakia the UK and Hungary. The momentum has slowed in Sweden, Finland and the Netherlands, although we can expect further progress towards market economies in these countries. Ireland is also likely to embark on radical reform.

Added together, these countries have 215m people, so the opportunity in Europe is larger than might at first sight appear. HCE



Bulgaria - What's the plan this week?

Bulgaria has a failed public healthcare system. And a reformist government which is liked by the EU has yet to get to grips with it.

The country is on its third health minister this year and has recently cancelled a hospital closure programme which would have shut down many small public and private hospitals.

The country has a spectacular abundance of beds and no money. That is partly because around 100 small private hospitals have been set up in the last three years. If they reach certain minimum standards, they can treat patients who can part pay with the state national health insurance fund.

The real issue is the inbalance between what is paid for a procedure in Bulgaria and what is paid in the rest of Europe. The National Insurance Health Fund is forced under Bulgarian law to reimburse the lion's share of procedures which take place in the fast growing private sector, where the number of small hospitals has gone from 40 to 100 in two years. This has left it incapable of producing a viable plan.

So the plan to cut hospital beds not only infuriated nurses, doctors and the general populace but also a series of entrepreneurs who have pumped millions into new facilities. Meanwhile, something like a fifth of the nurses left the country in 2010.

There is talk of insurance privatisation but, like its northern neighbour Romania, talk on healthcare never leads to reforms. The EU has pledged some €148m to improve some public hospitals and to boost oncology. But many public hospitals have lost their specialists.

Czech Rep – Care comes in from the cold

The Czech government is following a much more gradualist approach than its Slovak neighbour. That reflects the fact that the powerful regions are all run by the opposition socialist party.

Health reform is political dynamite. Three years ago the previous government introduced modest co-payments for citizens visiting family doctors. As hoped and planned, the policy led to a substantial drop in visits. Unfortunately, it also led to a protest vote which saw the socialists taking power in all the regional elections a year or so later!

However, the centre right coalition's victory earlier this year was a pleasant surprise for the private hospital sector which feared renationalisation.

Czech Health Minister Leos Heger has announced that the government's first priority is to "define standard care" and thus also define what specialised care includes. Patients will be able to pay extra money for treatments not currently included in the standard care. The new payment system, which Heger plans to implement "gradually", is expected to reduce the high level of corruption in the health system. The Ministry of Health will also monitor and limit the purchases of new technology. Lastly, Heger has said he will remain steadfast to doctors threatening to leave "unless their salaries are raised."

Insurers: Pavel Hrobon at Health Reform, a thinktank which favours the free market expects a measure to legalise top up payments. Officially, it is still illegal to pay for healthcare services in the Czech Rep. This has led to some private hospital groups, who mainly depend on servicing public sector patients, setting up two separate corporate entities, one purely public and the other private. The new measure might lead to the creation of a new supplementary insurance sector, although this is far from clear.

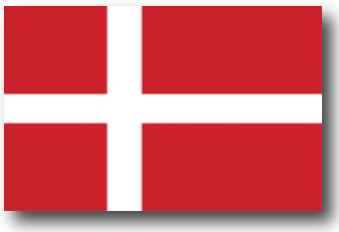
Care: Hrobon expects a measure which will recognise the long term care sector as an entity in its own right.

Hrobon says: "Today, the long term care funding is untransparent. A patient may end up in an institution controlled by the national health service, or one funded by social funds. The outcomes and financial situation will vary dramatically."

Hospitals: Around 30-40 municipal hospitals were privatised, mainly in the early 2000s, when many Czech hospitals were turned into joint stock companies in an effort to reduce mounting debt burdens. Almost all of these have remained in the public sector so far. Further privatisation in the immediate future looks unlikely, given the Socialists'

dominance at region level. The larger university hospitals controlled centrally are even less likely to be privatised.

However, outsourcing and management consultancy deals look possible. Longer-term, municipalities are likely to be forced to privatise hospitals as indebtedness grows.



Denmark – Is the party over?

