

STRATEGIC SCENARIOS 2020

# THE FUTURE OF CEE HEALTHCARE

---

Written by  
Central & East European Health Policy Network

# TABLE OF CONTENT

Acknowledgments	3
Foreword	4
Executive Summary	7
1. Consumer Rules	13
2. Government Serves	24
3. Industry Drives	33
4. Doctors Dictate	42
5. Wild Cards	50
Those Who Took Part	55
About CEE HPN	56

# ACKNOWLEDGMENTS

First and foremost, the authors of the "Strategic Scenarios 2020: The Future of CEE Healthcare" would like to thank Paul van Hoof for his trust and enthusiasm as well as to Glaxo Smith Kline (GSK) for the financial sponsorship in 2011. It was their contribution that enabled the start of a unique international think tank Central & East European Health Policy Network (CEE HPN) and its first product, the "Strategic Scenarios 2020: The Future of CEE Healthcare".

The production and copy-editing process was coordinated by Andrea Benáková. Peter Pažitný and Peter Balík were responsible for the proofreading of the book. The unique design of the book is an endproduct of Mária Rojko. The beautiful illustrations of wild cards are a masterpiece of Miloš Kopták.

The authors are thankful to the whole CEE HPN team, namely Lenka Borošová, Andrea Benáková and Ivana Morvayová for the smooth communication within the network, organization and coordination of events and administration of all CEE HPN issues.

The authors are grateful to Health Care Management Training Centre at the Semmelweis University for hosting the CEE HPN members at their premises during the Budapest workshop in March 2011.

# FOREWORD

The book "Strategic Scenarios 2020: The Future of CEE Healthcare" is a product of the Central & East European Health Policy Network (CEE HPN). It was born in structured discussions during four workshops and many hours of homework. We started to work in March 2011 and the last words were written in March 2012. Our **strategic scenario planning exercise** was facilitated by Ivan Perlaki.

The title of the book may mislead the reader as it might create a feeling that we know what will happen. However, we do not. Strategic scenarios present alternative futures that may happen and the reader should rather see them as **mental maps** of possible futures and not as four alternative predictions.

The future is open and cannot be predicted. The goal of strategic scenario planning is to abandon our initial ideas about the future and realize that the world of tomorrow may not correspond with our today's ideas about it. Strategic scenarios will remove the blinds from our eyes, will help us overcome our blindness and get rid of our tunnel vision of the future.

They will enable us to "think about the unthinkable". They will enable us to think over and above of our usual - individual, group, organizational or national - frame ("thinking outside the box"). They will enable us to realize that the future can bring us great opportunities and great threats that we have never thought about and, therefore, did not prepare for. Strategic scenario planning "gives us new eyes". We will never see the future the way we used to see it before.

Strategic scenario planning is the first, initial phase of our preparation for the future. If we want to be successful, we must prepare ourselves "to thrive" in any future. And, because we are unable to tell which scenario (or which combination of scenarios) will become a reality, we must thoroughly prepare for all scenarios.

We must be ready to take advantage of all great future opportunities and, at the same time, we must be able to face all big future threats (or should be able to prevent their occurrence) in all alternative scenarios. Naturally, a part of this preparation is our maximum effort to influence the future so as to pro-actively create as many great opportunities and prevent as many big threats as possible.

Our aim is not to predict the future, but to think about **major opportunities and threats** in different worlds that may occur in the future. The main advantage of these scenarios - when we think about them as of mental maps - is the fact that they force us to think about our behavior in the given alternative future. In other words, how would I - and/or other important stakeholders - behave if I lived in the scenario "Consumer Rules"? Or, how does the ordinary life in the scenario "Doctors Dictate" look like?

The main scenario dimensions are defined by a matrix of two independent **dominant uncertainties**:

1. Who are the power holders - consumers or doctors? According to the answer to this question we can have two absolutely different worlds: consumers' world and doctors' world.
2. The degree of liberalization and/or regulation of the healthcare. At the opposite ends of this dimension we have a very liberal environment and a very regulated environment.

**Matrix 1:** Strategic Scenarios 2020: The Future of CEE Healthcare

Consumers world	<b>Consumer rules</b>	<b>Government serves</b>
Doctors world	<b>Industry drives</b>	<b>Doctors dictate</b>
	Liberal environment	Regulated environment

The scenarios describe everyday life of the following key groups of **stakeholders**:

- **Consumers**

We consider this group as a broader concept rather than just patients. In this regard, consumers are defined as a group of people using healthcare services to improve their health status and well-being. In addition, consumers are making choices based on their preferences and accessible information.

- **Government**

Under the term government we understand the whole administration and regulation of the healthcare system in a broad sense. It is a group of people, who are members of the government, Ministry of Health officials, representatives of regulatory bodies and individuals creating different types of regulations for market players.

- **Doctors**

This is meant as doctors in a very precise meaning of the word. Doctors are doctors, not the providers, not the hospitals, not the nurses. Doctors are defined here as a powerful group protecting its own interests.

- **Industry**

The term industry stands in our analysis for a group of all influential players of the healthcare system, not only doctors. This group includes all providers (hospitals, clinics, doctors, pharmacists, lab workers, nurses, etc.) producers, suppliers, insurance companies and investors. The industry is also understood as a power group that sees healthcare as a profitable sector.

During the scenario planning exercise, we realized that CEE countries face a crucial problem of imbalance between population's healthcare needs and the availability of healthcare services, necessary to satisfy those needs. This imbalance creates two basic types of **problems**:

- Type 1 Problem: In this situation, the population has healthcare needs, but these are not met by the healthcare system, due to the lack of services and/or products that would satisfy them.
- Type 2 Problem: In this situation, there are available healthcare services and/or products offered by the system, but they do not match the real needs of the population.

**Matrix 2:** Strategic Scenarios 2020: The Future of CEE Healthcare

Services are not needed	<b>No problem</b>	<b>Type 2 Problem</b> Overtreatment Unnecessary care Dangerous care
Needed services	<b>Type 1 Problem</b> Undertreatment Waiting lists Corruption	<b>No problem</b>
	Lack of services	Availability of services

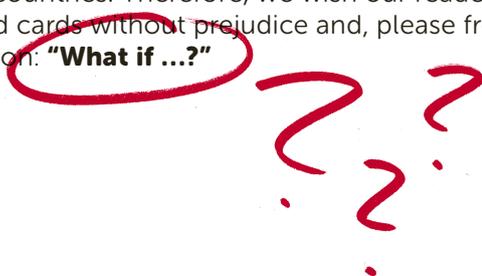
Essential parts of this book are five **wild cards**.

Wild cards - or Black Swan events - are events, which have extremely low probability but extremely high impact. They create existential risks for the stakeholders. Wild cards always appear as big surprises, therefore they can be randomly applied in any stage of the scenarios. In this book, you will find the following wild cards: buying immortality, hacking personal data, pandemics, solar flare and a Black Swan card. The Black Swan card is empty and tries to challenge your imagination and creativity.

At the end of each scenario you may find **weak signals** in a graphical timeline. Weak signals tell us well in advance which road from the present to the future we have been following and towards which scenario we are heading. They will enable us to get a considerable head start to prepare for taking advantage of great opportunities and eliminating or decreasing impact of big threats in the alternative future to which we are heading. To identify weak signals we must of course develop means for their monitoring and we must build a comprehensive environmental monitoring and scanning system: i.e. we must develop our **early warning system**. If you wish to know which CEE country is heading to which scenario, please regularly follow our early warning system on [www.ceeHPN.eu](http://www.ceeHPN.eu).

We are promoting a consumer oriented healthcare system, even though many of us live in the world where doctors dictate or industry drives. In the course of developing our scenarios we challenged our minds and we were also open to all ideas from people coming from culturally different regions.

The aim of this book is to initiate discussion about the future of healthcare systems in CEE countries. Therefore, we wish our readers an enjoyable reading of scenarios and wild cards without prejudice and, please from time to time try to ask yourself a question: **"What if ...?"**



# EXECUTIVE SUMMARY

## HOW TO READ THIS BOOK?

This book contains four scenarios and five wildcards. All scenarios begin in the course of the years 2010 – 2011 in Central & Eastern Europe. The scenarios are written in a non-country specific way, so they can be applied in any central or eastern European country. The scenarios are parallel, and therefore the reader is free to read them in any order. The wild cards are randomly distributed in the book and can occur in each of the scenarios.

The story line in this executive summary with the predefined decision tree and events leading to switch points between scenarios are our alternative of the events. The reader may think about another switching points and another timeline of events leading to different scenarios. We would be very happy to publish these alternatives on our website, so if you have an alternative decision tree, or a switching point, please be so kind and contact CEE HPN.

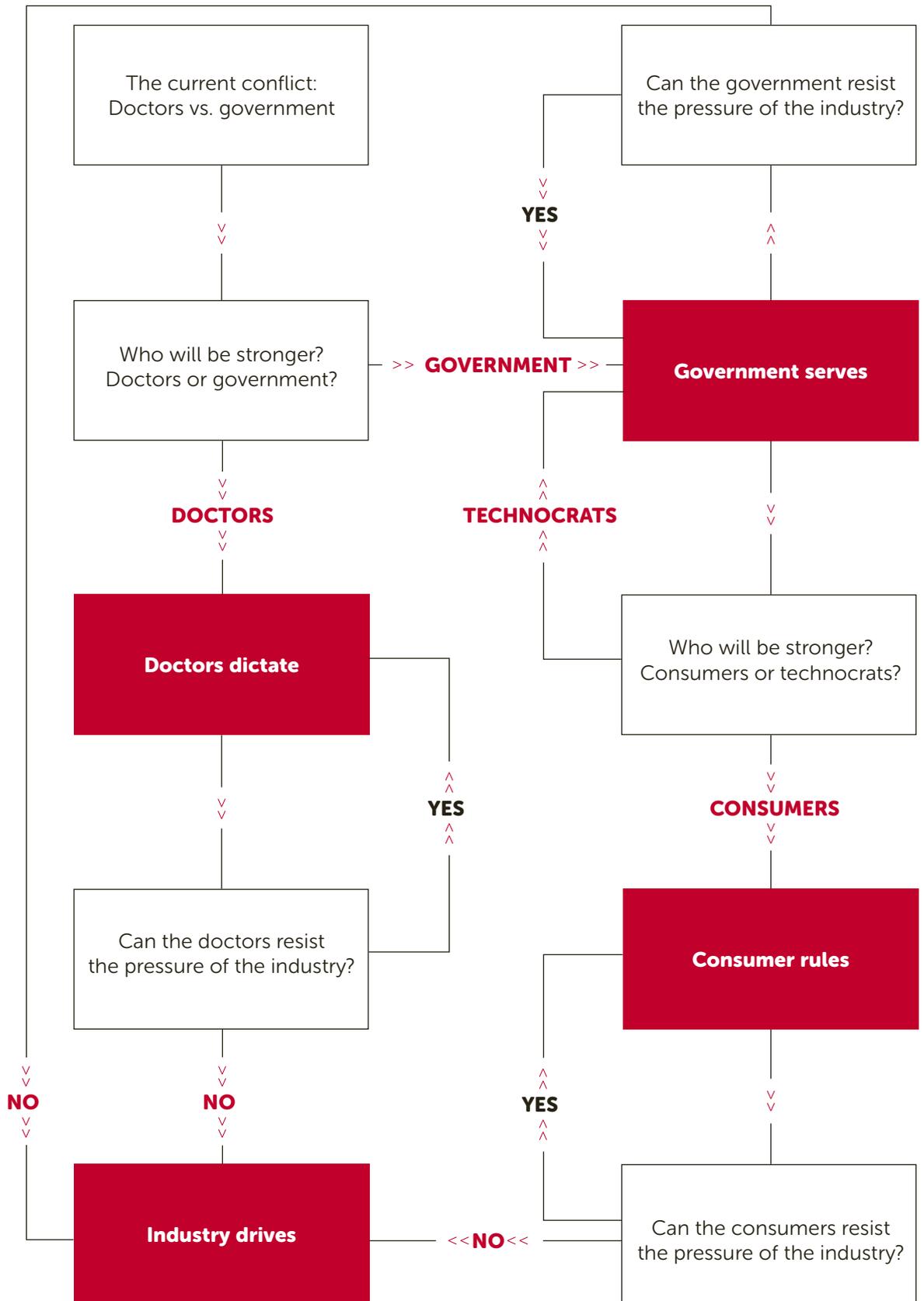
## THE CURRENT CONFLICT: DOCTORS VS. GOVERNMENT

Wage differences between CEE and Western Europe led to a significant outflow of health workers to the West. Substitution inflows into CEE from the East (the former Soviet Union, Turkey, Middle East, India) were more complicated and therefore insufficient. This trend increased the negotiating power of the remaining doctors and nurses, working mainly in hospitals. Their strike for higher wages was successful.

It started in the Czech Republic. More than 3,800 doctors signed the petition „Thank you, we are leaving“. They also gave their notice. After two months of negotiations the Minister of Healthcare backed and the doctor’s salaries increased by 5,000 CZK. As a result, almost all of the doctors were re-employed in their old job. The rising of doctors began. The leader of the Czech Association of Doctors became unemployed and the PR agency that was organizing and managing the strike on behalf of the Czech Doctor’s Trade Union has been nominated for the Global Sabre Award in the category Public Affairs.

The strike continued in Slovakia, the unemployed leader of Czech doctors and the leader of Doctors’ Trade Union in Slovakia cooperated together and doctors’ notices were given also in Slovakia. More than 2,400 doctors joined. They demanded better working conditions, higher wages, budget increase for the health sector and the end of the transformation process of hospitals to state-owned joint stock companies. Again, the doctors were successful. The government, which resigned one month before the strike, was weak to resist the pressure and lost the battle. The doctors’ wages were increased by hundreds of euros.

**Matrix 3:** The decision tree



# ALTERNATIVE SCENARIOS

## CONSUMER RULES

This scenario describes events that led to a radical departure from conventional wisdoms about the medical profession, society, and healthcare provision. Driven by young patient advocacy groups and engaged citizens using up-to-date information technology a series of political, social, and economic changes ensued. A new political force emerged that succeeded in implementing new legislation based on principles of sovereignty over one's body, accountability, transparency, respect for law and readiness to defend it, and fair competition that guarantees inflow of innovations and sustainability. There is a well-functioning competitive health insurance market with a large number of different health insurance products (health plans). However, all of them are offering (at least) the standard benefit package still defined by the law. Health plans can differ and compete with price, structure of the healthcare providers' network, different levels of applied managed care tools and the quality of administration as well.

## GOVERNMENT SERVES

In this scenario, the government refused to appease with the doctors again, announced a sound fiscal policy and hired a young group of technocrats to prepare a strategic plan. This scenario describes a system, where the main health policy tools are regulations and the attempt to handle the side effects of overregulation. In order to satisfy consumers' needs, the government did not listen to their preferences, however, the needs of the consumers were scientifically approached in an objective utilitarian way.

