Decentralization and Governance of Healthcare in the Czech Republic in the 1990s

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1. EXECUTIVE SUMMARY

There is no doubt that the Czech health sector offers a higher quality of care now than it did ten years ago. The system is equitable, ensuring access to comprehensive care for the whole population. The improvements in efficiency in healthcare provision were needed, especially to address the excessive amounts of beds and specialists. Nevertheless, the Czech Republic was relatively successful in the deep reform which moved from the inflexible state health system inherited from the communist regime toward a pluralistic health insurance system, albeit with many financial problems. In tracing the steps of reform, we were able to distinguish two different reform periods. The first half of 1990s was the period of major reform in health finance. The insurance system was introduced, physician practices were privatized, hospitals gained more autonomy, professional chambers were established, and patients enjoy free choice and access to modern health technologies. This reform period was, however, negatively affected by ideology, naïve radicalism, and lack of experience with public administration in a market economy. In the second half of the 1990s, the main reform topics, therefore, were economic stabilization, consolidation, regulation, and sustainability. The health sector is now more extensively regulated and to some extent stabilized. The 21st century opens with a wide public administration reform which will impact the health sector in ways we are not able to predict. Gains in efficiency will be welcomed. The last thing to note is the absence of a long-term reform concept based on sufficient and qualified analytical work. This leads to *ad hoc* measures directed at the most urgent problems but ignoring other areas, which will lead to further problems.

1.1 General Information

The Czech Republic is located in Central Europe and covers an area of 78,866 km^2. It is bordered by Poland to the north (762 km), Slovakia to the east (252 km), Austria to the south (466 km), and Germany to the southwest, west, and northwest (810 km). The total population according to the 2001 census was 10.2 million. In 1990 (the previous census), the population was 10.4 million. The female share of the population is 51.3 percent. The population density is 129.4 inhabitants per km^2. 75 percent of the population live in urban areas. The capital city of Prague concentrates about 10 percent of the total population. According to the last census the ethnic composition was 94.2 Czech, 1.9 percent Slovak, 0.5 percent Polish, 0.4 percent German. The official language is Czech. 59 percent of the population is atheist, 32 percent Roman-Catholic, 5.5 percent Protestant, 9 percent undetermined.

The country is administratively divided into 13 regions and the capital city of Prague. In the regions there are 205 communities with branches of public administration. For certain statistics, judicial/legal proceedings etc., the previous division into 76 districts is still used, where branches of some ministries and other central institutions operate.

1.2 Socio-economic Indicators

Chapters 2.6 to 2.8 include a broader description of the economic background of the state and the development of the Czech healthcare system. Here we will introduce the country profile with selected figures from 2002. More data and description of the economic situation and development with the special attention to healthcare is available in a recent study by the OECD: *Economic Survey—Czech Republic 2003*.[1] The Czech Republic has been a member of the OECD since 1965 (see Table 1).

The following charts show a dynamic view of those figures in the last thirteen years—the period of post-communist development: See Annex 1 and 2.

Table 1.
Basic Indicators 2002

Year	**2002**
GDP per capita (PPP $)	15,813
Labor force as % of population; of which:	52.6 M; 40.9 F
• Agriculture	4.8%
• Industry and construction	40.4%
• Services	54.8%
Unemployment rate %	5.9 M; 9.0 F
Education of population 15+ years (2001)	
• Elementary	22%
• Trained workers	37%
• Secondary	31%
• University	10%
Annual average rate of inflation %	1.8
Government revenue as % of GDP	46.6
Consumer price index	1.8
% of population age 0–14	16.6 M; 14.9 F
% of population age 65+	11.0 M; 16.6 F
Live births per 1,000 individuals	9.6 M; 8.6 F
Total fertility rate	1.2
Annual population growth per 1,000 individuals	–1.5
Life expectancy at birth	71.1 M; 78.4 F
Abortions per 1,000 live births	44.1
Marriages per 1,000 individuals	5.2
Divorces per 1,000 individuals	3.1

Source: Czech Statistical Office; Institute of Health Information and Statistics (IHIS).

1.3 Health and Healthcare Indicators

The main goal of the reforms of 1989/90 was to improve the health status of the Czech population, which had been stagnating since the beginning of the 1960s (compared to developed European countries). From World War II to the 1960s Czechs' health status was at the European standard. According to health indicators, for the period from 1960 to 1964 Czechoslovakia was ranked 10 among 27 European countries; by 1974

it dropped to 22, and by the 1980s to 27. This was determined by the overall decline of the social and economic level of socialist society. The means for improving it was to introduce a new healthcare system (whose features are described in the following text). This paper is not primarily focused on the history of the health status of the Czech population. The post-war period and especially the period since 1960 is described in the *Historical Yearbook of Healthcare: Czechoslovakia* (IHIS 1992). A complete description of the development with many charts illustrating the period since 1970 is available in the WHO "europaper" *Highlights on Health in the Czech Republic* (WHO 2001). The following table shows figures for selected indicators of health status, healthcare system resources, and their utilization.

Table 2.
Basic Health and Healthcare-related Indicators 2002

Indicator	Value	Indicator	Value
Crude death rate per 1,000 individuals	10.6	% of regular daily smokers age 15+	24.1
Standardized death rates (SDR) all ages per 100,000 individuals for:		Pure alcohol consumed per year per capita in liters, age 15+	16.2*
• ischemic heart diseases	179.2	Total health expenditure per capita US$	1,170
• cancer	233.8	Public health expenditure per capita US$	1,055
• cirrhosis of the liver	16.9	Health expenditure as % of GDP	7.4*
• cerebro-vascular diseases	456.0	Public health expenditure as % of total health expenditure	90.2
• infectious and parasitic diseases	2.7	Total inpatient expenditure as % of total health expenditure	39.3
• traffic accidents	11.9	Total pharmaceutical expenditure as % of total health expenditure	24.6
• diseases of the respiratory system	4.5	Salaries as % of total health expenditure	21.4
• diseases of the digestive system	3.9	Number of beds per 100,000 individuals	831
Tuberculosis per 100,000 individuals	11.8	Number of physicians per 100,000 individuals	389.8
Hepatitis (A, B, C) per 100,000 individuals	15.1	General practitioners per 100,000 individuals	72.2
Diphtheria per 100,000 individuals	0.0	Average length of stay (days) in critical care hospitals	8.3
Polio per 100,000 individuals	0.0	Bed occupancy rate (%)	72.1
Infant mortality rate (# of infant deaths per 1,000 live births)	4.15	Private hospital beds as % of total hospital beds	31.4
Maternal mortality rate per 100,000 live births	3.2	* 2002 data are estimates	

Source: Czech Statistical Office; IHIS.

Several charts show a dynamic view of these figures in the last thirteen years—the period of post-communist development. To better understand the position of the Czech Republic, we have also added average figures for the countries of the European Union: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, the United Kingdom, and also for Central and Southeastern European Countries (CSEC): Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia, FYR Macedonia, and Serbia and Montenegro (see charts in Annex 1 and 2).[2]

The level of the technical equipment for healthcare has improved rapidly in the 1990s. The following table shows present capacity not including establishments outside the healthcare sector (military hospitals etc.):

Table 3.
Technical Equipment

Medical Apparatus in Health Establishments as of 2002			**Number of Performances[3]**	
Apparatus	**Quantity**	**Number of Individuals per Unit**	**Total**	**Per Unit**
X-ray diagnostic apparatus	6,635	1,538	12,949,618	1,952
X-ray therapeutic apparatus	48	212,625	208,697	4,348
Linear accelerators, therapeutic irradiators	70	145,800	1,118,558	15,979
Radioisotope irradiators	24	425,250	12,159	507
Lithotripters—therapeutic	33	309,273	18,891	572
Ultrasonic scanners (sonographs)	2,583	3,921	5,767,535	2,233
Other radiotherapy apparatus	151	67,589		
Other Listed Apparatus				
Magnetic resonance (MR tomograph)	22	463,909	86,941	3,952
Laser, surgical	207	49,304	73,815	357
Laser, therapeutic	1,331	7,668	542,899	408
Biochemical analyzers (automated)	1,447	7,053	na	na
Hemodialysis units	1,268	8,049	na	na
Ventilators (for long-term lung ventilation)	1,891	5,397	na	na
Hyperbaric chamber, one place	10	1,020,600	na	na
Hyperbaric chamber, multiple	5	2,041,200	na	na
Other diagnostic and therapeutic apparatus costing over 2 million CZK (US $6,500) not listed above	781	13,068	na	na

Source: IHIS 2003.