The Danish private sector has grown fast over the last five years. Employers have seen private healthcare insurance as a way to recruit and retain staff in a country which even now has very low unemployment rates. And around 50 small clinics with anything from 100 beds down to 2 or 3 have done well out of a law which meant that after five weeks any patient can go direct to a private provider and get the state to pay. Tariffs we are told have been fat, although the private sector remains 2.5% of the total.

Both now look set to change. Elections could return the left in 2011 and more worryingly the present Danish government has just imported a tendering system from Norway which could reduce prices significantly.

Insurers: Around 1m Danes have private healthcare insurance – usually paid for by employers. If the left take power in 2011 they are set to end tax breaks on insurance. Whilst the Private hospital federation is up in arms about this, privately they reckon that the change will only cost an average of €100 per capita per year and that it will have little or no impact.

Hospitals: The much more worrying move is to tendering. This could have a really big impact on Denmark's small private clinics and is likely to lead to consolidation. If the left win they are also likely to extend the idea of free clinics. This allows public hospitals to set up small clinics to compete in the private sector. These clinics are not covered by the trade unions in the same way as the rest of the public sector and staff can be offered performance related pay. The private sector say they are unfair as public hospitals can and do subsidise them.

Finland – Patient choice may hurt private sector

Elections in April 2011 are too close to call, with a danger that an anti-immigration party may control the balance of power. The current centre right government has failed to step back, look at the system seriously and come up with a reform programme. This reflects the fact that healthcare is a very contentious issue pitting powerful private healthcare groups against doctors and other professional bodies.

Before Christmas, the government will put through a new Health Act which may weaken, rather than strengthen, the role of the private sector.

This will introduce patient choice for the first time in the public sector. This means that citizens will have the right to select the primary care centre they are seen at, and also to select the public hospital where they wish to be treated. Indeed, in most cases, patients will even be able to choose which family doctor or nurse they see at the primacy care centre.

Jukka Mattila, ministerial councillor in medical affairs at the Department of Social Services and Health says that, in his opinion, this will lead to patients who currently go private in order to enjoy choice, switching back to the public sector.

Hospitals: The Finnish public hospital sector is powerful and does not outsource willingly or frequently. There are been a couple of private public partnerships such as Jamsa hospital and Coxa. But further change is unlikely.

In general, Mattila says that primary care outsourcing has waned over the last year as has the overheated recruitment market, as many new doctors have qualified in the last five years.

France – Impressive plans, real change

Anglo-Saxon publications like *The Economist* like to deride the deeply unpopular President Sarkozy. But, in

healthcare, the government of Francois Fillon is pushing through a series of well-thought out, structural reforms designed to reduce costs, many of which favour the private sector and make France look like a classic consolidation play.

This includes the creation, 18 months ago, of 23 new healthcare regions which combine the strategic management of healthcare and care under one roof. The new system puts these directors in the driving seat. No longer can a care home group buy a plot of land and propose a home. Instead the region will decide where there are shortages and then set up a tendering process. They also have a mandate to rationalise. Small hospitals may be closed or merged. They are also supposed to bring together the care home and hospital sectors to create seamless care.

At the same time, the French government is quietly removing the barriers in areas such as diagnostic laboratories. A new reform of elderly care will also be launched in 2011.

France is also making changes to the primary healthcare sector, which Stephane Pichon at Your Care Consult says might make it possible to build private equity backed businesses. Walk in clinics and ambulatory surgery are both being encouraged.

And France has also recently licenced consultations over the phone or video conferencing between doctors and patients which may revolutionise services in rural areas and offer more opportunities.

The big, unanswered question is how will the heads of the new healthcare regions interpret their role?

Note that the free market think tank Institut Molinari thinks the state is meddling too much and following a dirigiste approach, rather than letting the market decide. Valentin Petkantchin at the Institut Molinari says they will try to micro manage everything. “The healthcare insurance deficit for 2010 is €11bn. The healthcare region leaders will be looking to cut costs wherever they can.”