The government objective for maximizing benefits for the whole society resulted in overregulation and created lots of reporting duties and unnecessary bureaucracy. Each change had to be tuned with new regulations. Major Superbodies played the decisive role in the system.

## INDUSTRY DRIVES

The social values and patterns, similar culture and heritage in CEE countries form a corruption-tolerant environment. No power group – neither doctors, nor consumers or social engineers – no matter how straightforward it appeared at the beginning, could resist the interests of profit-seeking industry for long. The capture of the stakeholders was sophisticated, slow, but perpetual and somehow inevitable. This is the story when industry drives. Industry took the lead and the focus of doctors and providers was on the procedures and not the patients. The number of specialized centers increased and at the same time interventions-based medicine dominated. The inequities in health increased and those centered on urbanized areas were better off. There was no demand for information; there was a demand for recommendation. Access brokers started to play an important role. Government was hiding behind the saying "the system is liberal, market players are responsible", while it was being deregulated and liberalized without a concept.

## DOCTORS DICTATE

In this scenario only doctors ruled the system. The president of the Medical Chamber became the Minister of Health and every new law had to be discussed first with the Chamber of doctors while only after its approval, the law was released for further comments. The managers of hospitals were solely doctors, who had to be approved by the newly established ministerial advisory board constituted only from doctors.

The power of doctors was further increased, because doctors acted also as staff at the Ministry of Health, heads of university hospitals, CEOs of insurance companies, health policy makers, academic staff at universities, and even as journalists reporting on medical affairs. An independent journalist, who was fired from a Medical Weekly characterized this situation as "white clan".

**Table 1:** Comparison of functions for each of the scenarios

	<b>Consumer rules</b>	<b>Government serves</b>	<b>Industry drives</b>	<b>Doctors dictate</b>
<b>FINANCING</b>	Competing health insurance companies financed through nominal premiums with means-tested system of public subsidies	National Health Insurance with a monopolistic position financed through health insurance contributions	Competing health insurance companies financed through health insurance contributions	National Doctors' Service financed through taxes
<b>POOLING</b>	Sophisticated risk-equalization system includes demographic as well as chronic diseases and acute hospital care predictors	Sophisticated risk-adjustment scheme provides regional redistribution of sources, based on scientific needs assessment	Risk adjustment inadequate due to lobbying, half-baked decisions and limited regulatory capacity of the government	Regional risk equalization based on doctors' preferences
<b>PURCHASING</b>	Flexible, outcome-based, guided by health plans and/or health consumers, supported by purchasing agencies	Global budgets, later followed by payments for outcomes	Fee-for-service, unstructured budgets and payment per case for hospitals Payment for outcomes blocked by providers.	Salaries, capitation and global budgets
<b>PROVISION OF SERVICES</b>	Patient-centered, coordinated, dependent on an all-inclusive information and communication system	Strictly according to guidelines and protocols	Highly fragmented, procedure and not patient-oriented Lots of unnecessary care is provided	The services are deemed to be inadequate with long waiting lists and limited access to health service

**Table 2:** Comparison of outcomes for each scenario

	<b>Consumer rules</b>	<b>Government serves</b>	<b>Industry drives</b>	<b>Doctors dictate</b>
<b>ECONOMIC IMPACT</b>	Health sector is stable and internationally competitive, one of the most important sectors of the economy.	Superbodies are successful in cost containment, and with cost effectiveness maximalized the healthcare benefit of the society	Both public and private costs are increasing without corresponding outcomes improvement and create threat to fiscal stability	Doctors Dictate Increasing doctors' salaries are continuously financed through increased VAT, property and consumption taxes
<b>FINANCIAL PROTECTION</b>	People enjoy a high degree of financial protection from being impoverished when they get ill	Proportional financing of the defined benefit package	Deteriorates due to semi-legal enforced payments by providers and inadequate pooling and risk adjustment	High corruption erodes the financial protection of the population
<b>HEALTH OUTCOMES</b>	Improved for the majority of the population with measuring the outcomes based on specific, well-defined criteria	Health status of the population improved significantly	Only very marginal outcomes improvement for some patient groups thank to new technologies. Worse outcomes due to limited access and quality especially in the area of chronic diseases	Health outcomes for patients improved randomly. Exceptions are patients skilful enough to get to the best doctor, and get the most advanced treatment
<b>EFFICIENCY</b>	The system satisfies extremely well the consumer needs, whatever they are	Very high due to health technology assessment, cost-benefit analyses and an objective needs based approach	Declined efficiency due to increased volume of unnecessary care and chaotic implementation of new technologies	Remained at a low level, because of low productivity of medical providers. Over and under-treatment became a common place depending on the doctors' attitude
<b>ACCESS</b>	Health provision accessible to all consumers in a timely manner and high quality	The network of providers is fixed and is designed to meet the defined criteria of access, such as traveling distance and waiting times	Very variable depending on the ability of the patient to get an access broker	Access to healthcare especially the advanced one has deteriorated as only selected centers had sophisticated means to apply modern technology

**Table 2:** Comparison of outcomes for each scenario (continued)

	<b>Consumer rules</b>	<b>Government serves</b>	<b>Industry drives</b>	<b>Doctors dictate</b>
<b>CONSUMER CHOICE</b>	Consumers can choose from several competing insurance companies and their rich offer of health plans. An integrated, publicly-accessible, information system provides instant access to rating of health providers and health insurance companies	Consumer's choice is limited. Local monopolies, minimal competition and strict guidelines do not bring a lot of opportunities for consumer's decision	Depends on ability to pay. Rather good for richer parts of the population	Consumer choice has remained very limited, and rationing of healthcare persisted.
<b>CONSUMER SATISFACTION</b>	Very high satisfaction. Consumer is at the center of the game, because he or she is free to allocate a large part of his or her resources to whomever he or she wants. Health providers and health insurance companies compete for consumers' attention.	Consumer's satisfaction is not declining while his choice is getting limited because of very massive communication and education campaign from the Government. Consumers are being convinced they receive the best available care.	Low, for obvious reasons in low-income groups, rather low among the better-off as well because of lack of information and fragmented nature of care	Consumer satisfaction is not great due to long waiting lists, weak voice of the consumer and access restrictions

# 1. CONSUMER RULES

2012

Healthcare simply lacked financial resources to provide care for sick and injured citizens. Waiting lists for certain medical procedures became a standard. Large medical facilities, especially university hospitals, gradually accumulated debts. An atmosphere of stagnation prevailed in most medical facilities. Towards the end of 2012 a **large group of disillusioned medical personnel left the profession to work abroad or in other sectors of the economy.**

Simultaneously, several bad cases of malpractice came to the attention of journalists and free-lance bloggers. This started to appear more often in the television and the internet. This attention on the doctor's underperformance soon revealed more **horror stories of unsatisfied patients** that completely dominated media landscape over the winter of 2012.

---

**From the blog: [www.hospitalwatch.eu](http://www.hospitalwatch.eu)**

**Views:** 157,232 (in last 24 hours)

**Date:** 29.11. 2012

Hospitals are collapsing. The debts of hospitals are more than 50% of their annual revenues and the Association of Suppliers expressed that their claims are unpaid for more than 400 days. The government refused to increase the resources for healthcare due to an austerity package of the state budget. In order to maintain the remaining popularity, the government persistently refuses to introduce user charges for hospital stay. In a university hospital, the suppliers of utilities were forced to stop the delivery of electricity, heat and water. The management of the hospital got into a desperate situation, because of freezing weather conditions. Due to this, patients were transported 30 kilometers to a private hospital, where they had to pay daily fees for admission. All patients except of the pensioners accepted this situation.

2013

In the spring of 2013, a medium-size bank collapsed and the cash flow of pharmaceutical companies further deteriorated. By the end of summer 2013 the health sector was exposed to severe pressure. **The government was unable to formulate a realistic contingency plan**, because large numbers of officials were still on holidays. By mid-September when people came back from holidays, they found out that pharmaceutical companies stopped drug delivery to medical facilities. State of medical emergency had to be declared by the government and the army was mobilized. Budget deficit significantly increased and the continuing turmoil resulted in the fall of government at the end of October 2013.

Concurrently, events accelerated in the cyberspace as well. **A group of young, dedicated cancer patients** (some of them with only few months to death) from internet social networks united with progressive street artists and launched a series of public gatherings, protests, awareness campaigns and acts of civil disobedience. They mastered public spaces in large towns, which turned into political battle grounds. Pavel Preker, an unofficial spokesman of the movement, died during one of these gatherings. **His emotional cover page story about his life challenged the traditional way of healthcare delivery.**

The death of Pavel Preker inspired not only ordinary people, but also academicians, independent analysts, civic associations and open society. Consequently, **alternative**

visions of the healthcare system were formulated by think tanks, universities, and independent networks. New educational courses promoting patients' rights emerged in the education system.

---

A farewell letter left in front of Prekers house among a mountain of flowers and candles. My dearest Pavel. I met you only in the virtual world, but I will miss you every day of my life. And I feel, my life will not last much longer. You and the leaders of the Movement showed me and other people suffering from cancer, how to live our life in dignity. We realized that we also have a voice and our illness should not be a handicap in formulating our wishes.

At the beginning, I was very shy and had no courage to ask for more. However, following your example; I became a real partner in discussions with doctors. My life is getting better, not in terms of the health condition, but self-confidence. My body is aching, but my soul is nurtured.

With deepest love

Maria

P.S.: See you soon on the other side

---

## 2014

In the summer of 2014, the country witnessed a massive strike of patients in front of medical facilities, hospitals and the Ministry of Health for more attention paid to patients. The strike was organized via social networks. The new government tried to solve the healthcare crisis by proposing technical adjustments, budgetary restrictions and anticorruption measures. Even though the situation deteriorated and the patients were forced to undergo specialized procedures abroad.

The benefit package was not defined, and so all health insurers were forced to pay for the whole care that was provided. Furthermore, they did not have enough tools to control expenditures and opportunities to increase revenues, because these were centrally regulated by the government. This trap was especially visible in the Main Health Insurance Company, which had no motivation and no technical skills to implement efficiency measures. It was not able to balance the difference between revenues and expenditures. As a result, the Main Health Insurance Company filed for bankruptcy.

## 2015



Due to the negative image of healthcare and the escalating problems a new political party, the Healthcare Consumers Party (HCP) was born. It operated virtually via the internet and social networks with its program focusing solely on healthcare. The Healthcare Consumers Party used the legacy of Pavel Preker to gain popularity among young and old, healthy and ill. Officially, the Healthcare Consumers Party was registered on June, 16th 2015. The new party was joined by health policy experts from market-oriented think tanks who drafted the design of a new, consumer-oriented system. They were experienced, because they participated in previous reforms in the region and knew exactly not only what to do but also how to enforce it. The party immediately initiated activities to increase the role of the consumer:

- First, they started to support individuals and groups to form local consumer associations and to monitor the quality of healthcare services.
- Second, they established an independent position of an Ambassador of Health Consumers. The role of the Ambassador was to collect and deal with peoples' complaints. To manage this, the Ambassador's team provided legal and psychological advice.

- Third, they regularly **informed the media about the complaints** the Ambassador was dealing with and massively attacked the government with stories of ordinary people who did not get a proper care.

Publicly demonstrated willingness for a consumer oriented system with lower corruption and fair access resulted into a **high penetration of media with health related content in the society**. These media adopted the new language paradigm and started to call the patients as health consumers. The government played the deaf and dumb with the aim to exhaust the party leaders. The popularity of Healthcare Consumers Party overran 30%.

The situation escalated after a serious illness of the president's wife in August 2015. A series of wrong decisions forced the President's administration to move his wife to another country with a safer hospital. Unfortunately, the first Lady did not survive the transport and died. **In split of a second, the healthcare system was not only the problem of the "sick and poor", but also of the rich and healthy.** The overwhelmed president joined the Healthcare Consumers Party and early elections were called for December 2015.

---

**Facebook status of the leader of the Healthcare Consumers Party**

We did it! More than 31%! Thaaaaaaaaaaaaaaaaaaaaank you all for your support :-)  
Monday 7. 12. 2015, 6.35 a.m. (just after the official election results)



2016

**The Healthcare Consumer Party became the leader of the coalition**, possessing the post of the Prime Minister, the Minister of Finance, the Minister of Health, the Minister of Social Affairs and the Minister of Education and Culture. The Minister of Health prepared the new legislation package within 6 months, which was based on the main ideas of the Healthcare Consumers Party. The package of the radically new health legislation was presented across the political spectrum and gained wide political agreement.

The paradigm shift incorporated in **the new legislation was supported by a group of medical professionals pioneering and advocating the orientation on consumer**. This started the emerging acceptance of the "consumer oriented" healthcare paradigm by medical profession and helped the smooth acceptance of the change by the population.

2017

On April 14, 2017 the parliament adopted the key legislation package. **The new laws paradigmatically shifted the healthcare focus from doctor centralism to the consumer**. For the first time in history, consumer associations united in one formation in 2017 and obtained massive funding from the government to launch an integrated health information system. This allowed establishing the National Health Accounts, a powerful tool for tracking the money flow in the healthcare system.

This was a paradigmatic change in the work of the consumer organizations. Before this change, they were supported mainly by pharmaceutical companies with the agenda to achieve higher funding for the healthcare system, and consequently for pharmaceutical companies. After this change, the government actively supported patient organizations to control the healthcare delivery. The intention of the government was not to protect providers or the industry, but to increase the power of consumers.

## THE PARADIGM SHIFT

### OLD PARADIGM

The patient organizations are supported by the industry to fight for more money from the government

### NEW PARADIGM

The patient organizations are supported by the government to control the healthcare delivery

The new legislation introduced the concept of health plans and nominal premiums. Each citizen has the responsibility to choose a health plan based on his or her preferences according to the scope of the benefit package versus its price.

In order to ensure fair competition between health insurance companies, the risk adjustment system was extended to include chronic diseases and acute hospital care since June 2017. The sophisticated risk-equalization system included almost the whole income base of the basic health insurance. The conditions for risk-equalization were strictly set by law to avoid manipulation and the newly established Health Insurance Market Authority operated the whole process. The average nominal premium rate was included in the risk equalization model.

The benefit package was based on the Integrated Health Insurance System, National Health Accounts and the experience with malpractice cases of the Ambassador of Health Consumers. Consumers, who wanted to know what they should receive in their insurance plan, also demanded the definition of the benefit package. The definition of the benefit package covered three dimensions:

- First, it was the timeframe, when the consumption of healthcare services had to be guaranteed to the consumer.
- Second, it was the financial constraints related to the provision of the services. The benefit package had a strict financial framework. It started with the deductible, followed with % co-payment and ended with stop-loss insurance. These financial settings were different according to the type of care and the social group.
- Third, treatment protocols defining the basic clinical framework

The government also lifted the restriction for professionals to enter the healthcare market. Qualification requirements diversified, the role of the doctors changed and more care was provided by licensed nurses. Since June 2017, there was a new licensing system with more categories of medical staff and lowered requirements for providing primary care. This was also driven by a decreasing number of primary care doctors. On November 17th, 2017, the Ministry of Health merged with the Ministry of Social Affairs.