2. THE ROAD TO REFORM

2.1 Brief Description of the Healthcare System Before 1990

The healthcare system in the Czech territory has maintained a relatively high standard, along with the economy and the general level of education. Obligatory health insurance for industrial workers was established in 1888. From 1919 to 1924, obligatory health insurance in the independent Czechoslovak Republic was extended to the entire wage-earning population. Payment of insurance contributions (4.3 percent of wages) was shared half and half between employer and employee; these contributions were managed by about 300 insurance funds. The funds covered all employees and their family members with healthcare provided by contracted private physicians and public hospitals. Insurance funds also compensated for lost wages during illness at approximately 60 percent of the relevant wage (salary) up to a maximum of 39 weeks.

In 1948 health and social insurance was unified into one obligatory system of insurance for all citizens. A sole Central National Insurance Fund (CNIF) was founded which covered all healthcare and illness benefits. The insurance, amounting to 6.8 percent of wages, was paid entirely by the employer. This amount did not include pensions for the elderly.

In 1951, a Soviet model was established and the CNIF was abolished. The state took over all healthcare coverage and financed it through taxes. All healthcare was provided free of charge. At the same time, all healthcare providers were nationalized and subsequently incorporated into regional and district institutes of national health. Since 1960 the Czech part of Czechoslovakia had eight regions and 76 districts. The form and function as well as the financing of this system from 1960 to 1991 is shown in Organizational Chart 1 in the appendix (this chart is necessary to understand the following text).

Each district (of the 76) had one District Institute of National Health (DINH), and each region (of the 8) had one Regional Institute of National Health (RINH), and so each healthcare organization (DINH, RINH) corresponded to only one administrative unit, either a district or a region. DINHs consisted of medium or small hospitals, large divisions for ambulatory care, polyclinics (with GPs and ambulatory specialists under one roof), healthcare centers (mainly for primary care), pharmacies, emergency and first aid services, hygienic stations, healthcare centers for enterprises, nursing schools, etc.

1. The average number of employees in a DINH was 2,690, of which an average of 390 were doctors. RINHs mainly consisted of larger and more specialized hospitals, polyclinics, and pharmacies. GPs did not form part of the RINHs.
2. Healthcare was financed through general taxes. The Ministry of Finance (MoF) allocated funds to regions and districts through the Regional National Committee (RNC) and the District National Committee (DNC). RNCs and

DNCs then distributed relevant funds to the RINHs and DINHs under their jurisdiction.

3. The Ministry of Health (MoH) methodically controlled the professional (medical) aspects of healthcare through a network of chief regional and district experts in each medical specialization. The MoH was also engaged in medical research and was ultimately responsible for hygienic supervision, drug administration, and overall financial control of health services.
4. All manpower of the RINHs and DINHs, from manual labor to the top specialists, received fixed salaries that inadequately reflected level of education and quality of work.
5. Directors of RINHs and DINHs were appointed by the heads of the RNC or DNC, after receiving approval by the Communist Party.
6. The area of responsibility of all health facilities was strictly fixed. Therefore, all citizens were allotted a specific GP, polyclinic with ambulatory specialists, hospital, and other services according to the citizen's domicile.
7. Preventive as well as curative healthcare for the economically active part of the population, on the primary care level, was organized through enterprise physicians. These physicians were employees of DINHs as well, but they worked exclusively with the enterprise employees. By the end of the 1980s, approximately 75 percent of the economically active population's healthcare was covered in this way.
8. All health services (with a few exceptions, e.g. dental gold, more expensive eyeglasses, etc.) were provided free of charge. Drugs were also provided free of charge, with the exception of a limited number of medicines or remedies which were available in pharmacies without a prescription.

2.2 The Role and Place of Healthcare on the Political-economic Agenda of the Government Before and After 1990

The socialist system of healthcare was a point of pride for the regime. This was partly justified before the end of the 1960s, but in the 1970s and 80s it was further and further from the truth. The government and the Communist Party did not reflect many severe problems (the worsening health status of the population, under-funding of healthcare, deteriorating medical technology, etc.); if they did, problems were neither resolved nor openly discussed. Only some quantitative data were used as a tool for political propaganda, e.g. the number of doctors, number of hospital beds, number of new hospitals, etc.

This twisting of reality had been slowly changing in the last years of the 1980s, consequent to the hidden political debate held inside the Communist Party on the sustainability of planned economy and other "achievements" of socialism. The problems of

the health sector were discussed in the government, and the MoH was ordered to prepare some moderate changes and improvements. Also research institutions were mandated to study problems in the health sector. However, this did not have any significant impact. In fact, the proper aim and content of changes being prepared at the MoH remained unknown, and the effort to ameliorate the system of healthcare was cut by the collapse of the communist regime in the Fall of 1989.

The first post-communist minister of health (a member of the temporary cabinet working before the first free elections in June 1990) was open to reform ideas and initiated an official preparation for health reform. He appointed a multi-disciplinary external task force, which in several months elaborated a first draft for reform, called the *Yellow Paper* (1990). After the first free elections the process was accelerated. Several members of the reform task force entered the MoH, one became the Minister of Health, and the new non-communist coalition cabinet declared the reform of the healthcare system one of its priorities.

In the next several months the second and more radical reform draft was elaborated (Potucek et al. 1990) and approved by the cabinet in December 1990. This can be taken as a turning point from preparation to implementation; however some steps were already completed before this. In the two years before the next parliamentary elections, the government developed real pro-reform activities. Key bills were approved and passed by Parliament, among other resolutions the autonomy of state hospitals and polyclinics, the launch of the National Program for Health Promotion, and the plan for property changes in the health sector.

Further development in the 1990s can be illustrated by the key programs of the various cabinets:

- 1992 (a center-right coalition dominated by conservatives and minor parties: Christian democrats and liberals): radical reforms of the healthcare system without limiting accessibility of services; privatization of health services; improving the social status of medical doctors and other medical personnel.
- 1996 (a right-center coalition—the same as in 1992): continuing reforms; continuing privatization of health services; definition of the guaranteed package of healthcare services; measures against spiraling cost; rationalization of hospitals.
- 1998 (social democrats): broadly accessible healthcare for citizens; equity and solidarity; strengthening the role of the public (i.e. non-private) sector of health services; quality assurance.
- 2002 (left-center coalition dominated by social democrats and minor parties: Christian democrats and liberals): broad accessibility, equity, and solidarity; economic sustainability of health expenditures; public sector reform.

Healthcare was not on top of the political-economic agenda after 1992, but important topics in health policy were discussed. From 1992 to 1995, the main attention of

the government was focused on the privatization of health services. In the mid-1990s, the danger of spiraling costs became urgent, and various cost containment measures were put on the government agenda over several years. However, reforms in the health sector were not assessed or reviewed, and almost no substantial reforms were launched or officially planned. The MoH itself was having difficulty finding its proper role and position in a new pluralistic system, and permanent quarrels with other major partners, e.g. the General Health Insurance Fund (GHIF) and the medical chambers, seemed to block any progress. One exception was the period from 1996 to 1997 under a rather strong Minister of Health (the only one in four decades who was not a medical doctor) when many short- and mid-term reform measures were prepared and implemented, and a long-term reform project was elaborated. This period, called the "second round of healthcare reform" or "the reform of the reform," was stopped by the political crisis that led to pre-term parliamentary elections. After 1998 the government dominated by the Social Democratic Party did not continue the reform process, and the word "reform" itself disappeared from the coalition's discourse.

Reform of the healthcare system in the context of political, economic, and social transformation of the CR in the 1990s:

Reform of the healthcare system was an inseparable component of the political, economic, and social transformation of the CR in the 1990s. Its position within this context can be described as follows:

1. The political changes in 1989 established a background for changes in the health sector, particularly for formulating and launching reforms. The acceleration of the political transformations after the first free parliamentary elections in 1990 also accelerated reforms in the health sector and created pressure to move them ahead.[4]
2. Liberal and market principles were the leading orientation for profound changes in the country in general, and reforms in the health sector were not a part of the "mainstream."
3. For economic transformations, the government needed a "social pillar," which, among other things, created specific requirements and limits for healthcare reform. The reform was intended to be "painless" both for consumers and for providers in order to avoid dissatisfaction with the general processes of transformation and to maintain public consensus and political support.
4. In spite of this broad concern, changes in the healthcare system (and particularly the consequent problems) were taken more and more as an agenda belonging solely to the health sector and the MoH.

Reform of the healthcare system did not avoid many rather negative features that were typical of transition as a whole, e.g.:

- Poor preparation and lack of evaluation: the reform draft approved by the government in 1990 had been "hot-tailored"—elaborated very quickly. Moreover,

its time horizon was limited to1992. However no evaluation was taken out after that first period and no innovative scenario was conceptualized for subsequent years. In fact, before 1996, conceptual work, analyses, and evaluation were considered useless.