French healthcare is based on a robust private sector with private for profit hospitals accounting for 25% of the beds compared to 12% in the USA. He thinks the present government will favour the public sector over the private, as often the local hospital is the largest local employee. “Right wing governments tend to try and control everything. The left is much more easy going.”

The uncertainty seems to worry investors. Whilst 3i and Australian listed group Ramsay are looking for hospital acquisitions, others, such as Blackstone/Vitalia, are more cautious.

Marc Benatar at 3i which owns Vedici is more upbeat. He says that it is clear that everything depends on the leader of the healthcare region. “Some of them favour the public sector. Some of them are being very slow to make any changes. Others are strong characters want to build much more cooperation with the private sector and are setting up joint ventures between the private and public sectors.”

Care: Care reform is on the agenda under Rosalyn Bachelot, the former reformist Minister of Health who is now in charge of care as Ministre des Solidarités. But the precise nature of the reform will not be clear until the second half of 2011. Bachelot says there needs to be a national debate on the place of aged people in society and whether care should be financed by what she describes as a "fifth branch of social security, an assured system or something mixed."

Petkantchin at the Institut Molinari says that the aim is create a new programme so that individuals pay in during their life time to meet the costs they incur when they are elderly.

Primary care: Pichon and Marc Benatar at 3i say that opportunities are opening up here. The country has also licensed remote diagnostics with doctors using video conferencing to diagnose conditions. Benatar says that this is “a real turning point in what things are permitted and reimbursed.”

Germany - Gridlock

What a mess! Operators tell Healthcare Europa that health minister Philipp Rösler has revealed himself to be a political light weight. The most charitable, academic Andreas Beivers at the University of Applied Science in Munich, suggests that senior politicians knew that health was so contentious that nothing could be achieved. That’s why they gave the job to a young and inexperienced politician!

In any case, when the Christian Democrat/Free

Democratic government lost the Nord Rhein Westphalia election this summer, they also lost all chance of any serious structural reform of the bloated German healthcare system as such changes would call for approval in the Landesrat chamber.

Essentially, the current government's so called reforms merely amount to putting up prices from 14.9% to 15.5% of pay for Krankenkassen patients and trying to curb hospital spending by a series of tortuous measures which shave 1% or so off total healthcare spend.

The only area where we are likely to see change is in care homes where the government has announced that it will be putting together a reform package for 2011.

In some ways the lack of reform is good news for the private sector.

It can, for instance, continue to rely on the existing and ridiculously high private healthcare insurance price list not changing for another 3 years. (Prices have been unaltered since the late 1990s).

Hospitals: Little change. The political atmosphere remains anti-privatisation. The good news is that the private hospital groups will not now lose their right to set up and own outpatient care centres (MVZs).

Care homes: The care home reform package is likely to prove bad news for the barely profitable care home sector with price decreases generally expected.

Insurers: Private insurers were left smiling by new rules earlier this year which made it easier to join private schemes. Expect further consolidation of the krankenkassen.

Hungary – Still as clear as mud

The Hungarian public sector is corrupt and underfunded. But it is good enough to have stymied the growth of the private sector which is limited to ambulatory clinics around Budapest and the luxurious (but unprofitable) Telki Hospital. The private imaging sector is in a strong position and is one of the few sectors of the market to enjoy high prices. Labs are rationalised and the prices are suicidally low.

Attempts to outsource hospital management to the private sector foundered two years ago. And plans to privatise healthcare insurance proved politically unacceptable.

Despite all the problems, private healthcare operators say that the public sector continues to produce quality care in many locations. Joe Ryan, CFO at Medicover says that recent attempts to crack down on corruption appear to be working.

The right wing Fidesz government, elected this summer, has a strong mandate and has appointed a real expert as health minister – Dr. Miklós Szócska who has run the national Health Services Management Training Centre for many years.

But, nearly six months on, it is impossible as yet to ascertain a coherent healthcare reform programme.

All Szócska was prepared to tell us at the Gastein Forum was that he would not attempt to outsource hospitals to the private sector.