## 2018

This is the era of new insurers and new health plans. The new legislation boosted the attractiveness of the health insurance market. New players entered the market, among others, an international insurance company and a domestic bank. Moreover, one of the biggest employers in the country also established a health insurance company. The increased competition between health insurance companies was oriented on the consumer benefit.

The increased consumer benefits resulted from savings due to price negotiations between health insurance companies and the providers.

The amount of money in the system increased, while the proportion of public sources decreased. This happened due to the high likeliness of health plans among the population and the increasing cost-sharing at the point of service. The reason for the incre-

ased cost-sharing was the consumption of healthcare services apart from preferred provider networks. Suddenly, there was much less illegal and unofficial payment.

2019

From 2019 on, **the preferred provider networks** became an arrangement of most health plans in the health insurance market. There are new jobs demanded as **care coordinators and health consultants**.

---

**HealthJOB: care coordinator**

**Our client:** a leading Health Insurance Company is searching for a care coordinator

**Job description:** care coordinator in an asthma disease management program

**Requirements:** high level of communication skills, stress-averse, time flexibility, ability to work independently, car and smart phone, bachelor's degree in nursing

**Payment:** 2.0 times the average salary of the national economy

**Next steps:** send your CV to HealthJOB, personal interview in our assessment center only with invitation

---

O.K.

The biggest TV channel sponsored the rating of health plans. This made independent analysts considering this TV rating as being subjective. Four new initiatives were launched to compete with their own rankings. Consumer associations were monitoring the quality of healthcare providers. **Independent consumer rankings of providers were perceived as credible and gained huge popularity among the general public.** A vital part of these rankings were comparison tables on prices on healthcare services between different providers. This was logical, because there were differences in consumer prices for health services throughout the system.

---

**A phone conversation of two sisters (Jane and Kate)**

**Jane:** Hi Kate, I need your advice – our mum just called me, because she needs to arrange a hip replacement for our dad. But, please, don't tell her I called you (sighs)

**Kate:** I had the suspicion that something is going on, but you know, I didn't want to ask them, they are always so organized.

**Jane:** eah, but in terms of healthcare, they are rather disoriented, therefore they need some help. I have the impression they are rather conservative and want to manage it on "their own", you know what I mean?

**Kate:** Yes, I know, but its 2019 not 1999, so I will check it on the web. I am sure they did not try it.

**Jane:** Did you find something?

**Kate:** According to the web, there are 4 consumer oriented websites, which are rating the providers for hip replacement. This one looks confident and user friendly. According to this site, there are 15 places in our country and 4 of them are rated by "A" mark, 8 of them are in the "B" category and 3 of them are rated with the "C" mark. Let me check where the "A's" are – ah, one of them is only 75 km away, which could be our first choice.

**Jane:** Thanks Kate, you helped me so much, please send me the link of the hospital to my email and I will talk to mum.

**Kate:** You are welcome, and tell her she can also call me more often.

---

The structure of medical societies and the medical chamber was changed by the dynamics of changes in capabilities; demand for health services as well as by the accelerating process of innovations in healthcare delivery. **More and more old members started to focus on their personal development without seeking support from these traditional professional structures.** They were looking for new forms of educational opportunities laying closer to the medical industry rather than relying on the official educational program of the medical chamber.

Effective anti-corruption measures such as **rewarding whistle-blowers or insiders reporting medical fraud** were followed by successful anti-corruption trials. Whistle-blowers were rewarded for their activity by a success fee of 10% of the government savings.

## END STATE 2020

**The healthcare sector was fueled by a robust structure of public-private revenue mix.** Public funding consisted of general tax revenues as defined by the law, as well as the revenues from alcohol and tobacco consumption taxes and some other "sin" taxes. Public sources from taxation were collected in a Central Healthcare Fund, centrally administered by the Healthcare Market Regulatory Authority, which was also responsible for regulating the private sector. The Authority acted as a public sponsor and provided subsidies for risk adjusted health insurance premiums. At the same time it kept reserves for covering temporarily cut-offs in tax revenues in an amount of 2% out of they yearly public expenditures.

---

### Health System in Transition 2020

#### Chapter 3: Financing and pooling

Health plan specific nominal premiums within the basic compulsory health insurance represent the second largest source in healthcare, counting for roughly 30% of overall funds. Nominal premiums are modestly risk-rated and reflect the risk profiles related to individuals' behavior. Means-tested system of public subsidies, funded directly from Central Health Fund, subsidizes up to 60% of average nominal premium for low-income population groups.

There is a compulsory modest cost-sharing scheme at the point of health service delivery, which is not subject to additional complementary health insurance. These co-payments count just for 5% of overall healthcare costs (including co-payments for medicines), as being subject of basic health insurance coverage beyond the stop-loss threshold.

Nevertheless, within the basic health insurance system, there is an option for high cost-sharing health plans. In this respect a substantial cost-sharing scheme (counting for more than 35% of all basic health insurance costs) is combined with the health savings account. The Health Insurance Company offering this type of a product in its portfolio subsidized this account. These subsidies are risk adjusted.

The total share of direct payments in the system reaches 25% of all healthcare costs, thus leaving just 75% of costs to third party payment.

Risk equalization applies both for health insurance premiums and subsidies of health savings accounts. Although law requires open enrollment, the risk-equalization system made market strategies based on (1) restricted coverage or (2) exclusions due to pre-existing conditions useless.

Supplementary health insurance counts for less than 5% of health care costs and covers mainly:

- a marginal group of healthcare services not included in the standard benefit package,
- costs of health services, which were unauthorized within the basic health insurance and found not medically necessary,
- alternative health care,
- cost-sharing enabled by the insurance

Source: European Observatory on Health Systems and Policies

There is a well-functioning competitive health insurance market with a large number of different health insurance products (health plans). However, all of them are offering (at least) the standard benefit package still defined by the law. **Health plans can differ and compete with:**

- price (i.e. nominal premium base rate),
- structure of the healthcare providers' network (including preferred and not-preferred providers),
- different levels of applied managed care tools,
- the quality of administration as well.

Some health plans extended the coverage for additional premiums via supplementary health insurance, while some offered solely the basic health insurance schemes for a nominal premium.

Due to the very strong position of consumers, almost each health plan in the market complied with the independent "National health plans scoring system", administered by the private **Association of Health Insurance Consumers, the most influential consumer advocacy group**. The association was established in 2019 and provides a very well structured comparison of health plans. Plans are scored through performance indicators:

- meeting access standards,
- showing the outcomes of the chronic disease management programs,
- rewarding healthy behavior patterns.

**The best ranking plans advertised their scores and claimed for higher nominal premium rates.**

### The best Health Plans in 2020 by category

Health Plan Name	Traveller	Demanding	Accountable
Health Plan Category	Narrow Plan	Preferred Provider Network	High Deductible Health Plan
1. Access to care	Meeting expectations	Meeting expectations	Exceeding expectations
2. Performance indicators in chronic disease management	Meeting expectations	Exceeding expectations	Meeting expectations
3. Rewarding healthy behavior	Exceeding expectations	Meeting expectations	Meeting expectations

Source: National Health Plans Scoring System

The sophisticated system of risk equalization, accessible re-insurance products and simple legal start-up requirements enabled the opening of new health plans. Newcomers were - for the first 6 months - not required to comply with the access standards stipulated by the health insurance law. Consequently, a dynamic health insurance market has been established with a remarkable level of start-ups, exits from existing health plans and redesigns of existing products.

However, the number of health insurance companies, operating both in for-profit and not-for-profit regimes, remained rather stable. Although one **nationwide state-owned health insurance company still existed, its market share in 2020 dropped below 30%**. All other health insurance companies were in private hands. The most successful of these was operated by the Society of Jesus.

There was a large number of specialized health plans serving special customer groups, for instance to patients with congenitive metabolic disorders. However, most of the health plans still targeted the general customer base.

**An emerging market of health coordination/purchasing agencies specialized for particular chronic diseases was established.** These agencies were able to build up attractive reward programs for chronically ill patients. They successfully collected the purchasing power of these patients and did aggressive purchasing on their behalf. The agencies charged their clients on a pre-payment basis and generated profit through success fee by creating savings to their customers.

This market grew together with the cost-sharing health plans, because their customers were able to pay for their services from their health savings accounts. This **flexible financial arrangement opened the room for great innovations in the health plan product design.**

Health insurance companies started to reflect the growing importance of these agencies, whose capabilities exceeded traditional purchasing capabilities of health insurance companies. This brought substantial innovations and changes in the healthcare markets. And so, the consolidated healthcare providers had to face new competition of highly specialized small healthcare firms competing with a low price. First, some **signals of commoditization of substantial parts of healthcare services appeared, for instance diagnostics, imaging and simple treatment cycles.** This was caused by the fact that healthcare providers had to bid for volumes of well-defined services demanded via on-line auctions.

Thus, the healthcare market was becoming more flexible than ever before. The so-called simple treatment cycles were already well defined in terms of the outcomes and risks. They were driven by standardized treatment protocols. Providers were used to guarantee results as a condition for claiming payments. They spontaneously developed interfaces for incorporating their products into larger disease management packages under particular treatment plans. This happened by using the already existing information exchange interfaces and **ubiquitous access to electronic medical records.** Huge and robust information technology and communication infrastructure was already in place. There are various smartphone applications to remotely monitor health status of people.

Treatment plans were still managed mostly within the traditional integrated health care delivery model. However, on top of this, they were managed by new care coordination/purchasing agencies. Those, used the directly purchasing services at the lowest price in the market.

The drug industry applied depot based drug delivery, as part of the medical services. Consequently, in 2020, **healthcare providers purchased more than 70% of all medicines.**

Healthcare was delivered without queues and "waiting lists" ceased to exist. Consumers could well express their preferences and claim their demand. This was possible due to "traditional" health plan memberships and an increased direct demand for services in the healthcare market, which was supported by care coordination/purchasing agencies.

This demand was met immediately in a well-structured healthcare market due to different purchasing arrangements that have been developed. Health insurance companies (through health plans administration) and new health coordination/purchasing companies shaped these markets to meet the changed demand of consumers.

In 2020, the health sector was a fully demand-driven industry. Healthcare providers invested in market research and innovations in order to better meet the changing requirements of consumers. They were hoping to succeed in the competitive healthcare market.

Although the industry was demand driven, the costs of medical treatment did not increase and the expansion of the healthcare industry was slowly coming to an end. At the same time, the industry started to focus on new opportunities concerning life style, health management, healthy ageing and healthy behavior coaching. This shift was enabled by changes in the design of health plans and supported by flexible arrangements introduced in the health insurance legislation.

---

#### **Consumer Survival Kit for the "Consumer Rules" Scenario**

1. get internet access
  2. get a smartphone
  3. get your licensed health consultant
  4. get familiar with your health plan
  5. get familiar with the new health coordination/purchasing companies
- 

Capacities of healthcare services were used more often to **meet the demand of customers from other countries: In 2020, this income exceeded 20% of all healthcare industry incomes.** At the same time, the biggest healthcare providers were opening new facilities abroad, mainly in Asia and Africa.

**Medical associations had no formal role.** Medical profession as a traditional well-organized professional community based on academic authorities and rigid life-long curriculums ceased to exist. The dynamics described above made the traditional regulation of medical profession impossible. State authorities couldn't simply track changes in requirements on labor force capabilities in the market.

In 2020, the country had one of the **most liberal legislations on the medical profession.** However, the job description, capabilities and responsibilities in the workflow of health services was very well defined and allowed to recruit professionals from all over the world. Only a minority of positions in the industry required, fluent language skills.

The responsibility for results and outcomes was completely shifted on institutionalized healthcare providers, and on health plans. This happened due to liability requirements linked with coverage entitlement. The only state institution involved in the healthcare sector was the Healthcare Market Regulatory Authority. It oversees the compliance of relevant stakeholders with the legislation.

People with short-term sickness were well informed customers, who were accountable for their health. They are self-confident when they deal with medical professionals and

are also able to research and verify information. **Patients with chronic diseases, able to choose from different health plans, became experts on health plans that are offered for their particular diagnoses.** These patients know their illness as well as management plans and they actively participate in the treatment plans.

Patients' organizations produced several competitive consumer ratings of health plans and providers, which served as a source of information for consumers and promote healthy lifestyle. This caused a general madness for healthy life style among the population. **Patients' organizations acted as substantial political lobbyists supporting consumer friendly legislation.**

The structure of consumer-oriented healthcare was driven by functions, outcomes and preferences of customers, and not by traditional roles of medical professionals. Licensed care coordinators and health consultants gained an important role in healthcare.

The health sector provided an **attractive business opportunity for all kinds of investors** because the line between health and other related areas such as beauty, cosmetics, wellness, fitness, healthy food, behavioral therapy was no longer strict.



TIMELINE	WEAK SIGNALS
2012	<ul style="list-style-type: none"> <li>• Large group of disillusioned medical personnel left the profession to work abroad or in other sectors of the economy</li> <li>• Horror stories of unsatisfied patients</li> </ul>
2013	<ul style="list-style-type: none"> <li>• The government was unable to formulate a realistic contingency plan</li> <li>• A group of young dedicated cancer patients, who are able to influence the paradigm shift</li> <li>• Leader with an emotional cover page story about his life challenging the traditional way of healthcare delivery</li> <li>• Consequently, alternative visions of the healthcare system were formulated by think tanks, universities, and independent networks</li> </ul>
2014	<ul style="list-style-type: none"> <li>• Massive strike of patients in front of medical facilities, hospitals and the Ministry of Health organized via social networks</li> <li>• The Main Health Insurance Company filed for bankruptcy</li> </ul>
2015	<ul style="list-style-type: none"> <li>• A new political party, the Healthcare Consumers Party (HCP) was born. It was operated virtually via the internet and social networks</li> <li>• The new party was joined by health policy experts from market-oriented think tanks who drafted the design of a new, consumer-oriented system</li> <li>• Establishment of local consumer associations</li> <li>• New independent position of an Ambassador of Health Consumers</li> <li>• The new party informed the media about the complaints</li> <li>• High penetration of media with health related content in the society</li> <li>• The first Lady did not survive the transport to a safer hospital abroad and died</li> <li>• In split of a second, the healthcare system was not only the problem of the "sick and poor", but also of the "rich and healthy"</li> </ul>
2016	<ul style="list-style-type: none"> <li>• The Healthcare Consumer Party became the leader of the coalition</li> <li>• The new legislation was supported by a group of medical professionals pioneering and advocating the orientation on consumer</li> </ul>

- 2017
- Increased competition between health insurance companies for the consumer benefit
  - Increasing ratio of private facilities
  - Increased consumer benefits from savings due to price negotiations between health insurance company and the provider
  - Prices for healthcare services publicly available
  - Measured and enforced performance standards
  - Less illegal and unofficial payments
- 
- 2018
- The era of new insurers and new health plans
  - The amount of money in the system increased, while the proportion of public sources decreased
- 
- 2019
- The preferred provider networks
  - Care coordinators and health consultants
  - Independent consumer rankings of providers were perceived as credible and gained huge popularity among the general public
  - More and more old members of medical associations started to focus on their personal development without seeking support from these traditional professional structures
- 
- 2020
- The healthcare sector was fueled by a robust structure of public-private revenue mix
  - Health plans can differ and compete
  - Association of Health Insurance Consumers, the most influential consumer advocacy group
  - The best ranking plans advertised their scores and claimed for higher nominal premium rates
  - Nationwide state-owned health insurance company still existed, its market share in 2020 dropped below 30%
  - An emerging market of health coordination/purchasing agencies specialized for particular chronic diseases was established
  - Flexible financial arrangement opened the room for great innovations in the health plan product design
  - Signals of commoditization of substantial parts of healthcare services appeared, for instance diagnostics, imaging and simple treatment cycles
  - Ubiquitous access to electronic medical records
  - Healthcare providers purchased more than 70% of all medicines
  - The health sector was a fully demand-driven industry
  - Meet the demand of customers from other countries: In 2020, this income exceeded 20% of all healthcare industry incomes
  - Medical associations had no formal role
  - Most liberal legislations on the medical profession
  - Patients with chronic diseases, able to choose from different health plans, became experts on Health plans that are offered for their particular diagnoses
  - Patients' organizations acted as substantial political lobbyists supporting consumer friendly legislation
  - Attractive business opportunity for all kinds of investors

## 2. GOVERNMENT SERVES

2012

The position of patients was very weak and they did not find any adequate protection of their rights. The system controlled by the doctors discouraged private investments and hampered money influx into the medical system through official investment channels. Corruption was an everyday practice. Many citizens sought care across the borders in the old EU Member States. In the absence of any feedback system the doctors tried to avoid comparison of their work. "We are saving lives, not spreadsheets!" The Government argued with the differences between the doctors, their quality, productivity and results.