- The vague role of the state: after the experience of the communist period, there was a general reluctance to enforce or accept any strong state role, even where appropriate. In the health sector this stimulated a rapid process of decentralization, devolution, and delegation, in which the MoH did not behave as a strong player and quite often did not fully use the extent of its tools and competencies. On one hand, this facilitated a sound spontaneity; on the other, it left space for various power games, lobbies, and special interests.
- Lack or regulation and control mechanisms: in the first reform period there was a conviction that freedom itself could form responsibility and lead to reasonable behavior by people and institutions. Gaps in new legislation and missing regulatory and control measures were a general deficiency. In the health sector, this led to excessive spending, overproduction, and over-utilization of care.
- A centralized approach and ignorance of foreign experience: in healthcare reforms, foreign experience and the expertise of international organizations (the World Bank, WHO) were taken into account in the period 1990–1992, however no plan for long-term and systematic cooperation or assistance was accepted. From 1992 to 1997, the prevalent attitude was that recommendations from international organizations and experts could not meet Czech needs.[5] There were exceptions with little impact, but the situation in general can be illustrated by the fact that the CR in 1991 rejected a World Bank loan targeting health sector reform, and in 1996 did not join the Ljubljana Charter[6] (the only post-communist country not do so, and together with the United Kingdom, one of two countries in the WHO European region not to); it joined much later due to the pressure from Parliament.[7]
- Discontinuity due to political circumstances: maybe more than another sector, reform in the health sector was very sensitive to politics. Even in a clearly-defined "reform or transition period" (1990–1997) the reform of healthcare was not a continual process. It suffered many setbacks and many steps remained uncompleted. As was mentioned above, after the left-wing shift following the 1998 parliamentary elections, there was no political will to continue, and reforms ceased.

2.3 Specific Reasons for Launching the Reforms

Reform of the healthcare system, formulated and launched in the 1990s, was inseparable from deep political, economical, and social changes in the Czech Republic (and

Czechoslovakia) after the "Velvet Revolution" of November 1989. However, specific reasons also existed.

2.3.1 Political Motivations

As described in the section on health and healthcare indicators, there was an apparent stagnation in health status beginning in the1960s. The main reason was the shortening of the mean lifespan (with a specific increase of mortality of men over 35 years of age) and an increase in morbidity and in partial or total disability (see tables and charts 1.2 and 1.3).

Mortality, morbidity, and disability increased mainly due to cardiovascular diseases and neoplasms, but also due to diseases of the muscosceletal and digestive systems. An increase in the number and severity of diseases caused by psychological and psychosocial factors was also observed. The rate of infant mortality was decreasing more slowly than in other countries.

Poor health cannot not be ascribed merely to health services, but it seemed evident that the poor quality of the healthcare system substantially contributed to the situation, which was described as "a chronic and deepening crisis of health and healthcare" (Kalina et al. 1991).

The main symptoms of this "chronic and deepening crisis" in healthcare are analyzed in more detail in section 2.4. Although they are based on a study made seven years after the launch of the reform, they do not differ significantly from what is presented in the *White Paper*—the reform draft approved by the government in 1990:

- a rigid, hierarchical system of health services
- lack of modern management, economical stimuli, and quality assurance
- deteriorating buildings and equipment
- an insufficient number of doctors and hospital beds for practical use (while statistically the CR was better off in both parameters than developed European countries)
- waste of resources, human potential, and public confidence
- missing links among primary care, secondary care, and hospital care, as well as between health and social care.

These problems created pressure for reform. Both politicians and experts emphasized that the system of health services had lost its ability to make rational decisions and to react flexibly to the health needs of the population. It had failed in its central mission—to encourage good health. Therefore, modification or partial changes to the system were regarded as insufficient, and a radical change, establishing a "completely new system," was seen as an appropriate challenge in the new political situation (see the sets of tables and charts 1.2 and 1.3).

2.3.2 Public Opinion

The first public opinion pool permitted and released before the collapse of the communist regime revealed healthcare and the environment as two principal areas of public dissatisfaction. Criticism of the existing healthcare system and desire for changes also popped up among spontaneous slogans from the Velvet Revolution. Public opinion was particularly sensitive to the following problems:

- Administrative barriers made the free choice of a physician and healthcare facility practically impossible.
- Privileges were offered to certain social and political groups and denied others.
- Health services were misused by politicians.
- Top positions were given to the *nomenklatura*.
- Information and data about health and healthcare was twisted and suppressed.
- Patients were treated in an impersonal manner.
- A shadow economy existed for health services.
- Medical personnel were awarded low social status.

Thus, a radical change of the system of healthcare was also a public aim. At the beginning, people did not appear to worry that "radical changes" would limit the large package of services that had been accessible free of charge.

2.3.3 Motivation and Relevance of Medical Personnel

Public sentiment tended to blame the system, not the people working in it. In fact, medical doctors and nurses never lost their prestige, but were regarded (as they regarded themselves) as professions degraded by the regime.

Several passages in the *White Paper* confirm this attitude.

> "The citizen, in spite of his proclaimed rights, had practically no rights in health services, neither as a patient nor as a health worker."
>
> ..."If [the system of healthcare] has not yet collapsed, this is only due to the moral motivation of the greater part of health workers, to which they adhered even under such unfavorable conditions and exerted considerable efforts to benefit patients and maintain their professional standards. Thanks to this motivation, the majority of medical branches have not lost complete touch with the standard of world medicine, in spite of all the barriers that separated us from the international medical community. However, in the last few years the moral reserves of our health services have been exhausted"
> (Kalina et al. 1991).

This may also illustrate the important position of health professions at the beginning of reforms. During and after the Velvet Revolution, the popularity of medical personnel actually increased due to the civic activism of many from the profession. Particularly medical doctors gained notable political influence over a short time, not only as a pressure group but as real initiators, designers, and leaders of reforms; also as politicians in the government, in Parliament and in numerous local councils. Many sought to reform healthcare not only in the name of medical professionals, but in the name of the public as well.

2.3.4 Economic Factors

It was clear in the 1980s that the communist economies were not able to compete with the market economies. The economic gap between the European Union and the former Czechoslovakia was widening. Large heavy industries (metal and steel, coal, machinery) dominated the local economy instead of the necessary rise of smaller and more flexible companies oriented to trade, services, and information technology. Lack of investments led to obsolete technology in industry as well as in the health sector. Many hospitals were located in old buildings in need of expensive renovations. The limited opportunities to sell products in developed countries caused a scarcity of convertible currencies. For the health sector, it was therefore difficult to import modern health technology and drugs from the developed market economies. For health workers, access to new technology and new drugs was seen as an important achievement of the changes of 1989.

2.4 Features of the Healthcare System Contributing to Specific Problems, which Then Became Main Goals of Reform

The main negative features of the healthcare system before 1990, which then became the main goals of reform, are as follows[8] (Jaroš, Kalina et al. 1998):

1. The general health status and mortality rate of the Czech population had steadily worsened since the end of the 1960s.
2. From 1970 to 1990, healthcare suffered a great lack of financial resources without regard to actual needs.
3. There was an overall centralization of healthcare, which augmented low efficiency, causing a great waste of the already limited resources.
4. A rigid state monopoly in the provision of health services eliminated any active participation by the citizen in the care for his own health as well as denying awareness of the value and costs of health.

5. Healthcare policy was permanently under the control of the Communist Party. Political preferences took priority over objective and professional criteria and influenced decisions in resource allocation, organization of health services, and planning of manpower.
6. Economic incentives were eliminated under a wage structure with barely differentiated, fixed salaries. This situation gave rise to a grey market (various forms of under-the-table payments, gifts, etc.).
7. There was an absence of any modern system for evaluation of quality and efficiency in healthcare.
8. Technical equipment and infrastructure were out-dated and obsolete. Only very limited imports of advanced health equipment or foreign drugs were allowed.
9. Motivation of health personnel deteriorated, and they ceased to identify themselves with the healthcare system as a whole.
10. Health promotion was implemented directly, but achieved unsatisfactory results.
11. Progress was measured by quantity rather than quality and/or efficiency.
12. Due to the dogma of "cost-free" healthcare, neither individual nor social values of health, nor the necessary expenditures for health maintenance were sufficiently appreciated.

2.5 How Problems Were Understood by Various Parties: the Government, Providers, National Experts, and International Observers (WB, WHO, etc.)