Insiders say that he is locked into disputes. "The Finance ministry is looking for savings, whilst he wants to pay doctors and nurses more, as he recognises that this is the only way to halt corruption and end the brain drain. Meanwhile, Szócska faces a fight with the deputy mayor of Budapest as to how to reform hospitals." Could this be a case of an academic failing to cut it in a world of tough politicians?

Ireland – Insurance could follow Dutch model

A general election at the back end of March now looks likely, with an alliance between Fine Gael and Labour as the almost certain outcome with the present incumbent Fianna Fail looking certain to be badly defeated.

Having taken the IMF/EU rescue package, Ireland faces bitter medicine. Dr Richard Layte says that the healthcare budget for 2011 has been cut €700m out of a total of €15bn. Unemployment is near 15% and many have seen their salaries cut 15-20%.

The Irish system doesn't provide free healthcare at

point of service. Apart from the elderly, pregnant and young children visits to doctors cost money and there is a per diem rate for hospital care. This helps explain why nearly half the population have private insurance policies, although Layte says the real reason is that this allows you to jump the queue. Getting rid of this two speed system is a priority for all political parties, but may not be affordable today.

Layte says the Irish healthcare system can be described as "unreformed and inefficient."

Fine Gael, the senior party in any coalition, is committed to introducing the Dutch model, in which everyone is forced to take out insurance with private insurance companies who are free to compete with each other and who can create a market in healthcare services. The poor and unemployed would be paid by the state, thus allowing the introduction of universal coverage. Labour is also surprisingly pro the private sector.

Hospitals: Ireland has seen an explosive growth in private hospitals funded by fat tax breaks. The short-term outlook for the sector is poor as the latest budget removes tax breaks and subsidies which encouraged private healthcare insurance.

Insurance: A change to the Dutch system would lead to big growth in a market where two of the top three players – VHI and Quinn - are for sale. Producing a system that was equable and competitive will not be easy. Attempts to produce a risk equalization scheme a few years back failed, as Quinn and Aviva didn't want to end up subsidizing the incumbent VHI. As in the USA, one problem will be that existing holders of private healthcare policies may feel aggrieved if the changes cost them money or lose them privileges.

Short-term, insurers face tough times. The number of individuals with cover has already dropped from 52% to the mid-forties and is likely to fall further. The removal in the latest budget of state subsidies and tax breaks will further hurt the sector as prices rise in January.

Care: Layte says that there is a national debate on the need for social care insurance. There are significant shortages of care home beds.

Italy

Healthcare and care has been delegated to the 20 regions. This has led to the emergence of a wide variety of different models. We interview Prof Francesco Longo of the University of Bocconi on the current structure and likely changes (*see p. 32*).

Netherlands – Big plans for a weak government

The centre-right wing coalition of Liberals and Christian democrats supported by the anti-Islamist party has a tiny majority of 76 out of 150 seats and none at all in the lower house. This means says Prof Erik Schut at Erasmus University that it will be dependent on the support of the Labour party on some issues. It may not be around long.

The coalition statement setting out healthcare goals is, nevertheless, quite radical. It indicates that it plans to continue the reform process that the Netherlands embarked on in 2005, when statutory insurance was handed over to competing mutuals with the aim of creating a market economy healthcare services.

Schut is sceptical that it can be put into practice, given the precariousness of the coalition. He points out that the rhetoric of the market has immediately been undercut by an enforced €300m cut in the hospital budget, which he reckons is a cut of 1-2% of expenditure. "A hospital director immediately said it would lead to 20 public hospitals going bankrupt," he said, although Schut himself doubts this will be the impact.

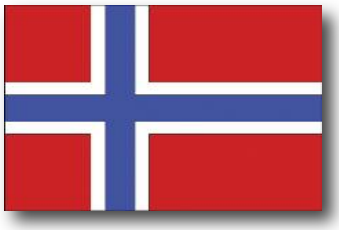
Hospitals: The coalition statement says that it plans to allow hospitals to pay dividends to shareholders for the first time – effectively ending the not-for-profit status of the 100 big hospitals which together provide acute care for the nation. A regulatory measure will be put in place to stop private hands getting hold of public assets cheaply. It is not clear what this means in practice or when this measure will be introduced.