Supported by the majority of population, that was upset by the hostage-like situation, **the Government refused to appease with the doctors again**. One of the trade unionists made a prominent TV interview under heavy influence of alcohol. The video became immediately very popular on YouTube. Additionally, it was proved that four out of six leaders of the strike (trade union board members) travelled frequently to luxurious destinations on the costs of pharmaceutical companies. Media uncovered that the president of the trade union repeatedly asked for direct payments from his patients in order "to treat them well". The image of the demonstrators was heavily damaged. !

Population became better informed and more demanding concerning the quality of healthcare. Unfortunately, patients' organizations have become unable to present a credible and sustainable alternative. Alternative treatment methods, such as homeopathy, traditional Chinese medicine and Oriental herb medicine financed partially by the National Health Insurance System became very popular.

Problems in the healthcare sector had serious fiscal impacts that needed to be addressed. The new government took a responsible approach, forced the country into **a sound fiscal** policy to reach the very strict Maastricht criteria related to the 3% government deficit. The Ministry of Finance provided with significant powers took the lead also in health policy and temporarily subordinated the Ministry of Health.

Under the pressure of Ministry of Finance, the Ministry of Health hired a team of domestic and international advisors in June 2012. They were asked to prepare a problem based health policy package in cooperation with IMF and WHO. The leader of the team was a technocratic health economist Lena Workovič, who had a PhD degree from Erasmus University of Rotterdam. She was supported by a **group of young technocrats** with diplomas from prestigious universities from both Western Europe and the United States, with a solid academic background and sense for social justice or, one could say social engineering. Based on the hard work of her team, in December 2012, Lena Workovič presented the key measures for the members of the government. The old good times of the government came back.

---

### **The last slide named "Summary of measures" of Lena Workovič' presentation for the members of the government on December 12th 2012**

#### **Summary of measures**

- Increase the legislative, regulatory and control role of the government
- Increase access to care by introducing treatment protocols supported by the National Board of Healthcare Standards
- Increase quality by enforcing of treatment protocols by the Central Quality Bodies

- Increase cost-effectiveness by scientific evaluation of medical procedures, technologies, drugs and medical aids supported by the Health Technology Assessment Agency
- Increase the position of patient by definition of the basic benefit package
- Increasing capital investments from public sources and PPPs
- Guarantee cost containment through centrally set remuneration for providers and wages for doctors and nurses
- Promote new media language focused on patients with the following key words: unity, solidarity, and vulnerable patients

20. 12. 2012, Lena Workovič

---

2013

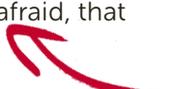
\* In February 2013, the government announced a **10 year strategic healthcare plan**. The concept of the plan was based on objective utilitarian principles to maximize healthcare benefits for reasonable costs and the leading role of the government. It was remarkable to see that, on one hand, the government acted very rationally, but on the other hand its language in the media was very populist. So, the government officials were able to transform the technocratic speech such as cost-effectiveness, or treatment protocols into words like unity, solidarity, and vulnerable patients. The main strategy of the government was to create "Superbodies", which acted both, as institutions for improving the healthcare system and as pillars of power.

\* In March 2013 the government **established the first "Superbody" – the National Board of Healthcare Standards**. The first role of the Board was to decide about the treatment protocols of the major 50 diseases representing 90% of healthcare expenditures (e.g. diabetes, cerebral ischemia, lung cancers, Alzheimer's disease etc.). The treatment protocols were based on the Health Technology Assessments and International Standards. The second role of the Board was to set minimum delivery standards for each of the above mentioned major diseases. The third role of the Board was to propose the inclusion and exclusion of treatments from the benefit package.

---

**An excerpt from a local US embassy report to Washington, March 2013  
Healthcare: The President of the "National Board of Healthcare Standards"  
has a PhD. from London School of Hygiene and Tropical Medicine.**

According to the newspapers, the newly appointed President of the NBHS is Mladen Borkovan – he obtained a PhD. at a renowned London School of Hygiene and Tropical Medicine. This is in line with the government's approach to find well-educated people with an academic background in order to solve the healthcare problems. Critics claim, that Mladen is a highly qualified academic, but he might have problems to manage the diverse group of other academics and medical professionals. Critics are also afraid, that the Board might turn into an academic battleground without real outputs.




---

The powers of the second "Superbody", the National Health Insurance were increased by the responsibility for implementing the treatment protocols approved by the Board. Based on the objective of cost containment, breaching the treatment protocol by the patient led to malus payments or to an exclusion from the the publicly covered services during the whole treatment process.

The revenues of the National Health Insurance were strengthened due to new taxes levied on environmentally harmful activities and unhealthy food such as soft drinks, food with high levels of sugar, fat or salt.

2014

In order to supervise correct implementation of protocols, **the government established the third "Superbody", the Central Quality Body**. It had significant armories at the disposal to enforce the treatment protocols. In order to ensure this task number of **medical supervisors** was needed.

---

**Advertisement in a nationwide professional medical weekly  
Medical supervisors needed**

The Central Quality Body is looking for candidates for positions of medical supervisors for the 50 major diseases to control the implementation of treatment protocols in health-care facilities.

Qualification requirements:

- University degree in medicine
- Ten years of professional experience
- Managerial experience welcome

Applications (CV and motivation letter) to be send to the Central Quality Body until March 8th 2014.

---

Each healthcare facility had to equally ensure provision of healthcare based on the treatment protocols, minimum delivery standards and provision of the treatments from the benefit package to each citizen. The fulfillment of these criteria by healthcare facilities was controlled by medical supervisors of the Central Quality Body. As the providers who did not fulfill the criteria faced serious fines, the unpublished control results became a serious media problem.

---

**An excerpt from a disclosed analysis for a private investor  
June 12th 2014**

The Central Quality Body (CQB) is a new regulatory body of the government. According to our analysis, it will be a tool for fining providers rather than protecting patients. We expect that the government will use CQB to punish private providers more strictly than the state owned providers. Based on these expectations, we advice to increase legal and medical vigilance in all private hospitals in order to face serious controls.

---

The Central Quality Body was blamed of manipulated and non-transparent practices, because the general impression was that it favored public facilities. In December 2014, the National Health Insurance stopped the reimbursements of private healthcare facilities, which did not fulfill these criteria. This led to a further enhancement of government power over the system. The fulfillment of the criteria became public only after a media pressure of the population, but for the excluded private facilities it was too late. This was a breaking point in the government health policy and since then, the rankings of providers were easily accessible on the web.

In spite of an enforced implementation of treatment protocols, the quality of care in public hospitals improved only slowly. This was an opportunity for the private providers, who attracted rich people and the upper middle class, who demanded care also without national health insurance coverage.

The pharmaceutical market was sophisticatedly regulated in order to meet two goals. Firstly, cost containment for the National Health Insurance and secondly patients' access to drugs. Margins moved to the level of the economically sustainable minimum. Pharmaceutical promotion was considered as an unnecessary type of activity and therefore it was significantly diminished. Generic programs were introduced, with total substance based prescription. The introduction of innovative products was partially inhibited. **A special HTA Agency, as the third "Superbody" was created to scientifically evaluate medical procedures, technologies, drugs and medical aids.** The Agency worked closely with the Board on the exclusion of certain treatments from the benefit package.

---

### **The mission of the Health Technology Assessment Agency**

The mission of the Health Technology Assessment Agency (HTAA) is to scientifically evaluate medical procedures, technologies, drugs and medical aids on the basis of cost-effectiveness. HTAA is a non-profit, non-governmental and independent institution financed from the National Health Insurance. The National Health Insurance pays 0.5% of its annual budget to the HTA Agency. The executive director of HTAA is appointed in the parliament for a 5-year term. He is fully independent. The outcomes of HTAA's work are binding for the Ministry of Health and for the National Health Insurance.

From the website: [www.htaa.eu](http://www.htaa.eu)

---

12  
- .

At the end of 2014, it was obvious that the Superbodies are the real power holders. On the other hand, the image of the government was harmed by the accusations about manipulation. In order to improve its image the government increased the level of patients' participation in the Superbodies. But this was only formal, because the **government silently financed fake consumer groups** and nominated their quasi leaders to become members of the Superbodies. This enabled further control of Superbodies by the government with a consumer oriented image.

2015

Since 2015, the government was successful in several projects. Firstly, it **very precisely defined the benefit package** and excluded many treatments from public coverage. Secondly, the government implemented several measures promoting cost-effectiveness. Thirdly, it also improved its supervisory role. The objective of cost containment was fulfilled, because the measures introduced in previous years resulted in moderate savings of 3% of the healthcare expenditures. However, both the voice of the patients and the dissatisfaction of healthcare providers were growing.

In spite of new regulatory measures, the patients were still unsatisfied with the quality of care. The government focus on maximizing objective utility led to weak answers of the system to individual needs and demands. Healthcare providers on the other hand expressed their concerns about the unsatisfactory financial resources of the system and forced the National Health Insurance to increase the remuneration of providers. In order to reduce the differences between the providers, the National Health Insurance had to define **the remuneration and wages through Central Order.**

Based on the recommendation of technocrats, the government asked them to prepare a **complex "Analysis of the population's healthcare needs" in order to have a scientific basis for decision-making on healthcare priorities**. Efforts favoring the establishment of a precise database were made together with significant government investments in the healthcare IT. Originally, this was planned for monitoring healthcare needs and health outcomes, however, the results rather reflected artificial statistics.

2016

**The government was not able to link the technocratically defined outcome approach with the financing system**. The main reason was that the centrally administered system was not able to monitor and satisfy individual needs. In spite of these complications, the government forced the National Health Insurance to change the financing system into a needs-based one. Global budgets were introduced for the providers, with complicated risk adjustment mechanisms. Basis for the calculation were the estimated unit costs and their predicted frequency. The role of the competition both on the providers' as well as the purchasers' side became moderate. The system's answer to these changes was the formulation of territorial monopolies. This was inevitable, because under the global budget scheme the interest of the National Health Insurance was to have a stable provider structure. Additionally, the global budgets were decided priorly, and so there was just a very small chance for others to compete.

**Healthy lifestyles started to be preferred within the healthcare system, while unhealthy habits were banned**. These behavioral changes reflected the centralistic and repressive government approach and were not part of the motivation scheme of the National Health Insurance. Heavy smokers, obese people, addicted individuals became persona non grata in the system. Co-payment policy was adjusted to take into account lifestyle. The amendment to the healthcare law caused a complete exclusion of alternative medicine from the National Health Insurance. This step was strongly discouraged by the majority of people.

---

### **§ 3 of the healthcare law**

1. Healthcare is an activity performed solely by a healthcare professional. The list of healthcare activities is stated in the Appendix A of this law.
  2. Healthcare cannot be performed by any other individual than a healthcare professional.
  3. Alternative medicine is not healthcare.
- 

2017

**The conflict between the "benefits for the society" and "individual preferences" was inevitable**. As a consequence of the universal approach and uniformity, those with specific disease constellations or higher subjective healthcare requirements felt excluded. On the other hand, for those with standard health problems, it became simple to arrange malpractice suits as treatment protocols were very well elaborated. On top of this, the government ensured enough capacities to control the enforcement of treatment protocols by medical supervisors. Due to the fact that **patients started to win malpractice suits**, the providers suffered substantial financial losses. In 2017 the volume of providers' damages, reaching 4% of total expenditures, jeopardized the financial sustainability of healthcare, mainly the private hospitals. The government introduced a compulsory coordination mechanism to prevent more damages and **created a Central Budgetary Fund to cover all additional malpractice expenditures**. Only state-owned hospitals were

eligible to use money from this fund. This resulted in lower negligence in implementation of treatment protocols. Additionally, the government introduced compulsory insurance of providers for malpractice cases including maximum limit of an individual damage.

2018

Overregulation of healthcare reduced the competition to minimum. **State-owned hospitals regulated by Superbodies took responsibility for care organization and crowded out the private players.** Competences for education of healthcare personnel and management of healthcare facilities were kept strongly in the hands of the government.

The fight for the position of the new leader of the National Board of Healthcare Standards resulted in an open conflict between the Patients League as a real consumer group and the National Patients Organization as a fake one. The Patients League was famous thanks to **the first addition of the "Patient's Guide" - the practical handbook for understanding the healthcare system.** On August 15th 2018, after a nasty media battle the Patients League representative was appointed by the government to become the President of the Board. To balance the decision-making power, two other members of the Board were represented by the National Patients Organization.

---

**The Patients League proudly presents the first edition of the "Patient's Guide 2018"**

Do you think you are lost in healthcare?

Do you know your entitlements resulting from the actual version of treatment protocols?

Do you want to win your malpractice sue?



Get yourself the first edition of the "Patient's Guide 2018", the practical handbook that helps you to better understand the healthcare system. If you order five examples, you get a 15% discount.

---

2019

Capital investments in the healthcare sector were predominantly financed from public sources. **The Public Private Partnerships became also very popular in financing hospital infrastructure,** because PPPs were not part of a strict EU methodology on deficit reporting. Private capital investments were very low.