Although in 1990 there was a broad consensus that the healthcare system needed reform and that changes were inevitable, the views on the principles, character, extent, depth, and tempo of reform differed from the beginning. Only several principles relevant for reform were clear and broadly accepted:

- healthcare free of charge at the point of delivery
- free choice of physician and healthcare facility
- decentralization of decision making
- high degree of autonomy for healthcare facilities and healthcare providers
- greater role for communities and municipalities[9]
- enhanced primary care and the role of general practitioners.[10]

The second reform draft—the *White Paper*—approved by the government in December 1990, signaled a more radical way of change, and several experts working on the previous document (the *Yellow Paper*) refused to support it. Neither in the government itself could a 100 percent consensus be reached, and very soon discrepancies appeared between the government and Parliament and between the government and providers.

When the new system of healthcare came fully into practice (on January 1, 1993) it fixed the permanent heterogeneity of views. Besides the government there were other powerful players: the GHIF and representatives of providers, particularly the Medical Chamber. Covert or overt power struggles among these major partners in health policy continued up to the year 2000. The different views of the center-right coalition governing from 1992 to 1997 often played an important role both in the government and Parliament.[11]

The views of the providers' representatives soon began to diverge, consequent to the different interests of various groups (hospitals, ambulatory specialists, GPs, etc.); among these groups the position of GPs was rather weak.

The views of national experts were also far from homogenous, although in the first half of 1990s they were not numerous and most were collaborating with the government to some degree. However there was a time when the MoH did not trust any external specialists, claiming they were unnecessary. Consequently, some joined other major players, e.g. GHIF or the providers' representatives.

Examples of important controversial issues in reform:

- health insurance in itself (versus a kind of NHS); particularly its rapid and poorly prepared implementation and the high share of the financing from insurance funds (versus multi-source financing)
- fee-for-service remuneration schemes for all kinds of services—both due to principle and due to the system's lack of caps and regulations
- extensive privatization, particularly in ambulatory services
- overspending, overproduction, and over-utilization of services and proposed cost containment mechanisms
- the position of GPs as "gate-keepers" versus free choice and access to secondary care
- definition (in extent and content) of an essential guaranteed package of health services
- the plurality of health insurance funds and proposals and the variety of insurance plans in the public sector

In many cases presented here, "heterogeneity of views" reflects different economic motivations: e.g. providers' representatives pushed for steps that would put more money in the health sector and strengthen the autonomy of providers, while objecting to limits and regulations. The government, particularly in the first half of the 1990s, sought similar but less radical measures, while the majority of specialists warned seriously against such steps.[12]

The role of external (international) participants was marginal. The World Bank loan—offered in 1991 and requiring oversight of the reform process—was rejected by the government.[13] Neither was there political will for a greater involvement by the

WHO.[14] Programs of bilateral collaboration (e.g. with the United Kingdom, the Netherlands, and the United States) provided some expertise and experience in certain areas, but they did not substantially influence government policy and the main course of reform. The same can be said about PHARE-funded projects and the NERA (National Economic Research Associates) country study in the second half of 90s (Hoffmayer 1994).

Some foreign specialists lacked sufficient knowledge about the Czech healthcare system and about the country's level of development and needs, often not differentiating the Czech Republic from much less developed Eastern European countries. Other visiting specialists (including from the WHO) made a positive assessment of the communist healthcare system and offered advice on what ought to be preserved. This was, of course, politically unacceptable.

3. REFORM

3.1 Analyzing Reform Objectives

The reform project of 1990:

The *White Paper*, which in 1990 established a basis for healthcare reform, summarized the main reform objectives as follows:

1. *The new system of healthcare will be part of a global strategy for health regeneration and promotion.*
   Health was not to be merely a matter for the health sector, but should be a priority for society as a whole. Health should be considered an important value during complicated, changing, and challenging social and economical circumstances; therefore individuals, families, and social groups were expected to understand the value of health and increase their motivation to adopt healthier lifestyles. An important aim was the introduction of a new system of healthcare as part of a comprehensive program of health promotion.
2. *Healthcare will be based on the free choice of well-informed citizens and communities.*
   This principle integrated many new, progressive, and nearly revolutionary ideas. An emphasis was put on principles of self-protection and promotion of health, self-care and care within families and communities, as well as on self-help groups, charities, and NGOs. Active participation of citizens in various bodies was encouraged through public initiative and control. This corresponded to broadly accepted ideas about individual responsibility, independence from the state, and the importance of civil society.

   In direct relation to health services, free choice of physician and healthcare facility were central principles. However, there was a presumption that some

rights and the participation of citizens would be derived from paying obligatory health insurance contributions and through optional, additional insurance, or direct payment for some services.

3. *The state will guarantee adequate healthcare to all citizens.*
   State guarantees were intended as part of the social security of citizens in a changing society. They included accessibility, equity, free care at the point of delivery, and a human approach. The term "adequate healthcare" presumed that an essential package of services would be defined. As it was expected that the cost of care would rise, state guarantees also included an ultimate guarantee of financial sustainability for the healthcare system.
4. *Monopolies on formulation, implementation, and control of health policy will be broken up and decentralized, and competition will be introduced in health services.*
   This objective was based on the following principles:
   - State control will be delegated to health insurance funds, professional organizations, and elected community and city councils.
   - Much of the competence of the MoH will be decentralized to district authorities.
   - Huge district and regional complexes, such as the DINHs and RINHs, will be abolished and dissolved into individual facilities that will form an essential element of the new system
   - Individual health facilities will be legally and economically autonomous, and due to patients' choice they will compete for service provision (see also item 8).
5. *Every community shall implement the principles of the state health policy in its territory*.
   The broadly accepted conviction that self-governing communities and towns (suppressed by the previous regime) should and will play a big role in the new society came to bear on the health sector as well. The key role was assigned to future "Councils of Health," in each community or municipality. Communities and towns also ought to ensure "adequate" services for their population by providing or contracting with their own facilities.
6. *Every citizen will have the right to choose his physician and healthcare facility.*
   This was intended to:
   - Essentially change the doctor-patient relationship from dependence and subordination to partnership based on confidence and mutual interest.
   - Introduce economic stimuli into the system (on the principle that "money follows the patient") and promote competition, leading to higher quality of services.
7. *The monopolistic position of state health services will be abolished. The prevailing form of healthcare provision will be "public" health services*.

This meant that healthcare would be accessible to the public based on public financing and would not be determined by ownership of health facilities, which might be either private or communal (municipal), by the church or the state.

8. *A basic element of public healthcare will be autonomous healthcare facilities*.
   Legal and economic autonomy, in contrast to the management of DINHs and RINHs, will promote flexibility and responsibility. Regardless of their ownership, they will be obliged by law to provide care for the public, if publicly financed (see also point 4).
9. *Therapeutic care will be particularly focused on primary healthcare and ambulatory care in general*.
   In a broad sense, "healthcare" included health promotion, preventive care, therapeutic care, and rehabilitation. All these subsystems ought to be interconnected, as they jointly affect the health of the population.
   In "therapeutic care," there was an objective to meet a WHO recommendation to transfer care as much as possible from hospitals to ambulatory care and, within the ambulatory sector, from ambulatory (non-hospital based) specialists to GPs.
10. *Healthcare will be financed from different resources*
    This will include obligatory insurance funds, the state budget, community resources, enterprises, citizens, etc.
11. *Obligatory health insurance will form an indispensable part of the healthcare system.*
    Compulsory ("social") health insurance was described not only as a "valuable social program" but as the "best way of financing health services," which—
    - protects the interest of citizens
    - motivates them to pay more attention to their health
    - stimulates providers to provide effective services.

    Insurance contributions were designed as individual and income-related, while the state would be obliged to pay contributions for children, pensioners, and the unemployed.

3.2 Analyzing the Implementation Process

Implementation of the 1990 reform was planned in five parallel but mutually linked lines:

1. *Establishing new bodies and institutions*
   The new pluralistic system required major partnership with the government in formulation and implementation of health policy by:
   - district health authorities
   - communities and municipalities

- health insurance funds (for the first period, a single fund with district branches was intended)
- professional organizations (medical, dental, pharmaceutical) and other bodies representing providers (e.g. hospital or GP associations).

2. *Changes in the structure and organization of health services*[15]
   - dissolution of RINHs and DINHs
   - legal and economic autonomy for individual health facilities, hitherto components of RINHs and DINHs
   - formation of a territorial network of health facilities.
3. *Changes in financing*
   - changes to budgetary rules of health facilities (a necessary measure with regard to their autonomy)
   - establishing a multi-resource system of financing
   - introduction of compulsory (social) health insurance.
4. *Changes in property structure*
   - transfer of partial ownership of health facilities to communities and municipalities
   - partial privatization, particularly in ambulatory services, pharmacies, technical services, etc.
   - establishing rules for the foundation of new facilities in the non-state sector.
5. *Changes in professional education*
   - introduction of new curricula with regard to these priorities: professional training for primary healthcare, attention to health promotion, prevention and rehabilitation, knowledge and skills in humanitarian sciences and psychosocial disciplines, modern management, ability to use information, language skills
   - ending monopolies of postgraduate studies (i.e. programs to be run by universities rather than the MoH institutes).