Insurance: The coalition says it wants to extend the sector of the market where insurers are free to strike deals and negotiate with the hospital groups. This is currently 34% of hospital expenditure. Schut says it is not clear how fast this will be extended.

Care: Today, care of the elderly comes under a different budget from that which has been given to the

insurers. The government has said it is committed to making the insurers responsible for negotiating long term care contracts. How this will be achieved is not clear. It looks as though the insurers may simply be asked to take over the commissioning job currently done by regional agencies without incurring any financial risks – in other words without having to insure the elderly. Schut says that it is very hard to see how to handle risk equalisation in elderly care and mental care and that until this is worked out any transfer to the insurers is likely to be limited and have little real impact.

Services to hospitals: The outsourced market in the Netherlands is undeveloped because many providers are forced to charge VAT which the hospital sector which is zero rated can not then reclaim. The government plans to eradicate this disparity which should make it much easier for the big hospitals to outsource.



Norway – Hates private sector

Run by a so-called Red/Green Alliance, which includes the Socialist Left, the government, in power until 2013, is perceived to be opposed to private healthcare, according to Villeman Vinje at pro-market think tank Civita. With a GDP per capita in 2009 of $78,000, nearly twice Switzerland's, Norway is Europe's wealthiest large country.

Vinje says that Norway has spent heavily on public sector healthjcare over the last decade but recent surveys shows its healthcare system is one of the worst performing in Western Europe with long waiting lists.

Norway has a brutal tendering system where private operators tender for large contracts. The winner takes all, leaving other operators with devastating losses. Norwegians who have been on waiting lists for a set period have the right to go private or go to abroad for treatment paid for by the state. However, he says that the government is reluctant to allow patients to do this.

A number of for profit and not for profit rehabilitation, child care and psychiatric institutions face closure after losing tenders. This includes Oslo Hospital, established in 1290, leading an opposition MP to quip that "the hospital survived the Black Death, but not this government."

But it is not all doom and gloom. Teres who we profile in this issue has done well from cosmetic surgery. Largely untouched by the recession private operators are doing well in cosmetic surgery, LASIK and dentistry which is paid for by working adults.

Poland – New insurance market set to build

Hospitals: The Polish government is trying to get an Act approved which would force municipalities to commercialise hospitals which exceed their debt limits for more than one year. The new act would make it compulsory for local hospitals to be put into a limited company structure if they ran into financial difficulties. The aim is to break the cycle where hospitals can rack up as much debt as they like confident that the government will forgive it every 3-5 years.

Some 50 or so public hospitals have already opted voluntarily to reconstitute along commercial lines. Advocates of commercialisation say that it leads to better governance as it replaces a political appointee with a board of directors charged with managing the hospital. If the act was passed it would probably lead to 40% of all public hospitals commercialising within a year or two.

Hospital privatisers, such as EMC and Know How, say that they would expect many municipalities faced with the new law to move swiftly towards privatisation and are anticipating that over the period 2011 and 2012 some 70 to 200 municipal hospitals will actually be privatised and sold off to private operators.

Insurers: Currently, healthcare insurers are stymied by a lack of private acute facilities. Whilst the sector is worth a total of 2.5-2.8bn Zloty according to the Polish Chamber of Insurance (PCI) almost all of that is run by subscription healthcare service companies, such as Lux-Med, Medicover and Enel-Med who have vertically integrated ambulatory facilities. In fact, the PCI says premiums for real healthcare insurance comes to only around 150m Zloty a year.

Under the new hospital act (see above) public sector hospitals would be freed up to take payments for treating privately insured patients. Whilst this is theoretically possible today, in practice the main public payor the National Health Insurance Fund outlaws the practice. This shift would enable traditional insurers to rapidly develop strong product offerings.

Under a new insurance act scheduled for early 2011, insurers would be able to offer tax-free additional private insurance to all citizens. The proposals here are not very concrete but it is believed the new offering would be supplementary and complementary to the public package.