In 2019, the National Insurance System introduced annual negotiations with the Patients League on the share of healthcare expenditures. The negotiations were based on scientific evidence, from the improved "Analysis of the population's healthcare needs" and second edition of the "Patients Guide 2019".

As of June 2019, the National Health Insurance introduced a **provider payment system based on outcome indicators.** This new payment mechanism replaced the Central Order remuneration system from 2015.

## END STATE 2020

In 2020, the government objective for maximizing benefits for the whole society resulted in overregulation and created lots of reporting duties and unnecessary bureaucracy. Each change had to be tuned with new regulations. Major Superbodies played the decisive role in the system:

- National Board of Health Standards – responsible for deciding on the treatment protocols of the major 50 diseases and for setting minimum delivery standards for these diseases.
- National Health Insurance System – in charge of the implementation of treatment protocols approved by the Board and responsible for remuneration of providers.
- Central Quality Body – responsible for enforcing Quality Standards as set by the law with the help of the medical supervisors
- HTA Agency – responsible for scientific evaluation of medical procedures, technologies, drugs and medical aids. It closely cooperated with the Board on the exclusion of certain treatments from the benefit package.

In these Superbodies, the main aim of the government was to facilitate dialogue between patients and the industry. This led to a more patient oriented system, in which the Patients League was involved in the policy-making process. The enforcement of patients' rights was high due to implemented treatment protocols and functioning medical supervisors. The system aimed to prevent failures and complaints more than ever before, though this made the system more expensive. In other words, **more safety required more money.**



In 2020, Patients League became a real part of the decision-making process. The League regularly expressed its views in harmony with the nationwide interests. The National Patients Organization remained a fake lobby force but its influence decreased. Each citizen was entitled to the benefit package provided under the universal scheme of National Health Insurance. Healthcare is predominantly financed through taxes and opt-out from the public system is impossible. Public spending was dominant and consumers' co-payment were marginal and reflected the consumers' preferences only formally. Opt-outs were not allowed, however, many people sought care in private facilities to satisfy their individual needs.

There were strictly determined treatment protocols based on scientific evidences and stakeholder agreements. Financing through global budgets with sophisticated adjustment mechanisms was the main payment mechanism applied. New outcome drivers were part of some payment mechanisms.

People with short-term sicknesses were provided with satisfactory treatment options in a professional manner, however, the system did not serve to their specific needs. Effective but not completely state of the art methods were available for patients with chronic diseases, but people with bad health habits were left alone.

Primary care providers were strategic partners of the National Health Insurance, because both, the health behavior and cost-effective preventive measures, became parts of the new health policies.

Providers of specialized outpatient care were publicly financed and firmly controlled by the Superbodies. The emerging private sector was in a promising situation, because the legal quasi-monopoly of the public facilities was not able to meet all patient needs.

Pharmacies were responsible for providing proper information to the patients and their business potential was narrowed by the strict regulations.

The professional activity and employment options of all healthcare professionals were laid down in strict rules. **There was no real room for personal excellence; the ideal of a good professional was the one who properly followed the treatment protocols.** There was an improving opportunity to join privately financed providers offering better employment options than the state ones. Defensive medicine was the mainstream practice, strictly following the treatment protocols.

Medical associations were rarely involved in the health policy processes and their lobby force was not really welcomed neither by young technocrats nor by the government decision makers.

The National Health Insurance was responsible for the coverage of the benefit package. Private health insurers were providing only complementary and supplementary health insurance.

The marketing potential of pharmaceutical companies within the National Health Insurance was very limited, because the cheapest drugs were preferred. The producers of pharmaceutical and medical devices were forced to submit sophisticated cost effective analyses to the Health Technology Assessment Agency, when they wanted to introduce new products to the market.

Investors, who refused the scientifically-based objective utilitarian stand point of the government, were crowded out from the remuneration of the National Health Insurance. Some Public Private Partnerships emerged, because they allowed increasing the level of healthcare investments and meeting the strict fiscal criteria imposed by the EU. The private providers system charging cash payments from the patients was besides IT the only environment for financial investors.

Collecting government's data and other scientific activities required a massive IT development. The government was an important purchaser of IT technologies, representing an important driver to the IT sector development. The position and responsibility of the government were very strong, because **the government fueled by technocratic concepts promised to maximize healthcare benefits for the society, but forget to deal with individual preferences.**

---

### **Patients' Survival Kit for the "Government Serves" Scenario**

1. Become a representative of one of the Superbodies.
2. Become a member of the Patients League.
3. Become a medical supervisor.
4. Get the second edition of the "Patient's Guide 2019".

---

### **TIMELINE**

### **WEAK SIGNALS**

2012

- Government refused to appease with the doctors again
- Government announced a sound fiscal policy
- Government advisory team composed of a young group of technocrats

2013

- Announcement of the 10 year strategic healthcare plan
- Establishment of the first "Superbody", the National Board for Healthcare Standards

- 2013
  - Increased powers of the second “Superbody”, the National Health Insurance for implementing the treatment protocols

---
- 2014
  - The government established the third “Superbody”, the Central Quality Body
  - Medical supervisors needed
  - A special HTA Agency, as the fourth “Superbody” was created to scientifically evaluate medical procedures, technologies, drugs and medical aids
  - Silent financing of fake consumer groups, which enabled further control of Superbodies by the government

---
- 2015
  - Very precisely defined the benefit package
  - The remuneration and wages through Central Order.
  - Complex “Analysis of the population’s healthcare needs” in order to have a scientific basis for decision-making on healthcare priorities

---
- 2016
  - The government was not able to link the technocratically defined outcome approach with the financing system.
  - Healthy lifestyles started to be preferred within the healthcare system, while unhealthy habits were banned

---
- 2017
  - The conflict between the “benefits for the society” and “individual preferences” was inevitable
  - Infrastructure standards very well elaborated and effectively enforced, so patients started to win malpractice suits
  - Creation of a Central Budgetary Fund to cover all additional malpractice expenditures for state-owned facilities

---
- 2018
  - State-owned hospitals regulated by Superbodies took responsibility for care organization and crowded out the private players
  - The first edition of “Patient’s Guide 2018” - the practical handbook for understanding the healthcare system

---
- 2019
  - The Public Private Partnerships became popular in financing hospital infrastructure
  - Provider payment system based on outcome indicators

---
- 2020
  - The government objective for maximizing benefits for the whole society resulted in overregulation and created lots of reporting duties and unnecessary bureaucracy
  - More safety required more money
  - There was no real room for personal excellence; the ideal of a good professional was the one who properly followed the treatment protocols
  - The government fueled by technocratic concepts promised to maximize healthcare benefits for the society, but forget to deal with individual preferences



## 3. INDUSTRY DRIVES

2012

The situation in the healthcare sector was influenced by three critical factors. Firstly, **the economic situation was stagnating** and was not very favourable. Secondly, there was **a massive outflow of medical personnel**. Thirdly, **the ageing of GPs and other doctors** represented a major problem, as well.

In 2012 the economy reported a small economic boom after the 2009 recession. This economic boom was timely limited and in 2012 the country experienced a slowing down in economic performance. The crisis had a W shape and the financial situation was unstable. Healthcare expenditures were still considerably lower than in Western countries and since no change in financing has been done, the "pay as you go" system was not able to create more revenues for the healthcare system.

The government weakened by the financial crisis and low trust of the population was not able to agree on a health policy plan, and so majority of measures were ad-hoc and short-term. **Many industry players perceived the weak government as an easy target of their lobbyist force.**

2013

In 2013, measured as % of GDP, healthcare expenditures were on the same level as in 2010. At the beginning of 2013 a large group of disillusioned medical personnel left the profession to work abroad or in other sectors of the economy. On top of this, the labor market protection in Western countries evaporated and the healthcare system faced a radical outflow of medical workers. This was a result of stagnation in financing and rising demand from abroad. In 2013, the healthcare system was facing a real shortage in medical personnel at all levels – doctors, nurses, emergency personnel, lab workers, pharmacists, dentists and surgeons and also psychiatrists - not talking about the anesthesiologists.

The third critical force was the ageing population of GPs. In 2013 more than 20% of GPs left their posts, because they were heavily above 70 years. In this complicated situation, the industry saw its opportunity to steer the wheel.

To replace these shortcomings, **the government decided to introduce liberal legislation to ease the entry criteria for medical personnel** to the healthcare market. The liberalization started with pharmacists and slowly continued throughout each specialization. Existing providers unsuccessfully opposed the new legislation. After long negotiations the compromise was reached only after the promise of the government that the market entry criteria will be more liberal with the key powers staying with the providers - especially prescribing drugs, sending patients to hospitals, etc. There are rumors, that after a key meeting between the government and the most powerful persons representing the providers, **the government made a commitment not to strengthen the rights of patients and not to impose strict control over providers.**

---

### **14. 4. 2013 / From a freelance blogger with the nickname Pharmacists:**

#### **My arguments against the liberalization:**

1. Being a pharmacist is a mission, not a business.
2. A pharmacy has to belong only to pharmacists, because only pharmacists know what is the best for the patient.
3. If the owner of the pharmacy is not the pharmacists, then economic goals are preferred and not the clinical ones.

It was enabled that also lab workers are allowed to be responsible for the pharmacy, not only pharmacists. The very strict academic criteria for students were eased. Since September 2013 **the studying time for medical doctors was shortened to 4 years instead of 6** and the residents were allowed to do their specialization exams in 1 year and they did not have to wait 3 to 5 years anymore. In December 2013, **the healthcare market was opened to foreign doctors and nurses**. A special regime was introduced to attract qualified medical staff from former Russian countries and India. This concerned not only medical practitioners, but also academicians were welcomed. **The Easternization of medical universities began**.

## 2014

**Opening a GP practice in 2014 became very easy**. It was allowed for internists to “re-specialize” and the licensing criteria were set up to encourage as many young doctors to open their ambulance post as possible.

The healthcare system witnessed a dramatic change in the structure of providers. Many **young medical professionals started their business, many foreigners from Asia opened their medical posts and nurses supplemented the work of doctors**. It was not surprising to speak Russian to the doctor when being treated, or that the government approved new quotas for doctors from India.

Information asymmetry increased. **Due to strong interrelation of powerful providers and weak politicians, there were no valid data on performance, outcomes or costs of providers**. There was a very weak state control of providers and the state protected the rights of providers and not the patients. This situation strengthened the position of the industry. The induced demand on drugs, lab tests and diagnostics like CT and MRI raised double digit and became an important source of doctors’ income. **The number of Doc-Techs rose significantly on a yearly basis**. Due to high induced demand and rising power of Doc-Techs there was **a huge rise in medical activities across healthcare providers**.

**There was no precise definition of basic benefit package**, and so the providers charged both insurers and patients on a fee-for-service base. Consequently, **the share of private expenditures significantly increased**.

---

### **Weekly analytics: The Doc-Tech providers on the rise: plus 18% annually**

The number of so-called Doc-Techs is rising. Doc-Tech is usually a young doctor utilizing an up-to-date technology to induce demand for his practice to seek high profits on unnecessary but well-paid procedures. The Doc-Techs usually provide their patients modern gadgets to monitor their health status remotely. These include portable blood pressure monitoring machines, blood sugar meters or observers of vital functions linked with a blue-tooth technology to the client’s mobile phone and sending his or her data regularly to the Doc-Tech.

According to the Statistical Office, in 2014 the number of doc-techs rose by 18% and the expenditures of insurers on tests and diagnostics increased by 24%, which was 7 ppt. higher than in 2013 (17%).

---

2015

In 2015, publishing individual provider data became very rare and usually this data collected was inaccurate or false. There was no drive for more transparency in doctors' performance and publishing outcomes per provider. The only source of information was the Statistical Office and the insurers. Although the rules for market entry were liberalized, it paradoxically did not lead to more transparency on the market. **The patient pathways were based on personal contacts or on cash payments – formal or informal.**



**There was no chance for a fair access to care.** According to an independent study, the differences in access between urban and rural population as well as between the poor and rich were increasing. The system was in strong hand of industry driven providers and they set the rules. Which treatment is suitable, which drug is the best was solely their decision. **The empowered patients were seen as "problematic".** Waiting lists were a very strong tool in providers' hands and they were using them to skim the economic rent from the patient.

The so-called informed consent was just a formality without any practical reason. The doctors did not pay attention to the patient. **Procedures were important, not the patients. Activity was important, not the outcome.** Newly established providers were very quickly organized by the industry to cartels and had a strong bargaining power against the insurers.



The insurers were not able to implement any payment mechanism, which would include payments for coordination of care, or payments for performance. **Fee for service payments dominated the market.** There was no pressure on providers to increase quality or to become accountable for their outcomes.

Life of people and their access to care was very different. Industry driven providers had the best access to healthcare services and were silent and powerful organizers of healthcare services. **For patients, knowing a doctor personally was a guarantee for a solid care.** If there was no personal relationship, the outcome of the treatment was unpredictable. **People were chasing mobile phone numbers of influential doctors.**

---

### **A phone conversation of two sisters (Jane and Kate)**

- Jane:** Hi Kate, I need your help – our mum called me right now, that she needs to arrange a hip replacement for our dad. But don't tell her I called you (sighs)
- Kate:** I had the suspicion, that something is going on, but you know, I didn't want to ask them, they are always so organized.
- Jane:** Yeah, but in terms of healthcare they are rather disoriented, so they need some help and I think they are rather conservative and want to manage it by "their way", you know what I mean?
- Kate:** Yes, I know. Ivan, one of my best friends is a doctor, so I will call him to ask for advice. He helped me also last time, when I needed a dermatologist. It was not cheap, but I did not have to wait and the doctor was very cute.
- Jane:** You mean you had to pay something extra?
- Kate:** Yes. But he works in a state hospital, so I had to pay him informally.
- Jane:** And you think it will be the same situation in this case?
- Kate:** I think so, maybe we even have to pay more...



PS: In 2020, Ivan turned 46 years and became one of the best personal access brokers. During this phone call he did not even know that such a profession will be highly rewarded in the future.

2016

The increased liberalization in the provider sector led to an increase in private payments and the ability to pay became very important. The governments increased the amount of public sources very slowly and their arguments not raising the amount of public money were based on slow economic growth and on raising efficiency. This led **the governments to heavily liberalize the insurance market**. Their expectations were that liberalization will increase purchasing powers of health insurance companies and that they will seek for higher quality for lower price (value for money).

As it turned out later, these expectations were never fulfilled. **Low regulatory activities and a weak knowledge base of the government led to the approval of liberal insurance laws without proper resource generation, pooling and consumer protection.**

2017

The health system funding became more regressive. Rich people were avoiding taxes and social insurance contributions and they rather paid cash or with their power and influence. The situation of the poor worsened. The news on 22.7.2017 focused on this inequity by naming it "The Post-Code" lottery for expensive drugs. It pointed out the fact that getting an expensive drug is a lottery rather than a function of the system. It was named under the term "Post Code", because it reflected regional area code, while there were only few places with very good access to very expensive drugs. **There was no Health Technology Assessment**, therefore the entry of drugs to the healthcare market was not transparent and was the subject of rumors on corruption.