As for the timetable, all these changes were planned for two years only (1991 and 1992) and all crucial steps were actually implemented in this period. The reform of the healthcare system was later seen as a “big bang” with a subsequent period of stabilization. This was already reflected in the *Yellow Paper*: “It will probably take three or four years before the new system will be stabilized and another three years to be really efficient. However, the changes cannot be postponed. The basic steps can and must be done in the next two years” (Potucek et al. 1990).

Prior requirements were that the system in transition would not have to lose its elementary capability to provide healthcare, and would avoid any threat to the health and lives of citizens. To minimize risks of rapid changes, measures were planned as follows:

- Each reform step was prepared and tested in local and regional pilot projects.
- Information was disseminated to the public with the aim of building consensus.
- Implementation of prepared steps was to be carried out without hesitation, as any delay would increase discontent and decrease confidence both of citizens and health workers.
- Special interest groups cooperated in order to prevent negative tendencies and enforcement of partial interests.
- Existing institutions were not abolished unless and until their necessary functions could be ensured otherwise.
- Working and living condition of health workers were improved, and their training and democratic participation in the new system was assured, thus preventing emigration or departure from the health sector.

With arguments, excitement, and problems, but also spontaneous activity and collaboration among major parts of the health sector, the 1990 reform scenario was fulfilled and the new system was roughly completed by 1993.

The first round of the reform: 1990–1994

In a short period of time, the former Soviet system of healthcare (the "Semashko model") was replaced by a European pluralist model based on social health insurance and public-private cooperation in provision (the "neo-Bismarckian model").[16]

A. New institutions and organizations were established that participated in the development and implementation of health policy. The General Health Insurance Fund (GHIF) was established, and, after it, another 26 health insurance funds appeared in the field. Professional organizations were created by law (a Chamber of Physicians, Chamber of Dentists, and Chamber of Pharmacists). Simultaneously, other influential associations of different health service providers (general practitioners, ambulatory specialists, hospitals, home care centers, etc.) emerged. Regional and District Institutes of National Health (RINHs and DINHs) were abolished, and numerous healthcare facilities obtained their economic and legal autonomy.
B. The state guarantees health services particularly through the health departments of the district authorities. These departments are headed by district health officers.
C. De-monopolization and decentralization was introduced, and many health service providers were privatized, especially in the ambulatory sector.
D. Provision of healthcare was separated from financing. Obligatory health insurance was fully implemented in 1993. Health insurance funds remunerated providers on a fee-for-service principle. Some investments in hospitals, a part of the emergency health services and hygienic services were financed by the state budget (partially through district authorities).

E. Citizens could freely choose physicians, hospitals, and health insurance funds. The state guaranteed equal access to a relatively broad range of health services to every citizen.
F. In 1993, the government accepted the National Health Program as the basic document for further development of health promotion and primary prevention.

Reforms happened quickly after its infancy, and with relative success, although it was not entirely in conformity with the original intention. The proposed multi-source financing was not sufficiently developed: the greater part of healthcare expenditures were still covered by insurance contributions and community shares are still relatively small. Primary care has not been fully appreciated and has been less utilized and funded than in Western Europe. On the contrary, the cost of expensive, specialized ambulatory care and hospital care has become increasingly disproportional.

After 1992, there was a strong effort to privatize a maximum number of health facilities, including hospitals. Nevertheless, the intention to privatize hospitals was also unsuccessful. Regulatory measures were not applied quickly enough and the numbers of critical-care beds were not sufficiently reduced. Most large and university hospitals fell into serious economic difficulties.

Many problems could have been and were foreseen; however, they were not prevented in time. Since the first government paper on healthcare reform was submitted in 1990 (the application of which should have ended in 1993) no other comprehensive study was developed that would define targets for Czech healthcare and/or include a program for implementation – until recently. Therefore, the new healthcare system represented a set of partial, sometimes contradictory intentions rather than a gradually implemented conception. Although simplified, organizational charts 2 and 4 in the appendix give an idea of post-reform healthcare provision and financing.

The second round of reforms: 1995–1997

Instead of stabilizing, the new system encountered many serious problems in the mid-1990s. They were caused by several factors:

1. A high number of health funds competed against each other and with the GHIF—many of these small or medium funds came soon to the verge of collapse, which transferred financial difficulties to healthcare providers.
2. The open-ended, fee-for-service remuneration scheme, which motivated providers to overproduce services, stimulated supply-induced demand and drained insurance funds.
3. Spending for new medical technology and drugs was excessive.
4. Privatization costs were covered by health insurance.
5. Oversupply and redundancy of services in secondary care (both ambulatory and bed care).

Financial crisis in the health sector stimulated an initiative by the government. In December 1995, the MoH launched a new program with measures and steps for the short-, mid-, and long-term horizons. The objectives were as follows:

1. Short-term: use administrative measures to stop spiraling costs.
2. Mid-term:
    - Implement cost containment mechanisms through contracts between health funds and providers.
    - Change the remuneration scheme: implement capitation payments for GPs and service-based functional budgets for hospitals, while FFS was to be kept only for ambulatory specialists.
    - Define the "gate-keeping" position of GPs, and limit free access to secondary care (e.g. with a by-pass fee).
    - Limit the guaranteed package of care; form a space for additional (private) insurance; introduce more co-payments.
    - Rationalize the network of health funds (i.e. decrease their number).
    - Stimulate the "sleeping" privatization of hospitals.
    - Rationalize the network of hospitals (i.e. decrease their number and number of beds).[17]
    - Launch a program of quality assurance.
3. Long-term:
    - Continue to change remuneration schemes and implement a case-based payment for hospitals and ambulatory specialists.
    - Transfer payment of insurance contributions for people without income from the state to the respective individual (if possible by increasing social benefits and pensions) or employed family members.
    - Change the system of social health insurance (several alternatives were offered: a variety of insurance plans, optional private insurance, medical savings accounts, pre-paid care, or coexistence of all these models).

In the next two years (1996–1997) the government succeeded in stopping spiraling costs and implementing—at least initiating—other planned steps: cost containment measures through contracts between health funds and providers; changes in the remuneration scheme, and program of quality assurance. Also many collapsing health funds were closed. However, the whole reform project remained incomplete and then was stalled completely by the political crisis in the fall of 1997.

Looking back, the practical impact of the second round of reforms in the health sector was more in financial stabilization than innovative steps. After the 1998 parliamentary elections, the reform objectives, proposals, and ideas were abandoned, with of the quality assurance program the only exception. The next push for reform was not expected until the reform of public administration in 2003 (see section 3.3).

3.3 Redistribution of Powers and Responsibilities in Decision Making and Administration: Administrative Decentralization, Devolution, Delegation, and Providers' Autonomy

Redistribution of powers and responsibilities was a substantial feature of the reform process in the health sector. The general trend of decentralization in a broader sense is specified here according to the following definitions:[18]

Administrative decentralization (de-concentration): decision making is transferred to a lower administrative level. The rationale for this type of decentralization is that the need for central administrative bodies can be reduced and local innovations can be easily implemented. The expected effect is increased effectiveness due to a frontline approach to problems and opportunities.

Devolution (political decentralization): decision making is transferred to a lower political level. Devolution brings about more local decision-making power; therefore it can facilitate local innovations.

Delegation: tasks are allocated to other actors, with the potential advantage of faster implementation and greater productivity.

Privatization: tasks are transferred from public to private ownership in order to make activities free from political (or administrative) dependence, more flexible and innovative. On this type of decentralization see more in section 3.5.

3.3.1 Administrative Decentralization (De-concentration)

In the first period, the DINHs and RINHs were dissolved and the health facilities obtained a high degree of legal and economic autonomy. The central health administration was incorporated into the District Authorities (DAs) in the form of health departments headed by District Health Officers. District Health Officers were not directly managed by the MoH, but were only under methodological guidance and supervision of the MoH.[19]

DAs were charged with assuring the state guarantees in health services and "adequate healthcare" on their territories. Among other things, they had the competence to approve foundation of and register new health facilities.