The new insurance packages would cover services not currently offered in the basic package, such as dental cover, and also services for which there are long queues.

This could lead to the development of products ranging for a mass market complementary top up product at, say, 50 zloty a month to a replacement package at zloty 2,000 offering cover for acute care.

Care: Currently there is little or no provision for the long-term care of the elderly in Poland. The PCI thinks that within 4-5 years new legislation would be passed creating an obligatory insurance payment for all citizens which would be taken out on a pay as you earn basis. This would be the foundation of the big expansion in this sector.

Portugal – Tough times ahead

There is a very real danger that Portugal will follow Ireland and Greece into an EU/IMF rescue. If Greece and Ireland are anything to go by, this would lead to many workers losing 20-25% of their income and unemployment leaping to 15%. This bodes badly for the private sector in the short-term as it demand for private healthcare. Countries also tend to slash any NHS expenditure with private providers rather than tackle inefficiencies in the public sector.

In any case, the embattled left wing government is hostile to private sector which has grown hugely over the two decades and now accounts for 40% of all secondary care according to Teófilo Leite, head of the Association of Portuguese Private Hospitals. The APHP told Healthcare Europa that the private sector was now around 90% of diagnostic imaging and labs, as well as dentistry. APHP says the private sector has now moved into continuous care and rehabilitation and is beginning to move into care homes and assisted living.

Around a third of the sales of the big hospital groups come from shortening NHS patient waiting lists, on average at prices a third lower than public sector rates.

Hospitals: Plans to allow the big hospital groups to not only build but also to operate PPP hospitals were scaled back when the present government took power. Academic Susanna Oliviera at the University of Porto says she has seen anecdotal evidence that private patients are going back to the Portuguese NHS, as economic uncertainty increases.

Insurance: The private sector looks very exposed to an economic downturn.

Romania – Collapse of the public sector

Romania has a corrupt, inefficient and under-resourced public healthcare sector which has seen real budget cuts over the last year with expenditure falling from a low 3.6% of GDP in 2009 to something closer to 3% in 2010. Several recent scandals involving new born babies are rocking faith and confidence in the system.

The government has followed a radical programme. Regional and municipal hospitals have been dumped in the lap of local government without adequate budgets to pay for their continued working. Their future remains deeply uncertain.

Meanwhile, the government plans to introduce payments for non-student adult Romanians to access the public sector. Payments via a healthcare will be €139 a year. First proposed for mid 2010, expect implementation in June/July 2011.

As in Bulgaria, there is a continuous brain drain. Since 2007 some 6,000 of the country's 41,000 doctors have left and this year a further 2,500 or over 7% have quit due in part to a 25% wage cut.

Hospitals: Public hospitals could well be sold off or outsourced to private management. This has already started with Medlife taking over part of a public hospital in Brasov. But it is far from clear that private hospital operators will want to take on the burden of under-resourced and corrupt institutions backed by a weak government. Meanwhile, private hospital capacity is building fast.

Insurance: It is not clear whether private insurance policies will take over from the publicly funded statutory system with the introduction of the new health cards next summer.

Care: There is no formal care home sector in Romania. The elderly are cared for at home.

Serbia – top up insurance and private public partnership

Under reformist President Boris Tadic, Serbia is striving to seek EU entry. Meanwhile there have been recent changes in healthcare reform.

Insurance: Serb government is considering introducing a private, top up complementary insurance package to sit on top of the statutory NHS offering.

Hospitals: There are also plans to widen collaboration with the private sector to provide better cover for heart surgery, dialysis and more complex diagnostics. The Minister of Health Prof. Dr. Tomica Milosavljevic recently visited the private Clinic-hospital Centre Beograd which has carried out over 200 operations for the national health fund.

He said that cooperation should be intensified with the main idea that quality, safety and availability of services should be as equitable as possible for all Serbian citizens.

Slovakia – Insurance privatisation, hospitals professionalised

The new government in Slovakia is set to put in place widespread reforms which may eventually lead to hospital privatisation, says Peter Golias at thinktank Ineko.