The pooling became very complicated, especially after 2017. Unregulated liberalization led to multiple purchaser systems with weak risk adjustment mechanisms, and **so risk selection was the main business strategy of health insurance companies**. The healthy consumers were regularly faced with aggressive risk selection campaigns by insurance companies.

2018

Liberal environment with high profit and weak regulation led to an increased number of insurance houses. There were 25 health insurance companies on a market with 15 million inhabitants. **These markets were unattractive for managed care companies and also disease management programs were rare**. The reason was the weak risk adjustment system. There was even an attempt of a health insurance company to implement a complex disease management program on chronic diseases. Due to the fact that the risk adjustment scheme did not support the differences in health status, and at the same time the company attracted a high volume of ill people, the health insurance company had to bear high losses and bankrupted.

---

**14. 6. 2018 / Daily news: The MEGA Health Insurance Company bankrupted**

After attracting a huge number of high-risk insurees the MEGA health insurance company did not survive the 2017 fiscal year. The insurance company started a new disease management program for chronically ill and the program attracted high-risk individuals. Since the risk adjustment system has a weak predictive power and the number of chronically ill was higher than 40% of the total number of insurees, the MEGA was unable to cover its duties. After 6 months of struggling, the health insurance company announced bankruptcy.

---

2019

Mainly providers drove the migration of insureds between health insurance companies. Other ways of attracting insureds were aggressive marketing campaigns in the media and insurance brokerage, as well.

As a reaction to heavy liberalization and unsatisfied consumers, the governments started to increase their regulatory power. But this was a formal approach rather than an establishment of a real regulatory framework. The new regulatory framework under the hidden control of the industry was weak in enforcing patients' rights. The government was firefighting and protected the industry driven providers more than consumers.

Due to missing rules, a paradox situation emerged. On the one hand, **providers produced lots of services that were not needed or had zero value for the consumer**. On the other hand, waiting lists occurred for people that could not pay cash or the production of these services was not profitable for the industry. Malpractice was heavily discussed, but with no consequences and there was **no public evidence that a patient won a malpractice sue**.

END STATE 2020

In 2020, **the "marriage" between industry and providers had its golden age**. The position of industry driven providers in the health system was dominant. Especially doc-techs were very popular among people. On the other side, there were **no mechanisms that would send unskilled doctors and poor providers out of the system**. The industry driven providers decided about the treatments, drugs and medical aids and provided only very limited information about their activity. The main source of information was the "word of mouth" and the main vehicle to receive a quality care was to have lot of money or a mobile phone with contacts to important doctors. **Institutionalized access brokers served as door openers to the top doctors and providers**.

---

#### **5. 5. 2020 / Tabloids: Do you already have your personal access broker?**

If you don't, rather get one. According to our information from health providers, the quickest way to get treated is to have your personal access broker. The broker personally knows lots of doctors and providers and has direct access to them. The role of the broker is to find adequate timing in the doctor's schedule to find an appointment to its client. Ivan, a very successful access broker revealed us his business model. He said that he pays the doctors on a mixed basis. The first part of the money goes in a form of a fixed monthly pre-payment (for answering the phones, having free capacity). The second part of the money is based on real activity made by the doctor.

Once the clients decide to find their access broker, they have to pay a monthly lump sum to the broker and an additional fee for extra services. According to Ivan, there are approximately **50 access brokers**, but **the number is increasing**. Most of them are doctors, as they have the best possibility to find and create the "network" among their previous colleagues or schoolmates. The estimated remuneration of the access broker is approximately 4 times higher than the salary of a skilled doctor.

---

After the liberalization of providers and insurance markets, the number of providers grew steadily, however, their quality generally fell down. On the other hand, there were perfectly equipped health centers and doctors, but not for every patient. Most of the providers were paid on a fee-for-services base. **There were no incentives for care coordination, or outcome improvement. Industry driven providers and Doc-Techs formed a substantial part of the market**. They functionally privatized university hospitals and

used their capacities for running their own business. It was not unusual that Doc-Techs' privatized the profit that hospitals were supposed to generate from their patients. At the same time, they also shifted the cost back to these hospitals.

For health insurers the dominant strategy was to purchase low quality care for low costs and avoid risky insurees. Due to the fact that no data on quality and outcomes were published, the contracting between health insurance companies and providers was based on costs per service and on cost per activity, and not on quality and outcomes.

Pharmaceutical companies loved this era. It was their chance to influence providers and increase their power with monopoly for drug prescription. Many decisions depended on the ability to pay as well as on personal relationships with the doctors, hospital managers or influential people.

The basic benefit package was not defined and the patients did not know what their rights were and what services were covered. This left a lot of space for silent rationing and further increased the power of industry driven providers. Patients and consumers did not know their entitlements and so the providers were free to decide about their treatments and ask for informal payments.

! The bribe insurance was very popular. More than 30% of the population possesses some sort of bribe insurance. The co-payments are not allowed officially, and so the bribe insurance provides a full-scale coverage for the situation, when there is a need to give a high bribe. The administration of the bribe insurance was problematic in the beginning, because the patients reported higher bribes than they actually gave. This was solved by the "bribe" tables, which are the result of a study made by insurance companies among providers.

---

### Consumer Survival Kit for the "Industry Drives" Scenario

1. Get mobile phone numbers of good doctors.
2. Get an access broker.
3. Get a vital functions observer connected to your doc-tech.
4. Get a bribe insurance.

---

Providers were charging plenty of semi-official payments. It was not clear what was covered from public sources and what was not. An average citizen could afford these copayments and had a choice of providers, but with very limited information about their performance. Poorer people could not afford to pay and were treated only in public hospitals and clinics.

Patients with chronic diseases were the main losers of the healthcare system. First, the payers and consequently the providers tried to avoid these costly patients because of poor risk adjustment and the not well developed payment mechanisms. Second, most people could not afford to pay for a private alternative in a long term. Population health outcomes were not improving.

Patient's organizations were formed but their claims were dismissed. However, a "Pirate" Patient Advocacy group was formed, but it was ignored by government and attacked by providers. This led to frustration and decline of patient's organizations as power holders. Enforcement of patients' rights did not exist – basic benefit package and treatment protocols were not defined. There was no official comparison of providers. The main strategy for primary care providers was to become Doc-Techs, who are paid

on a fee-for-service basis. Providers of specialized outpatient care profited due to charging patients semi-legal payments. Partial consolidation by investors led to interesting profits. Competition arose mainly in highly populated areas.

Hospitals could extract most of the money from the system. Big medical investments were driven by the industry mainly to state hospitals. It was not unusual to find the most advanced technology in rotten buildings. This technology was used in many cases by Doc-Techs to serve their private patients. People threatened by serious illnesses sought care in hospitals and were ready to pay whatever they could afford. Hospitals remained in most of the cases local monopolies.

Pharmacies were fighting for prescriptions. Expensive drugs were concentrated in hospital or related pharmacies. Pharmacy chains emerged in highly populated areas. Small rural pharmacies were struggling with low profitability and late payments from insurers. Pharmacists' role was limited by physicians. **Pharmacists witnessed a lowering status of the profession, which started to be perceived as a supply rather than provision oriented.** Permission for supermarkets to sell OTC drugs only deepened their frustration.

Doctors were able to extract higher salaries. They had the power but used it rather shortsighted. Technology-oriented specialties were significantly more profitable. Nurses were able to get better salaries following the physicians' demands. In a doctors' dominated world they do not get more competencies but some providers outsource more work to them unofficially.

**Due to inadequate regulation health insurance companies concentrated on cream skimming and extracting additional payments from their clients.** Effective purchasing was blocked by providers. From the investors' point of view, there were interesting short-term opportunities in privatization of health insurance. Financial investors have unique but limited opportunities in niches of operation of insurers. However, **strategic investors were very cautious, because of not existing and not transparent rules.**

Large international innovative pharmaceutical companies were forced by their HQ to employ strict ethical standards. This opened more space for local generic companies. On the other hand the strong role of the Doc-Techs led to alliances between innovative pharmaceutical companies and providers who were able to shift costs of modern drugs to the health insurance company and to their clients.

Suppliers of medical devices admired this era, because **personalized medical devices were very popular.** People started to use every kind of health gadgets and Doc-Techs induced lots of diagnostical and imaging tests. Suppliers of expensive technology (MRIs) thrived in an industry driven non-transparent environment.

## TIMELINE

## WEAK SIGNALS

2012

- The economic situation was stagnating
- A massive outflow of medical personnel
- The ageing of GPs and other doctors
- Many industry players perceived the weak government as an easy target of their lobbyist force

- 2013
  - The studying time for medical doctors was shortened to 4 years instead of 6
  - The healthcare market was opened to foreign doctors and nurses.
  - The Easternization of medical universities began
  - The government decided to introduce liberal legislation to ease the entry criteria for medical personnel
  - The government made a commitment not to strengthen the rights of patients and not to impose strict control over providers

---
- 2014
  - Opening a GP practice in 2014 became very easy
  - Young medical professionals started their business, many foreigners from Asia opened their medical posts and nurses supplemented the work of doctors
  - Due to strong interrelation of powerful providers and weak politicians, there were no valid data on performance, outcomes or costs of providers
  - The number of Doc-Techs rose significantly on a yearly basis
  - A huge rise in medical activities across healthcare providers
  - There was no precise definition of basic benefit package
  - The share of private expenditures significantly increased

---
- 2015
  - The patient pathways were based on personal contacts or on cash payments – formal or informal
  - There was no chance for a fair access to care
  - The empowered patients were seen as “problematic”
  - Procedures were important, not the patients. Activity was important, not the outcome
  - Fee for service payments dominated the market
  - For patients, knowing a doctor personally was a guarantee for a solid care.
  - People were chasing mobile phone numbers of influential doctors

---
- 2016
  - The governments to heavily liberalize the insurance market
  - Low regulatory activities and a weak knowledge base of the government led to the approval of liberal insurance laws without proper resource generation, pooling and consumer protection

---
- 2017
  - The health system funding became more regressive. Rich people were avoiding taxes and social insurance contributions and they rather paid cash or with their power and influence
  - There was no Health Technology Assessment
  - Risk selection was the main business strategy of health insurance companies

---
- 2018
  - These markets were unattractive for managed care companies and also disease management programs were rare

---
- 2019
  - Providers produced lots of services that were not needed or had zero value for the consumer
  - No public evidence that a patient won a malpractice sue

---
- 2020
  - The “marriage” between industry and providers had its golden age
  - No mechanisms that would send unskilled doctors and poor providers out of the system
  - Institutionalized access brokers served as door openers to the top doctors and providers
  - There were no incentives for care coordination, or outcome improvement. Industry driven providers and Doc-Techs formed a substantial part of the market

2020

- For health insurers the dominant strategy was to purchase low quality care for low costs and avoid risky insurees
- Pharmaceutical companies loved this era
- Lot of space for silent rationing
- The bribe insurance was very popular
- Patients with chronic diseases were the main losers of the healthcare system
- Decline of patient's organizations as power holders. Enforcement of patients' rights did not exist
- Pharmacists witnessed a lowering status of the profession, which started to be perceived as a supply rather than provision oriented
- Due to inadequate regulation health insurance companies concentrated on cream skimming and extracting additional payments from their clients
- Strategic investors were very cautious, because of not existing and not transparent rules
- Personalized medical devices were very popular



## 4. DOCTORS DICTATE

2012

Inspired by the development in the Czech Republic and Slovakia, **medical strikes** hit Hungary as well as Poland. **Together with the Czechs and Slovaks, Hungarian and Polish doctors established a common V4 medical trade union as a coordination body.** They started to coordinate their activities and distribute their know-how from the strikes among the members. The conflict between the government and doctors ended with the victory of doctors and the commitment of the government to increase doctors' salaries.

The government was helpless to resist the **massive media pressure of doctors, who were claiming "healthcare is not a market", "medicine is not about money" and "life is priceless".** !

The raise of salaries did not exactly solve the unsatisfactory and worrisome situation in healthcare. However, the crisis in Europe and the Eurozone put strict budgetary constraints on public finances. As no additional revenues were available to cover the costs of increasing salaries, this policy has inevitably deepened the debts as well as further problems. Salary delays ignited another protest.

As a consequence of economic crisis and continuous doctors' strikes, healthcare could not maintain the previously set quality of care. Educated, middle class individuals and companies were increasingly seeking high quality private care for their families and employees. They started assessing the **quality of healthcare as a potential hurdle for living or working in CEE.** Institutes like IMF and World Bank were also getting more concerned about the deteriorating quality of the healthcare.

An important percentage of population opted out from the provider system, paying practically double for their care. However, government in this period mostly just waited for better luck times, having no bravery to radically transform the system. The inequalities and unjust situations became more common due to lacking resources and persisting corruption. Health care outcome success dropped. **The low quality was noticed even by the elderly people, who normally accepted easy access without too much quality requirements.**

---

### **The declaration of the Senate of Elderly from 9. 10. 2012**

The Senate of Elderly is concerned about the situation in healthcare. Elderly people have high co-payments for drugs and the access to modern drugs has worsened after the new austerity package of the government.

Elderly people count for 16% of the population, many of them suffering from diseases. We appeal to the government to:

1. Guarantee a free access of elderly people to drugs and medicines
2. Improve the standards of care for chronic diseases
3. Increase the amount of money in the health care system

Disclaimer: The Senate of Elderly is a civic association of people older than 65 years and has no political ambitions.

---

2013

Spectacular cases of people, who lost their life or health as a result of being declined by insurance companies to undergo the prescribed treatment or diagnostic tests, all received emotional media coverage. An outbreak of Escherichia Coli in the country's capital resulted for the immediate need to hospitalize 400 patients, including 200 children. 20 children died, because the response to the outbreak was slow due to the bureaucratic process, and there was a limited number of pediatric beds in the region. **The doctors' lobby together with the media was successful in persuading the public and the Ministry of Health to build more "inpatient beds",** rather than fixing the process of disaster response. On top of that, the lack of staff in case of massive disaster proved that more doctors were necessary.

As it soon turned out, there were more cases reported by doctors where patients were refused the treatment due to cost cutting. This led to a reverse direction in the trend – going away from economical medicine towards a higher need. This showed vast deficiencies in the medical supply.

**In June 2013, the doctors accused the economists, that they ruined the system. Moreover, a group of ambitious doctors was able to persuade the public and the government, that only doctors are able to solve the situation.** They prepared a law, which demanded medical education as a basic precondition for all important decision making posts in the healthcare system.