Nevertheless, the real executive, controlling, and financial power of the DAs in healthcare issues was rather vague, and limited by the high degree of autonomy of providers and health insurance funds (HIFs). DAs appointed directors of district hospitals and of other facilities belonging to the state network, and they could allocate some resources to them from the district budget (e.g. for investment). DAs were also responsible for organizing First Aid Medical Care. In the area of contracting services, DAs were empowered (by the 1997 Act on Public Health Insurance) to proclaim and

conduct tenders for contractual partners of HIFs but HIFs were not obliged to respect the result of these tenders.

Consequent to the reform of public administration, DAs were abolished by 2003.

3.3.2 Devolution (Political Decentralization)

The 1990 reform draft put a great emphasis on devolution to self-governing communities and towns (see sections 2.5 and 3.1). This reform objective was subsequently almost completely abandoned, and devolution has come back onto the agenda only after a decade, with the reform of public administration.

There were two important steps:

1. The formation of regions (13 in the country + the capital city of Prague as a special region)—in principle self-governing territories with elected assemblies and councils, but also performing tasks decentralized from the central administration (by 2001).
2. The abolition of district administrations and authorities (by 2003) which meant the transfer of competencies from 76 district authorities to 205 "commissioned communities" (usually the 76 former district towns and another 129 smaller towns) but also upwards to Regional Authorities (RAs)[20] (see section 1.1 as well as Chart 7 in the appendix.).

While the reform of public administration deeply affected many areas of public life, its impact on the health sector was insubstantial, particularly in terms of decentralization. As part of the first step, six health facilities (two big hospitals and four smaller institutions) were transferred from the MoH to respective RAs. However, after abolishing district administration, another seven health facilities (all larger mental hospitals) were transferred to the MoH.[21] All district and smaller hospitals and other health facilities administered by DAs (1,100 in total) were transferred to RAs along with other competencies in healthcare (see Charts 4 and 5 in the appendix). Communities and municipalities were not empowered again, and overall the process has seen more re-centralization than decentralization.

A double role and double competence for regional authorities (self-governing as well as "transferred" in the sense of decentralized central administration) has complicated the health sector. Hospitals are owned and run by regional authorities through self-governments,[22] while competencies for registration of non-state facilities, tendering contracts with HIFs, and other duties were transferred (see Charts 5 and 7 in the appendix). This double model of public administration existed in the city of Prague for a long time, and may prove viable in the new regions as well.

3.3.3 Delegation

As for delegation, there were three substantial steps launched just in the early years of the reform (1991–1992) linked with the abolition of the state monopoly in the health sector (see also sections 2.5 and 3.1).

1. *Delegation of Professional Control Over the Medical Profession and Quality Assurance in General*

Professional chambers (of physicians, dentists, and pharmacists) were established by the law in 1991. The chambers are mandated to support and control their respective "independent professions." They are expected to guarantee quality of healthcare through enforcing professional standards for doctors and pharmacists; they grant licenses necessary for the registration of healthcare facilities with the public administration, and they address complaints from patients. Membership in these chambers is obligatory even for professionals employed by state/public services.

Other health professions (nurses, psychologists, rehabilitation workers, etc.) are not "independent" in the sense of chamber legislation but they play a similar role in professional issues as "advisors" to public administration. Major associations of providers (of hospitals, GPs, and independent doctors contracted by HIFs) are by law involved in central negotiation processes among HIFs, providers, and the state. The Czech Medical Association (an umbrella organization for medical chambers) in cooperation with the Czech Medical Chamber, has been developing standards and guidelines for diagnostic and therapeutic procedures since 1997.

Delegation of professional control has been only partial, as the state is perceived by the public (and desires to be perceived) as the ultimate guarantee of quality care. Therefore some delegation and consequent responsibilities have been matters of debate. Particularly, the Czech Medical Chamber has presented itself as a strong partner to the state.

2. *Delegation of Healthcare Financing*

The state founded the GHIF in 1992, but 26 other branch or regional health insurance funds were are also operating there in the health sectors. Due to financial instability, their number decreased to 11 in 1997 and 8 in 2003. Patients are free to choose each of them, as HIFs have to be open to everybody without limitation to any special branch or territory. All HIFs are obliged to provide the same coverage under the same conditions as guaranteed by the GHIF. They have the right (not the duty) to contract providers.

Delegation of financing has not been total (some share of state and local budgets is in capital investment) but very substantial. HIFs administer a high proportion of health expenditures—namely the GHIF as a major fund (covering 70–75 percent of the population) has been in some sense more powerful than the government.

3. *Delegation of Healthcare Provision*
The 1992 Act on Non-public Provision of Healthcare abolished the long term state monopoly, opening doors for providers in private, communal/municipal, church, or NGO sectors.[23] This delegation was a key act in the whole reform facilitating the way to the pluralistic system. More about it also in the next section.

3.3.4 Functional Decentralization and Providers´ Autonomy

Functional decentralization in the system of care provision began (in 1991, i.e. at a very early stage of the reform process) as a decomposition of the former RINHs and DINHs. This did not mean only administrative abolition of RINHs and DINHs and autonomy for hospitals with polyclinics. Particularly polyclinics were often deconstructed into autonomous practices that were later privatized.

The delegation of healthcare provision mentioned above (often called "privatization of provision") and also the delegation of financing, which separated financing and delivery of healthcare, contributed substantially to the processes of functional decentralization in the system of care provision and formation of the network of autonomous health facilities.

Also, many physicians established private practices outside the former polyclinics. All independent providers work under contracts with health insurance funds. "Private" in this sense thus means "private provision with public financing."

The total (rounded) number of health facilities increased in 1995 to 23,800. There were 1,300 state-owned, mostly bed-care facilities, from which 220 were run by the MoH and 1,100 by the DAs. Of the 22,500 non-state health facilities, 500 belonged to municipalities and 22,000 were private, 17,000 of the latter were single doctor practices. This has not changed significantly since that time.

3.4 Major Players' and Stakeholders' Roles, Interests, Contributions, and Mutual Cooperation

3.4.1 Major Players and Stakeholders in the New System of Healthcare —their Roles, Interests, and Contributions

1. *The Ministry of Health*
In the new system of healthcare designed in 1990, the MoH was not expected to play a dominant role. As mentioned elsewhere, after decades of strong state control, there was a

general tendency rather to diminish the role of the government and its ministries. In the health sector itself, the vision of a pluralistic system did not allow the MoH any role in health policy greater than that of one partner among many. Of course, the MoH ought to have an unavoidable role in the legislative process and it was also expected to be an institutional leader of reforms, but more in the sense of coordination than of directive management. Its role in direct administration was expected to be marginal.

The following should illustrate the development from vision to reality: After abolishing the regional administration in 1990, the MoH administers about 220 institutions, i.e. much more than before (see also section 3.3). This burden, together with new administrative agendas (privatization, control over HIFs), lack of expert capacity (and, in some periods, even a reluctance to listen to expert opinion), political discontinuity, and other factors contributed to the difficulties for the MoH in finding its appropriate position in the new system.[24] Often it failed both in its role in the legislative process and as an institutional reform leader. On the other side, in spite of being problematic and unpopular,[25] the MoH was able to resolve several critical situations (spiraling costs, medical strikes, etc.) and, if necessary, to act as an ultimate guarantee of accessibility and quality of care for the public.

2. *The General Health Insurance Fund*

The GHIF was established by the 1991 GHIF Act. Due to its dominant position among other HIFs,[26] the GHIF had real financial and political power, but often acted as an opponent to the MoH in political struggles. This was particularly obvious in the period of 1993–1995, when the GHIF was reluctant to share data with the MoH or implement cost containment measures recommended by the MoH; on the other hand, MoH policy often ignored the GHIF. In the first several years of its existence, the GHIF was predominantly occupied by developing its organizational structure (about 100 district- and sub-district branches) and its information system, and it behaved more as a passive financier of services than as a prudent purchaser. This changed in 1996, and since that time the GHIF has been managing its finances and its contractual policy cautiously. The major contribution of the GHIF is in maintaining the financial stability of the health insurance system and insurance-funded services: in spite of serious difficulties from 1995 to 1997, the system never came to such an imbalance that it would jeopardize the health needs of the public.

3) *Professional chambers*

Professional chambers (of physicians, dentists, and pharmacists) were established by the 1991 Chamber Act. The act itself was a matter of discussion between the government and Parliament.[27] The government took issue with the law because it attributed power to the chambers without clear responsibility. Also, obligatory membership in chambers even for professionals employed by the state or public services violated government

policy. However, Parliament, with the "white coat" lobby behind it, voted in favor of the law, leading to lasting tension between chambers and the government. Chambers were mandated to perform professional control over the "independent" professions—to guarantee quality of healthcare through appropriate professional standards for doctors and pharmacists, and to provide licensing for the registration of non-state facilities and single practices. With the exception of the latter, the professional responsibility of the chambers did not become visible or transparent until much later. Instead, chambers were active in advocacy of professional interests, often behaving as a kind of trade union. A decade passed before the mandate for professional control and quality guarantees were fulfilled (see charts 4 and 5 in the appendix).