Insurance: Today, workers have to take out statutory healthcare insurance with one of three companies, the largest of whom General Health Insurance Company is state-owned and has a 70% marketshare and the second, the Common Health Insurance Company has a 25% marketshare and is majority owned by private equity group Penta Investments. The third is owned by Achmea/Eureko, the big Dutch insurer. These marketshares mean, says Golias, that there is no real competition.

The previous government passed laws stopping privatised statutory healthcare insurers from paying their shareholders dividends, a move which effectively made them into not for profits. This was challenged in the courts and found to be illegal. Golias says the government is now negotiating on the level of profitability that the insurers can enjoy. “Some level of profitability will be restored but it will be tightly controlled.”

Golias says the government wants to create real competition between the insurers. To do this, the government says that it wants to split up the large state-owned insurer and to thus create several more competitors. But Golias says that there is a lot of political opposition to privatisation.

The government is also keen on price transparency and wants all insurers to have to reveal all deals they do with providers. Golias is sceptical of this move: “publishing all contracts may actually lead to a growing risk of cartels.”

Golias says that insurers are already free to choose providers and strike deals. Insurers are driving a move towards day surgery which is often carried out in smaller privately owned clinics.

Hospitals: All public hospitals are to remain in state hands but to become joint stock companies. Golias says: “They will be commercial companies operating under commercial law.” This will limit the debts they can take on and force them to be run on professional lines. It will also be possible for the first time to compare and evaluate the profit and loss lines in different hospitals for the first time.

Golias says that he thinks, long-term, these hospitals will also be privatised, but that this will not happen in

the four year life of the present government. Many smaller hospitals and clinics were privatised 5-6 years ago.

Pharma: The government is squeezing prices down. It first stipulated that if the price of a drug is higher than the average of the six lowest then the price had to go down to this level. More recently this was changed to the level of the second lowest in the EU.

There has also been a strong drive towards generics. Pharmacists are now instructed to supply generics even if doctors prescribed a brand name.

Spain – Could Alzira fly?

Getting a clear picture is very difficult as this is dependent on the 17 healthcare regions who have a lot of autonomy. Overall, the present socialist government in power until 2012 is not likely to turn to the private sector. Indeed, it looks set to end the privileges enjoyed by 3m in the army, the civil service and the judiciary which allows them to access private healthcare (see separate news story).

Early elections do look like a distinct possibility and the right wing Popular Party which pioneered the Alzira model is well ahead in the polls.

Alicia de Miguel, a former health minister in Valencia and a hospital doctor herself says that, whilst none of the parties are likely to be shouting about it in their manifesto, co-payments are likely to be introduced on doctor's visits and for prescriptions. PPP is likely to be extended. The NHS is also likely to outsource more widely in order to save some money, according to Norbert Galindo at Catalan imaging group CSC.

Were the centre-right Popular Party to win power this could herald a move towards wider adoption of the Alzira model in which a consortium of private operators provide primary and secondary care to a region of 200-300,000 people. This has now been proved to lead to 20% cost savings and higher levels of patient satisfaction through better management of doctors who, in the public sector have a tendency to skive off in the afternoons to do private work.

De Miguel reckons a PP win would herald a big expansion of the model although she cautions that it doesn't work for university and reference hospitals with their higher cost base.

But implementation would probably depend upon the PP winning a majority in a particular region. In fact, a PP majority doesn't guarantee the adoption of the Alzira model. This has not happed in Castile Leon or Galicia, although, Alicia de Miguel, the former minister of Health for Valencia and a hospital doctor herself, says that Galicia might move in this direction. This reflects the fact that these are small regions each with less than 2.5m people. The PP is already in power and running the Alzira model in two of the four bigger regions (Valencia and Madrid). It is less likely to win power in solidly socialist Andalusia (8.1m). Conversely, it is possible that some socialist regions may adopt an Alzira type model. De Miguel says: "Some socialists accept the need for change."