2014

Since January, when the law came into force, **only doctors ruled the system.** The president of the Medical Chamber became the Minister of Health and every new law had to be discussed first with the Chamber of doctors while only after its approval, the law was released for further comments. The managers of hospitals were solely doctors, who had to be approved by the newly established ministerial advisory board constituted only from doctors. The power of doctors was further increased, because doctors acted also as staff at the Ministry of Health, heads of university hospitals, CEOs of insurance companies, health policy makers, academic staff at universities, and even as journalists reporting on medical affairs. An independent journalist, who was fired from a Medical Weekly **characterized this situation as "white clan".**

They were proving their point by the following statement: "Only we know what people really need. We decide how to allocate healthcare funds. We are the best in assessing your healthcare needs as we have done it for generations." Here the Jung's archetypic of an old wise sage was observed, whose advice nobody questions.

In September, **medical universities placed limits both on the number of students (numerus clausus) as well as on those admitted for specializations.** The 89-years old dean of the medical faculty very well summarized the situation in his opening speech of the new academic year: "We are saving the profession's prestige". At the same time, the Ministry of Health approved a government decree on **high healthcare market entry barriers for doctors from abroad.**

 **Patients found it extremely difficult to win a malpractice case,** because only medical courts could find doctors guilty or general courts relying on doctors' expertise opinion. **Doctors protected doctors.** There were some spectacular legal cases against physicians who became scapegoats, mostly at the time of political turmoil. There were highly publicized and finalized in convictions, and at the same time daily substandard care went unnoticed, as physicians controlled the legal process.

Health insurance companies were annulled, because doctors saw them as redundant intermediaries that ate up their money. Therefore, all private health insurance companies left the country. Health Insurance was replaced by a tax financed National Doctors' Service (NDS). Regional medical boards of NDS determined contracts and prices for doctors and providers. The NDS was governed by doctors, therefore the doctors were able to extort a favorable amount of working hours and minimal number of staff. As every doctor acted according to ethical principles and his or her best knowledge within the realm of holistic medical science and too many variables that came into play, nothing like "cookbook medicine" was possible to apply. Similarly, one could not measure treatment results, and comparing doctors' work was immoral.

The influx of medical doctors from the East was banned. Yet, the free flow of medical staff within the EU member states caused doctors' drain from the country. It was a strong argument expressed by the doctors' lobby for a rise in doctors pay range in order to stop the trend. In order to cover the increased doctors' salaries, the government increased the VAT.

2015

There was no place for a free market and competition. The medical market existed solely for small private clinics with doctors sending their patients to public hospitals. The dominating opinion was that hospitals and public clinics should act for the patient's best interest and not for economic reasons. This led to a reduced interest in the hospital sector by private investors, except for doctors themselves. It soon became clear that financing healthcare from public funds is extremely burdensome for the state. The government increased the property taxes to balance the system. !€

There was no independent supervision over the medical profession and no institutionalized oversight of clinical quality. Malpractice cases were won by doctors, who were "washing their own hands." On top of this, doctors expressed bigger demands than ever. Colorful debates erupted in the parliament with opposition parties accusing the government of killing its own citizens due to an inadequate healthcare funding. After the elections the situation changed and a similar debate took place again with the former Minister of Health. He stood up in front of the member of the Parliament showing a photo of 6 years old Nenushka, who died due to a delayed treatment and the current minister did not approve her transfer to a famous university hospital abroad. Nenushka's mother sat for a week in a tent in front of the Parliament with a banner demanding the government to resign.

2016

Forced by the National Doctors' Service, the Parliament approved a new law on public health expenses. They were planned to grow annually by 0.25% above the real GDP growth. Unfortunately, rises in doctors' salaries achieved during trade union strikes caused an increase in hospital budgets. Decreased funding from legal private sources increased the pressure on the state budget. In order to cover the growing costs fueled by doctors' salaries forced the government to raise the alcohol and tobacco consumption taxes and to introduce mandatory complementary health insurance. This was accompanied by cost-sharing policies for drugs and prolonged waiting lists.

2017

The system under doctors' management showed signs of inefficiencies. The waiting queues for services got longer. As a response, the government tried to introduce on-line queuing. The rationing, being the case for chronic disease patients, helped to

increase the demand for alternative solutions, not in line with the legal system. **The black market flourished and corruption grew.** Private clinic doctors were paid for admitting patients to public hospitals. Quasi legal foundations were created to pave the way for "clean" bribery.

Expenditures on drugs grew by double digits. **Doctors, being only bound by the Hippocratic Oath, prescribed drugs according to their conscience and with patients' wellbeing in mind.** This led to the situation where share of drugs on the healthcare budget grew faster than the whole budget.

2018

Healthcare costs exceeded 10% of the GDP and kept growing. Therefore, **the Ministry of Finance called for rational systemic solutions.** This, unfortunately, required a dialogue with doctors, who were opposing the adoption of innovative solutions. Their arguments to defend the need for an increased funding included higher salaries for doctors, continuity in medical progress, availability of a cutting-edge diagnostic and other medical equipment, which, naturally, presented higher costs.

2019

The relativity of the increased costs was pointed out, because the number of people above 65 amounted to 18% of population and kept growing. **Medical science took credit for the increased life expectancy.** Following this trend, the National Doctors' Service initiated the development of the cutting-edge technology for sustaining life in coma and terminally ill patients, who consumed huge financial means. On the other hand, some advanced treatments including organ transplants were available and doctors forced the government to pay for that kind of treatment. However, there were concerns, that they might cause financial bankruptcy of the system.

There was a growing number of single senior citizens households. As the societies became more affluent, elderly people accumulated substantial savings, and some of them were able to spend part of it on their healthcare needs. This contributed to the rise of private care houses. Medical care was funded by the state while boarding and housing services were covered privately.

**Unfortunately, the system was experiencing a shortage of middle and lower medical personnel.** They were satisfied with the offers of the best private centers and were not attracted by the public sector. This led to a division of healthcare for those who could afford to buy it privately and those who simply could not afford it.

Unlike other employees, doctors were allowed to freely decide about their retirement age. At the same time, **they had obligatory membership in the medical associations.**

END STATE 2020

Patients had no immediate access to care and had to use lot of Emergency Rooms (ER) facilities. Access to care for patients with acute illness was quite good, but the individual choice of doctors was not. Most of the acute care was delivered through ER, rather than primary medical doctors. Patients were often transferred from one ER to another hospital for inpatient care, because the "bed situation" in each city was rather unpredictable.

**Primary physicians served mostly as a pit stop and gatekeepers.** Chronic care was delivered predominantly by specialists, because primary doctors felt that people, who

happen to be chronically ill, posed an undesired burden on their practices. Some of the seriously sick people were able to get specialized care in tertiary institutions, however, the bottlenecks to get there were gruesome.

Patient power groups failed and they did not succeed to change the system. **Patient organizations representing the patients with chronic diseases tried to organize themselves but they were humiliated in the medical press. They were considered as an unprofessional group of people lacking any medical knowledge with little right to speak on complicated medical matters.** A leftist newspaper organized an action trying to rank individual hospitals according to the perceived quality of care. The action was very successful and allowed the newspaper to introduce an "internet user fee" to access the details of the ranking.

Primary physicians were paid "per capita". The smart ones tried to market themselves to young and healthy citizens, while access for sicker and older patients was limited. A newspaper described the story of a "very smart" doctor who opened a "capitated practice" in Geriatric Medicine in a rented apartment on the fifth floor with no elevator. The National Health Fund assigned 2000 patients to him, however, as expected, he was only able to show up in his office for 2 hours a day and later he was moonlighting in a local ER. **Providers of specialized outpatient care had tough times, because primary care doctors were transferring patients to them.**

Ambitious and dedicated doctors tried to do their best, but they also faced stiff penalties from the governing bodies if they ordered too many lab tests, x rays and CT scans. It was not easy to find a cardiologist or gastroenterologist, because some of them enjoyed part time positions abroad and had little time for practice in their home country.

In October 2020, the Director of a local hospital ran out of funds, and so only emergent cases were treated in the course of November and December. Due to this fact, he was considered fiscally responsible, because in 2019 he ran out of money already in August. He was still hoping to be the next deputy Minister of Health, therefore he did not want to repeat the same mistake. **Shortage of funds led to some hospital department closures,** lamenting of the local press, as well as to a mixed reaction from the local government. The Mayor of the town was successful to convince the central government to keep the department open and allocated 10% of the local municipal budget to the hospital. Thanks to this great performance he was elected as an MP to the National Parliament. !

**The lobby of the pharmacists was successful in passing a law about pharmacy chains being against the law.** Consequently, the bargaining power for bulk purchases became non-existent. Pharmaceutical companies continued with close cooperation with doctors as their target group. Therefore, they adjusted their promotional budgets in a way that corresponds with the needs of the doctors. The National Doctors' Service created a unit devoted solely to bulk purchases of brand name drugs to be distributed and used in the state run hospitals. The program has been quite successful, but corruption accusations of the members of the unit were frequently raised. !

**Doctors have done fairly well and their incomes rapidly and constantly rose.** Some left abroad; some kept 3 jobs at the same time. They have developed over time the sense of invincibility, because they responded mostly to their governing professional bodies that were rather friendly. On the other hand it became easy to lose a job, so the sense of job stability deteriorated. The competition on the level of individual department grew to an extreme, because becoming the chairman essentially guaranteed the influx of private patients, and tripling the income. A national newspaper did a great investigation on Dr. Havlanek who placed monitors and microphones in his colleagues' office to prove that he took bribes, thus excluding him from becoming the chairman.



Some doctor and science success stories were also prominent. Thanks to a public-private partnership of a young doctor with the National Genetic Institute, a new compound was developed. In the clinical studies, it showed superior outcomes over existing treatments for lupus. As this was a multibillion-dollar market, their IPO brought the young doctor-scientist to prominence and made him an overnight billionaire. Tabloid papers showed his photos dating a young famous rock singer. **Applications to medical schools increased by 15% that year.**

Private clinics, which are usually founded and managed by doctors, did well, but mostly in cases when they were operated by prominent members of the state run system. Coming to those as a private patient usually guaranteed quick admission and inpatient treatment if needed.

Nurses did so-so. Their incomes were steady but low, and they enjoyed a great job security. If they did not like it, they could always move abroad and work in a nursing home. The EU is great! At the same time, possibilities for the education of nurses were missing and an average nurse of the country did not reach the level of those in western European countries. **Foreign politicians publically acknowledged the support for Central European medical workers taking care of an aging western European population.**

**Pharmaceutical companies were in a good condition**, because the doctors demanded more innovative drugs for patients. At the same time, there were difficulties to put a cap on reimbursements of drugs prescribed by doctors. MRI suppliers reported extraordinary performance in 2020 due to a great number of new medical equipment orders.

Venture Capitalists saw just a few of new opportunities and had to stop the negotiations with the providers on a promising project concerning a new hospital chain. A new regulation for the usage of personal blood pressure surveillance appliances was not passed. This happened, despite massive lobbying activities of the IT Company, which provided these devices.



A multinational company was awarded by a large contract to create **Electronic Medical Records in all state run hospitals** and outpatient clinics in the country. It was based on an IT system used in the US Department of Veterans Affairs. They were worried that the contract will not be implemented on time, because their local branch was also responsible for other projects in the country. Nowadays, they are implementing the system in 100 hospitals and 450 clinics. At the same time, they are training more than 3000 end users.

---

### **Consumer Survival Kit for the "Doctors Dictate" Scenario**

1. Become a doctor!
  2. Marry a doctor! 😊
  3. Place your children to the medical faculty!
  4. Become a member of the executive bodies of the National Doctors' Service
- 

### **TIMELINE | WEAK SIGNALS**

- |      |  |
|------|--|
| 2012 | <ul style="list-style-type: none"> <li>• Medical strikes</li> <li>• Together with the Czechs and Slovaks, Hungarian and Polish doctors established a common V4 medical trade union as a coordination body</li> <li>• Massive media pressure of doctors, who were claiming "healthcare is not a market", "medicine is not about money" and "life is priceless"</li> <li>• Quality of healthcare as a potential hurdle for living or working in CEE</li> </ul> |
|------|--|

- 2012
  - The low quality was noticed even by the elderly people, who normally accepted easy access without too much quality requirements

---
- 2013
  - The doctors' lobby together with the media was successful in persuading the public and the Ministry of Health to build more "inpatient beds"
  - In June 2013, the doctors accused the economists, that they ruined the system. Moreover, a group of ambitious doctors was able to persuade the public and the government, that only doctors are able to solve the situation

---
- 2014
  - Only doctors ruled the system
  - Characterized this situation as "white clan"
  - Medical universities placed limits both on the number of students (numerus clausus) as well as on those admitted for specializations
  - High healthcare market entry barriers for doctors from abroad
  - Patients found it extremely difficult to win a malpractice case
  - Doctors protected doctors
  - Health insurance companies were annulled, because doctors saw them as redundant intermediaries that ate up their money
  - Health Insurance was replaced by a tax financed National Doctors' Service (NDS)
  - In order to to cover the increased doctors' salaries, the government increased the VAT

---
- 2015
  - There was no place for a free market and competition.
  - The government increased the property taxes to balance the system.
  - There was no independent supervision over the medical profession and no institutionalized oversight of clinical quality

---
- 2016
  - In order to cover the growing costs fueled by doctors' salaries forced the government to raise the alcohol and tobacco consumption taxes and to introduce mandatory complementary health insurance

---
- 2017
  - The black market flourished and corruption grew
  - Doctors, being only bound by the Hippocratic Oath, prescribed drugs according to their conscience and with patients' wellbeing in mind

---
- 2018
  - The Ministry of Finance called for rational systemic solutions. This, unfortunately, required a dialogue with doctors, who were opposing the adoption of innovative solutions

---
- 2019
  - Medical science took credit for the increased life expectancy
  - Unfortunately, the system was experiencing a shortage of middle and lower medical personnel
  - They had obligatory membership in the medical associations

---
- 2020
  - Primary physicians served mostly as a pit stop and gatekeepers
  - Patient organizations representing the patients with chronic diseases tried to organize themselves but they were humiliated in the medical press. They were considered as an unprofessional group of people lacking any medical knowledge with little right to speak on complicated medical matters
  - Providers of specialized outpatient care had tough times, because primary care doctors were transferring patients to them
  - Shortage of funds led to some hospital department closures

2020

- The lobby of the pharmacists was successful in passing a law about pharmacy chains being against the law
- Doctors have done fairly well and their incomes rapidly and constantly rose
- Applications to medical schools increased by 15% that year
- Foreign politicians publically acknowledged the support for Central European medical workers taking care of an aging western European population
- Pharmaceutical companies were in a good condition
- Electronic Medical Records in all state run hospitals



## 5. WILD CARDS

Essential parts of this book are five wildcards. Wild cards - of Black Swan events - are events, which have extremely low probability but extremely high impact. They create existential risks for the stakeholders. Wild cards always appear as big surprises, therefore they can be randomly applied in any stage of the scenarios. In this book, you will find the following wild cards: buying immortality, hacking personal data, pandemics, solar flare and a Black Swan card. The Black Swan card is empty and tries to challenge your imagination and creativity.