4) *Independent providers and their representation*

The high degree of provider autonomy and the abolition of the state monopoly in care provision also determined the position and power of independent providers and their representatives. Major association of providers (of hospitals, GPs, and independent doctors contracted by HIFs) together with professional chambers, formed a strong lobby, which often played a dominant role in the health sector. The pressure for special interests[28] was involved in reform implementation, backing some steps and blocking others. The fee-for-service remuneration system, the Chamber Act, and privatization were pushed ahead, while cost containment measures, budget capping, contractual volume limits, rationalizing of services, and attempts to implement state quality standards were blocked and rejected.

5) *Consumer representation*

The idea of more room for "consumer voice and choice,"[29] met with many misunderstandings. Medical chambers usually declared that they were speaking and acting on behalf of patients. The involvement of the public in HIF boards and hospital advisory bodies was rather symbolical. Initial reform ideas of "health councils" and an important role for local communities in the healthcare system were abandoned. As in other sectors, there was no political support for any form of a direct democracy, and the opinion that citizens ought to assert their interests only through elected political representation prevailed.

It was many years before a consumer association was established, and when it was, it was rather militant for a time, blocking and criticizing many reasonable measures as attacks on consumer rights and claims. The legal platform for consumer advocacy was given as late as 1997 by the new health insurance law—consumer representation then became a partner in the central negotiation process among HIFs, providers, and the state.

3.4.2 An Overview of Pluralistic Decision Making (Representation in HIF Boards, the Central Negotiation Process, etc., As Legislated by the 1997 Health Insurance Act)[30]

To illustrate previous the previous section, here is an overview of pluralistic decision making in practice: (1) composition of boards of health insurance funds, (2) partners in negotiation about guaranteed basic services and prices, (3) partners in the mechanism relevant for the elementary network of services and facilities.

1. *HIF Boards (see Charts 4 and 5 in the appendix)*
   a) Central board of the GHIF
      - one third: representatives of the government delegated by the MoH, the Ministry of Labor and Social Affairs (MLSA), and the Ministry of Finance (MoF)
      - one third: representatives of employers, nominated by representative organizations (e.g. the Industrial Chamber of the Union of Trade and Industry [ICUTI]) and approved by Parliament
      - one third: representatives of employees and other insured parties, approved by Parliament.

   b) Local (district, regional) boards of the GHIF
      - one half: representatives of employers, nominated by ICUTI
      - one half: representatives of employees and other insured parties, approved by the District Assembly before 2000 and the Regional Assembly after 2000 (representation of public administration is missing at this level).

   c) Boards of other HIFs (branch or regional)
      - one third: representatives of the government delegated by the MoH, MLSA, MoF
      - one third: representatives of employers, nominated by ICUTI and approved by Parliament
      - one third: representatives of employees and other insured parties, approved by Parliament.

2. *Central negotiation mechanisms*
   a) Negotiation on the list of items of care (list of procedures):
      The list is an essential document for two reasons:
      - It includes a precise itemization of guaranteed basic services, which the law defines only generally.
      - It describes conditions for providers for individual items of care, and attributes to each item its value in "points," which determine remuneration.

b) Negotiation partners:
   - The GHIF and other HIFs
   - professional chambers
   - associations of providers (hospitals, GPs, contracted doctors)
   - scientific societies (usually branches of the Czech Medical Association)
   - associations of the insured (consumer representation—new in 1997).

   The MoH itself is not involved in the negotiation process, but it has to review the results from the viewpoint of legal aptness and public benefit, before it is officially published.

3) *Public tenders for care provision*

Public tenders for care provision did not exist before 1997. They were implemented in order to improve the contractual policy of HIFs, to encourage transparency, and promote public control. Public tenders were intended as a tool for maintaining and regulating an elementary network of health facilities. In general, tenders for hospital care are issued by the MoH, tenders for ambulatory care by the district before 2000 and the regional authorities after 2000 (see also chart 4 in the appendix).

Members of the tender commission are as follows:
- a delegate of the MoH or the respective regional authority
- a delegate of the respective professional chamber
- a delegate of the respective HIF
- an expert in the kind of healthcare in question.

Local community and consumer representation have no place in the commission even if the subject of tender is closely linked to local needs. Moreover, the impact of a tender can be only symbolic, as HIFs have contractual freedom and are not obliged to respect the result of the tender.

3.5 Privatization of Provision and Redistribution of Healthcare Infrastructure Property

The 1992 Act on Non-state Provision of Healthcare abolished the state monopoly on care provision, opening doors for providers in private, communal/municipal, church, or NGO sectors. Delegation of care provision was a key act in the reform process (see also section 3.3). In fact, it facilitated provision in the private sector (which has developed extensively in ambulatory care) while providers in other sectors (communal/municipal, church, or NGO) have remained marginal. This makes “privatization” an adequate term for the process.

Privatization of provision was promoted by separating care delivery from care financing, and by contractual competencies of new HIFs. The great majority of independent providers were working under contract with health insurance funds. "Privatization" in this sense meant development of "private provision–public financing" (Barr 2004).

Privatization of provision followed soon after the decomposition of the former RINHs and DINHs. This did not mean only administrative abolition of RINHs and DINHs and autonomy for hospitals with polyclinics. Particularly polyclinics were often decomposed to single practices that were later privatized. Private contractual doctors rented rooms in former polyclinic buildings usually transferred to communities or towns or still state-owned.

Privatizing a building, which was then rented by a group of doctors or another party, was another method of privatizing ambulatory care.

Physicians who lacked necessary capital to open new practices, rented equipment from the polyclinics where they had worked previously.

Other than these forms of privatization based on former polyclinics, many physicians established private practices in rooms rented elsewhere or even in their family houses.

At present, the majority of primary care providers (95 percent) and ambulatory specialists (74 percent) are private in the sense mentioned above (private provision–public financing[31]). Single practices are a dominant form of private care delivery in the ambulatory sector. Joint or group practices, centers with a group of closely collaborating private doctors, or even private centers employing doctors and other medical personnel are rather exceptional. At present 26 percent of (mostly highly) specialized ambulatory care is delivered in state, regional, and municipal facilities, mostly hospitals.

After 1992, there was also a strong political effort to privatize hospitals. Nevertheless, it has been unsuccessful. Hospital privatization met with serious political as well as financial obstacles. There are only about 10 small, private, church- or NGO-owned hospitals in the country with less than 2000 beds (3 percent of total capacity). Debts and lack of municipal finances for capital investment were the main reasons that municipalities were not eager to take over hospitals on their territory, even free of charge. At present, only 29 (14 percent) of towns and municipal hospitals with 5,700 beds (8.5 percent) (see also Table 3.9.1. on page 48 and Chart 6 in the Appendix). After the Social Democrats came to power in 1998, the intention to privatize hospitals was abandoned. Thus, the major changes in property ownership in the hospital sector were mere administrative measures in the recent reform of public administration, when hospitals were transferred from abolished districts to regions.

Pharmacies and health resorts are predominantly private. The pharmaceutical industry was privatized during the 1990s, and market mechanisms control supply and demand.

3.6 Changes in the Funding System; the Introduction of Social Health Insurance; Multi-source Financing; the Role of the State; Communities, Municipalities, and Other Customers

3.6.1 Economic Performance and Health Expenditure

The level of financial resources allocated to health depends to a large extent on the economic performance of the country. It is important, then, to know that the economic performance of the Czech Republic is relatively high in comparison with other post-communist countries, but it is still substantially lower than the performance of other EU countries. During economic transformations, gross domestic product decreased and gradually regained its original level only in 2000 (Table 4). However, one must consider the changing quality and structure of the GDP. Economic analysts and politicians are now admitting that the Czech economy will not reach "Western" levels in the short period optimistically expected in 1989. The economy has remained burdened for longer than other transition countries with a large number of poorly performing enterprises, kept alive by soft loans from state-dominated banks (OECD 2003).

Existing difficulties in the national economy undoubtedly affect the whole health sector. This means that resources allocated to health will be not sufficient to finance higher (i.e. West European) quality health services. The health system has faced the task of maintaining complex and quality healthcare amidst a worsening economic situation. In spite of that, the quality of service improved without threatening equity. The health system was under-funded during communism, which changed in 1993 with the introduction of health insurance. From that year on, the growth of health expenditures is more or less in line with the economic development of the country. Health expenditures have reached common European proportions (7–8 percent of GDP—see Table 4). Public health expenditures as expressed in statistics do not include health expenditures outside the health sector (e.g. military); therefore the real numbers may be slightly higher. Private payments are seen as a complementary resource, not reaching 10 percent of total health expenditures. Private insurance has been insignificant.