Note that November 2010 elections in Catalonia, the wealthiest region, saw the ruling Socialists trounced by the moderate nationalists with the PP also winning seats. It is unclear as yet what impact this will have on the Catalan healthcare services sector which boasts a unique mix of private and public partnerships. The short-term impact is likely to be limited as the current model was kept by the socialists when they took power in 2003.

Care: A law passed two years should enable the elderly and their relatives to exercise patient choice which should eventually lead to an expansion in the private sector. However the funds simply are not available to finance this at the moment.

Sweden – Specialist care is next on the block

The centre right won the elections but only just and are dependent on an anti-immigrant party Sweden Democrats for a majority. This means that the government can't force counties and municipalities to more to patient choice models which favour the private sector.

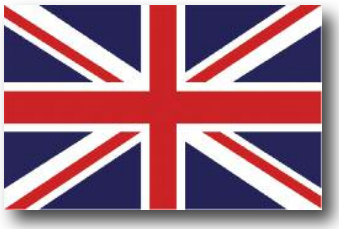
The counties to watch are Halland and Stockholm which have strong reformist reputations and are both introducing systems to encourage specialist care including a lot of ambulatory surgery to move into the

cheaper outpatient sector.

Primary care: Patient choice has been introduced by all counties but on different terms. In left-wing counties new centres have to offer such a wide range of services that setting up is prohibitively expensive. Generally, it remains expensive to start a new primary unit and build a customer base. Expect larger groups to acquire to build chains. Sources estimate that across the country 20% are now private so there is still a way to go.

Most patients have not made a choice and just stuck with their existing provider. It is possible that a law could be introduced which would allocate a certain percentage of non-choosers to any new primary unit which is opened in an area thus immediately giving the primary centre a critical mass.

Care: Outsourcing by tender applies across the country, no matter what the political complexion and has led to a big growth in the private sector. This government will introduce legislation 2014 which will force all counties and municipalities to introduce the choice system for homecare. As with primary care, much hangs on the details of how it is introduced.



UK – the future looks bright for the private sector

Under previous left of centre Labour governments, the national health services was pumped with money and an anti private sector culture was not discouraged. The result, according to the OECD, is that: "The quantity and quality of health care services remain lower than the OECD average, while compensation levels are higher. "

The coalition government has embarked on radical restructuring, with procurement of secondary care transferred from 130 regional bureaucracies called primary care trusts to family doctors who are expected to amalgamate their purchasing into consortia.

The government is also continuing "chose and book" whereby patients can chose where they have procedures carried out. Any willing provider can put themselves forward for this work, which means the small private sector, in theory, is now competing on equal terms with NHS hospitals.

The government is also much friendlier to private sector outsourcing than its predecessor. The unreformed and unproved lab sector looks certain to change radically, with a move towards joint ventures or outsourcing.

But there is a big question mark as to whether the small (and not very well run) private sector which has been heavily dependent on private patients and the small private healthcare insurance sector will be able to rise to the challenge. Used to very high EBITDA margins in the region of 25-30%, senior managers say that historically the sector has been poorly run, although that is changing with the entry of international players with management skills such as Australian operator Ramsay.

The Office of Fair Trading has just embarked on a wide ranging review into the private healthcare market, in particular into whether the insurers' agreements with hospitals are anti-competitive.

Laing's Review from Laing & Buisson shows that, overall, the sector bucked the recession with a 7.5% rise in sales to £3.76bn in 2009 but its reliance on NHS services grew almost four-fold over the previous two years, rising to 22% of the total from just 6% in 2007. It could grow much further fairly fast. William Laing thinks it could quintuple to £2bn.

Whilst in France, Norway and Italy private hospitals which offer elective surgery are paid between 20% and 50% less than the tariffs received by the public sector, in the UK they receive the same amount. Whilst some NHS tarrifs look low compared to continental counterparts, this does suggest that the margins for the private sector are likely to be high.

HEALTHCAREEUROPA will continue to report on policy change in these countries, and more, throughout 2011.

If there are specific regions you would be interested in us targeting please let me know on max@healthcareeuropa.com and we will add to the comprehensive list of countries that we already report on each month.

Thank you for your support throughout our first year, we look forward to returning in 2011.