### PANDEMICS

#### **February 12th, 2016**

Quynh-Anh Lam, a small 4-year-old Vietnamese girl is normally playing around their modest house in Ap My Hoa with the chickens and the ducks that are almost an integrated part of the family. 4 days ago she got ill and during the night she got high fever, diarrhea and she was coughing badly. Her parents became really worried but were not able to take her to the hospital in Thanh Po as she was too ill to be transported. Unfortunately this evening Quynh-Anh Lam died. Meanwhile more people in the village got seriously ill.

#### **February 20th, 2016**

The national Influenza Centre in Ho Chi Minh City, received the information that in the village of Ap My Hoa people were getting seriously ill and a high number of ill people actually died. They invited their local WHO representative to the area and were able to take blood samples from some of the people infected. They warned the government to prepare and put in place the national pandemics plan.

#### **February 25th, 2016**

The WHO, through their Collaborating Influenza Reference Centre in London, had a strong indication that the identified H5N1 virus has a high human-to-human transmission factor and declares the outbreak official. Several countries supported by the European Commission, European Centre for Disease Prevention and Control (ECDC) as well as the WHO contacted vaccine producers with regard to the production and availability of a vaccine against H5N1 and reinforcing the advanced purchase agreements on antiviral and vaccine production.

#### **March 28th 2016**

Throughout Vietnam and other Asian countries, the number of casualties quickly exceeds the outbreak of 2009. The first cases reached the US and the UK and the WHO after strong internal debate, taking into account the experience from the 2009 pandemics outbreak and the public scrutiny, declares the highest state of emergency. DG Sanco and DG ENTR together with European Medicines Agency and ECDC formed a taskforce and activated the joint procurement of pandemics vaccines process that was agreed in 2012. The vaccine producers, however, promised that they will do what they can but they already indicated that given the speed of the transmission and the severity of the outbreak, they will not be able to prevent many deaths.

#### **March 31st, 2016**

The first cases of H5N1 were reported in Slovakia and Poland.

#### **April-May 2016**

The pandemics flu was spreading fast. CEE countries were activating their pandemics preparedness plans. The plans, however, were tested properly during the 2009 pandemics outbreak and hospitals are full of patients. Schools were closed and the industry was severely impacted.

In Western countries, government members, the army, doctors and nurses were provided with antiviral therapies and facemasks that were stockpiled. However, in many CEE countries these were available only in a limited number.

By early May in many CEE countries the emergency status was declared. Hospitals were full. Few doctors and nurses, supported by soldiers, tried to treat the patients but they had to refuse many. Vulnerable populations like the Roma were severely affected and the death toll amongst them was approaching 20% of total population. In CEE the average death rate of infected people was 30 % like the rest of Europe but this percentage was increasing quickly and diverging from Western Europe due to lack of resources and preventative organization.

### **June 6th 2016**

The first batches of Pandemics Vaccines arrived to Central Europe. Government officials, the rest of the army and healthcare workers were vaccinated quickly but vaccination for the population was heavily impaired due to the fact that logistics was impacted dramatically. The army was supporting logistic companies the best they could. Radio broadcasts warned affected families not to leave their homes to try and get the vaccine. The public panic rose to a level that worried citizens attacked warehouses and other places, where vaccine supply was provided.

### **July –December 2016.**

Millions of people in the world welcomed the first signs that the pandemics is in retreat at the end of July. In October 2016 the pandemics was officially declared under control. Globally, the pandemics of H5N1 reached a death toll of 250 million. Within Europe, Central Europe was hit hardest with 20 million casualties. The impact on GDP globally is 13%, in Europe 8%. Central Europe, however, was affected by 14%. The chaos was hard to describe and during 2016 slowly basic facilities were restored.

### **2017**

Population was vaccinated against H5N1. World leaders declared 2016 as the "year of never having it again" and several top summits of scientist and policy makers analyzed the best practices from 2016.

Central European policymakers explained the population that there were significant shortcomings in the preventative measures that the likelihood and severity of a potential outbreak was heavily underestimated and that healthcare systems were clearly not able to provide the right number of resources and support as in other parts of Europe.

### **2018-2020**

In all CEE countries, healthcare was prioritized in the fragile recovering economies to improve the standards and number of healthcare workers. The average % of GDP invested in healthcare increased to 10%. Central Europe will be recovering probably till 2021 to reach the level of GDP in 2016.

## SOLAR FLARE

**In December 2012**, a massive increase of solar radiation, also known as "Solar Flare" hit the Earth with exceptional impact. The Solar Flare placed all electronic devices and systems immediately out of order. Consequently, its impact on the digital society and healthcare systems was disastrous.

The basic utility infrastructure was dysfunctional. Satellite and electronic communication was severely disrupted as was the data storage in various places on the globe. Transport routes were cut off and it was impossible to secure transport routes for supplies, medicaments, emergency patients and medical and public-order personnel. Without electricity, it was dark all over.

International Banking and Financial system collapsed within minutes. Health insurance companies had to admit irreplaceable losses of medical and financial information. Lots of cutting edge research and medical knowledge was irreversibly lost, including experimental data and electronic know-how. Medical students returned to study from paper books. Internet, GPS and mobile computing was simply gone.

Numerous traffic and industrial accidents happened due to dysfunctional traffic lights and control systems. The emergency forces simply could not cope with high number of fires, injuries and chemical and industrial incidents. Major medical record databases were damaged. The record keeping went basically back to the Pen & Paper methods. High tech imaging and diagnostic life-supporting devices in hospitals were running on diesel generators, which could work only up to 24 hours.

Special crisis management committees were set up to take control over the situation. The communication and.

Suddenly, without electricity, and generators with no more energy, only basic healthcare delivery was available. It was practically at the level of mid 20th century. The impact on medical electronic equipment, however, was nothing compared to the long-term effect of massive radiation after the solar flare. In the following years, hospitals were overwhelmed by the high number of cancer patients and the genetic malformation. Pharmaceutical companies recovered relatively quickly after the lost years in research. A bio-tech genetic company that claimed to be able to recover minor DNA changes saw its shares skyhigh. The waiting lists for specialized cancer treatment grew longer and longer. Those lucky ones with private insurance were able to pay.

The cost of long term palliative treatment provision became unbearable for the state health insurance schemes. Some insurance companies were bailed-out by their governments, while others were allowed to seek for innovative multi-generation health insurance products.

The negative economic outlook forced the government to further limit the public expenditure for national health systems. The quality of health outcomes and availability of treatment was poor mainly to the chronically and critically ill population. Rates of mortality began to increase dramatically after decades of gradual improvement.

However, the hard times, brought some very innovative solutions in terms of health status monitoring. The comparative national average Heart Beat indexes and Cholesterol indexes become published daily. This served not only as a precise stress indicator for governments, but allowed also personally targeted cardio-vascular prevention and treatment.

## HACKING OF PERSONAL MEDICAL DATA

### **July 14th, 2017**

A group of hackers called "drillers" published on their web site [www.drillers.xl](http://www.drillers.xl) the medical status and healthcare spending of all government officials and members of parliament. In their memorandum, they said, this was an act of protest against the poor data protection of the health data in the state managed central e-health database. They also said they downloaded all current and historic health data of the population.

In the past, the governmentally supported e-health project was heavily criticized by the media and the independent analysts. The core of critics was focused on poor data protection and missing security standards in the legislation. In spite of that, the government supported the project from EU funds and launched it in December 2015.

### **July 15th, 2017**

The headlines of tabloids were full of politicians' names and their illnesses or diseases. It turned out, that the Minister of Transport was a psychiatric patient. Member of the agricultural committee in the Parliament was HIV positive. The Minister of Justice had cancer and two members of the Parliament had a sexually transmittable disease.

Moreover, data on spending revealed, that most of politicians regularly got treatments that are not covered in the benefit package. At the same time, the health insurance company paid for their treatments abroad huge sums and denied these treatments to not prominent insurees.

### **July 17th, 2017**

To pour more oil in the fire, the leader of the "drillers" – Mr. Hacker sent a video message to all relevant media from a secret hideout and said that they were ready to negotiate with each citizen about the price of not publishing their medical data. He said that there were no financial limits in negotiations. Three hours later, one of the richest business man of the country offered, that he was prepared to buy the whole database for € 10 million. The proposal was refused by Mr. Hacker being unattractive.

### **August 20th, 2017**

According to the media news, the hideout of the drillers was not found. According to drillers, in the first 30 days after the public proposal, they were contacted by thousands of people and they were negotiating with every client. The police was powerless. The government accused the drillers from cyber terrorism and initiated an international hunt after the hacker group.

### **December 11th, 2017**

The hackers were still not found, but they claimed that they revenues from data selling reached € 25 million with the average price of € 1200 per health record.

### **March 9th, 2018**

One of the clients of the "drillers" who bought his own medical data, started a lawsuit against the government for negligence at the European Court of Human Rights. He wanted back his money that he paid to drillers (2000 €) and on top of it a "stress" compensation of € 100 000. He claimed that this covers the stress he had to live with for 6 weeks, until he settled with drillers and he did not know whether his personal data will be published or not.

### **May 9th, 2018**

Until today, there are 519 people, who joined the lawsuit against the government and the total claimed damage rose to more then 50 million €. Until today, the drillers were not found.

## BUYING "IMMORTALITY"

**On February 2, 2015**, the leading pharmaceutical company NextLife introduced a brand new nano therapy called Life200. The brand name Life200 indicated, that after experiencing the therapy, the person can live up to 200 years. The company did not want to publish the initial price of the nano therapy and said it is the matter of demand and supply. Right after this statement the shares of NextLife sky-rocketed. NextLife informed that already in the first month, they had more than 22 clients. In the second month there were 145 and in the third more than 500. At the end of the year, NextLife opened new clinics in Europe, Asia, Australia and Africa.

In 2016, they had more than 100 000 clients and the company estimated that their potential target group is 100 million people all around the world (1.5% of the overall population). The success of the Life200 was enormous, not only for its ability to prolong life but also for its prevention and healing abilities. As it later turned out, this potential was heavily underestimated. !

The Life200 raised a heated debate on ethics and equity. The NextLife Company offered the product solely to opulent and well-off clients to maximize profits and refused to lower the price and provide the therapy to poor people. Consequently, people started to take loans and mortgages to cover their Life200 therapy. Banks were very happy to provide new loans for this purpose, because after taking the therapy, the life of the person was dramatically increased, so the financial risk was lower and the banks were able to provide loans and mortgages for 50 or 100 years. In 2019, more than 15% of population in Europe and USA already undertook the Life200 therapy.

The decade 2010-2020 ended as it started: with a financial crisis. The only difference was that in 2010, the crisis was a debt crisis arising from greed. The 2020 financial crisis arose from fear of death. The people who underwent Life200 therapy were healthy and had long life perspectives, but the economy was not prepared for such a new class of people and was not able to create enough new jobs, so the "young and healthy" started to have problems with repaying their loans and mortgages. There is no surprise that both crises from the start and the end of the decade promised the people life in luxury and conquering death. In this world, something important was missing: humility and soul.

# THOSE WHO TOOK PART

**Peter Balík**

Analyst at Health Policy Institute, Slovakia

**Slavomír Batka**

Actuary - Team Lead, Vice President at Swiss Reinsurance Company Ltd, Switzerland

**Andrea Benáková**

Marketing & Communication Specialist at Central & East European Health Policy Network, Slovakia

**Lenka Borošová**

Communication Manager at Central & East European Health Policy Network, Slovakia

**Péter Gaál**

Dean of the Faculty of Health and Public Services at Semmelweis University, Health Services Management Training Centre, Hungary

**Paul van Hoof**

Government Affairs Director GSK Pharma Europe Brussels office at GlaxoSmithKline, Belgium

**Pavel Hroboň**

Managing Partner at Advance Healthcare Management Institute, Czech Republic

**Zsombor Kovácsy**

Chief Attorney at Kovacsy & Partner Law Firm, Hungary

**Adam Koziarkiewicz**

Health and R&D Expert, Poland

**Adam Kruszewski**

Co-owner and President of KCR S.A., Poland

**Tomáš Macháček**

Founder of the Health Reform.cz, Czech Republic

**Jaroslav Molik**

Underwriting Life & Health Reinsurance at UNIQA Re, Switzerland

**Peter Pažitný**

Partner and Executive Director at Health Policy Institute, Slovakia

**Darinka Perišić Reinicke**

Consultant, AGE/GIZ, Germany

**Ivan Perlaki**

Founder and Senior Consultant of Ivan Perlaki Consulting, Facilitator of scenario planning exercise for Central & East European Health Policy Network, Slovakia

**Frederik Cyrus Roeder**

Managing Director at Healthcare Solutions Lithuania

**Eszter Sinkó**

Deputy Director at Semmelweis University, Health Services Management Training Centre, Hungary

**Jan Skowronski**

Director of Interventional Cardiology and Director of Chest Pain at OSF St. Anthony Medical Center, USA

**Milena Gajić Stevanović**

Head of NHA unit, Institute of Public Health of Serbia, Serbia

**Tomáš Szalay**

Partner at Health Policy Institute, Slovakia

**Angelika Szalayová**

Partner at Health Policy Institute, Slovakia

**Radim Tobolka**

Executive Director of Health Reform.cz, Czech Republic

# ABOUT CEE HPN

## CORE VALUES

### **Innovation**

We support innovative solutions for the benefit of the consumers.

### **Transparency**

We support transparency in performance of medical providers and health insurers so that consumers are able to make choices based on reliable information.

### **Individual responsibility**

We support individual responsibility in each health status – either healthy or ill. We believe that also ill people can contribute by their responsible behavior to improvements in their health status. We believe that adequate financial responsibility of people is necessary to protect their sovereign position as consumers.

### **Fair competition**

We believe that fair competition is a key driving force leading to better products and services in health care to fulfill consumers' preferences.

### **Fair access**

We believe that each individual has a right for fair access to health care services. Fair access means consumer choice of provider, scope, place and time of the treatment that is clear of corruption and stress from refusal and lowering the dignity of consumers.

### **Public money protection**

We support the financial sustainability and efficient utilization of the public finances.

### **Local focus with CEE experience**

Each member possesses a high knowledge of the local healthcare system. We believe that local people are the best drivers for change in their countries. Together, as a network, we can share experience and learn from each other.

## MISSION

Our mission is to influence the healthcare system change in CEE countries for the benefit of the consumer.

## VISION

Our vision is to have a strong network of functioning local think-tanks in at least 5 CEE countries by 2015. These local think-tanks are recognized as a point of influence towards consumer oriented healthcare systems.

THANK YOU

RESIDENCE AND CONTACTS



CENTRAL & EAST EUROPEAN HEALTH POLICY NETWORK  
PROKOPOVA 15, BRATISLAVA, 851 01 SLOVAKIA

WEB [www.ceehpn.eu](http://www.ceehpn.eu), [www.facebook.com](https://www.facebook.com), [www.linkedin.com](https://www.linkedin.com)

MOBILE +421-948-662600 Lenka Borošová

MAIL [ceehpn@ceehpn.eu](mailto:ceehpn@ceehpn.eu)