Until 1992 health services were financed from the state budget (see Chart 1 in the appendix). Health budgets were determined centrally and distributed downwards through the administrative hierarchy with its political priorities. Entitlement was based on citizenship with minimal cost-sharing. The system was equitable, but obsolete by Western standards, with low responsiveness and low efficiency. The introduction of health insurance was a main part of the radical transformation of the health system.

Illness benefits are not paid by health insurance funds and employers, as in Germany, but from social security, which is also responsible for pensions, unemployment benefits, and other social benefits. Contributions and expenditures are part of the state budget.

Social insurance totals 34 percent of wages (26 percent paid by employers). Illness insurance contributions, part of social insurance, are 4.4 percent of wages.

Illness and health insurance are two separate systems—a fact often criticized. Illness insurance is the only social insurance in the country, which is not compulsory for the entire population. The self-employed may opt out and consequently not receive benefits during illness (see Charts 2 and 3 in the appendix).

There are also some differences between employees and the self-employed regarding health insurance contributions. The self-employed are still a matter of some confusion to public administration in general (see Table 4).

Table 4.

GDP and Health Expenditure, 1990–2002

Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
GDP : current prices (1990–100)	100	120.4	134.6	162.9	188.9	220.5	250.2	268.3	293.4	303.8	317.0	347.4	363.4
GDP : constant prices (1990–100)	100	88.4	87.9	88.0	89.9	95.3	99.4	98.9	97.6	98.0	101.2	104.4	106.4
GDP per capita based on exchange rate in US$	3,367	2,479	2,886	3,387	3,976	5,035	5,597	5,142	5,529	5,305	4,943	5,548	6,822
GDP per capita in purchasing power parity in US$	11,262	10,370	10,875	10,806	11,269	12,205	12,995	13,161	13,175	13,553	14,277	15,194	15,813
Inflation	**9.8**	**56.6**	**11.1**	**20.8**	**10.0**	**9.1**	**8.8**	**8.5**	**10.7**	**2.1**	**3.9**	**4.7**	**1.8**
Total health expenditures (1 billion CZK)	31.3	39.5	45.6	73.1	86.4	100.7	110.7	118.9	129.9	134.9	142.1	158.8	163.9
Total health expenditures (as % of GDP)	4.99	5.24	5.42	7.16	7.31	7.29	7.06	7.08	7.07	7.15	7.25	7.40	7.4
Total health expenditures in PPP per capita in US$	562	543	589	774	824	890	917	932	931	969	1 035	1 124	1 170
Public health expenditure per capita in US$	540	525	562	734	790	825	848	855	856	887	945	1 026	1055
Public health expenditure as % of total health expenditure	96.2	96.7	95.5	94.8	95.9	92.7	92.5	91.7	91.9	91.5	91.3	91.2	90.2
Total in-patient expenditure as % of total health expenditure	na	na	na	na	na	29.6	33.8	35.6	35.4	33.9	34.6	36.6	39.3
Total pharmaceutical expenditure as % of total health expenditure	21.0	18.4	21.1	19.4	24.7	25.6	25.5	25.3	25.5	23.0	23.0	24.03	24.6
Salaries as % of total health expenditure	na	na	na	na	17.4	16.9	17.8	17.6	17.2	18.5	19.2	20.0	21.4
Public budgets (%)	96.2	96.7	24.3	17.8	16.0	15.0	11.4	9.6	9.1	9.7	9.6	8.6	8.7
Health insurance funds (%)	0.0	0.0	71.2	77.0	77.9	77.7	81.1	82.1	82.8	81.8	81.7	82.6	81.5
Private Expenditures (%)	3.8	3.3	4.6	5.2	6.1	7.3	7.5	8.3	8.2	8.5	8.6	8.6	8.3

Source: The Development of Financial Indicators of Economy and Health System until 2001, IHIS after; data from 2002 are estimates.

3.6.2 General Characteristics of Public Health Insurance

The government, already in 1990, approved the draft of the new healthcare system in the hope that it was possible to quickly overcome the shortcomings of the previous system. The government, therefore, decided very shortly after the fall of the communist regime to move the state-financed system towards a system based on obligatory health insurance. Transformation from a tax-financed system to health insurance was accelerated by pressure from health professionals, who expected improvements in their incomes. The GHI financed health services after 1992, but in that year the fund received money from transfer from state budget, not from insurance contributions. The public health insurance scheme was introduced fully on January 1, 1993.

There are three types of insured parties according to the type of contribution payment. For employees, the health insurance contribution is 13.5 percent of pre-tax wages (see Chart 2 and 3 in the Appendix). The contribution is divided between the employer, who contributes 9 percent, and employee, who pays 4.5 percent. The second category is the self-employed, who pay 13.5 percent of 35 percent of their net income before taxation, with upper and lower limits. For citizens without income (children, pensioners, the unemployed, women on maternity leave—forming over half the population) the state budget pays fixed monthly contributions, defined by law as 13.5 percent of the current minimum wage.[32] The whole population is covered by obligatory public health insurance, which assures access to a comprehensive healthcare package (diagnostic procedures, ambulatory and hospital care including rehabilitation and care for the chronically ill, prevention, drugs and medical appliances, medical transport services, other prescribed treatments). Medical care is covered from health insurance funds, while illness benefits are paid from the state-run social security administration.

Health insurance funds are legally autonomous public organizations, which collect contributions and purchase health services from their contractual providers. The GHIF was founded with the intention of covering the whole population. In 1992 the collection of contributions had not yet started, and the GHIF received money from the state budget. Later that year, Parliament approved an act that allowed the establishment of other, 'branch' health insurance funds. This initiative appealed to the tradition of plurality of illness insurance funds, abolished by the communist regime. However, the HIFs formed under this act differ from traditional employer-based funds, because they are open to everybody and compete with each other. Their number rose surprisingly quickly during from 1993 to 95. Funds were established by ministries (military, interior) and large industries (Skoda-Volkswagen, banks, mines). In 1995, there were 27 HIFs in operation, but this number decreased gradually for financial reasons to only nine funds in 2003. Citizens have a free choice of insurance funds and can change once a year. Despite the fact that many members left the GHIF for branch funds, the GHIF remains the major insurer, covering nearly three-fourths of the population in 2002.

3.6.3 Risk Adjustment and Problems of Coverage

In order to prevent risk selection among the insured and to protect funds with high risks from financial difficulties, insurance contributions are redistributed by a simple formula. HIFs keep 40 percent of collected contributions, and the other 60 percent along with all state contributions are subject to redistribution. This risk-adjustment scheme is simple, with a weighted redistribution dividing insured persons into two age categories: one share for individuals under 60, and three shares for an individuals 60 and over. A redistribution scheme of contributions indexed by age and sex has been developed and proposed, but not approved by Parliament. The GHIF with the highest proportion of pensioners and lowest income groups benefits most from the redistribution (see Charts 2 and 3 in the appendix).

Proposals for radical reductions to the healthcare package covered by public health insurance have not been successful. The introduction of individual "medical saving accounts," pushed ahead by former prime minister Vaclav Klaus, did not meet with broad political acceptance either. It cannot be expected that such radical reform measures would, even in the future, threaten the financial accessibility of the health services or disadvantage the poor. Solidarity with the ill and equal access to healthcare are highly valued in Czech society. Nevertheless, the financial sustainability and over-utilization of certain services are strong arguments for some regulatory out-of-pocket payments. The appropriate design of such policies and its political support are not, however, easy tasks. With improving economic conditions, higher income groups will surely demand a higher quality of healthcare and more comfortable way of service delivery (private accommodations, no waiting, etc.). Such demands could be satisfied through improved performance of the public system, or if not, the space for private medicine has to be opened.

3.6.4 Development of the Institutional System and Its Relations to the State

The reality of health insurance in its first years showed that there were serious drawbacks in the regulation of funds—the naive liberalism of reformers had negative results. Some insurance funds behaved more like private companies than organizations mandated to protect public interest. Accountability was vaguely defined, which made it difficult for state authorities (the MoH and the MoF) to efficiently control use of public resources. Unrealistic expectations and plans, managerial failures, and missing regulations led to financial problems with several funds. The funds were abolished, in which case their members automatically became members of the GHIF, or merged with financially stronger funds. The power of the government over the health system increased; one may even

observe a trend toward re-nationalization of the health system. It should be noted that governance in Czech funds significantly differs from traditional self-governing systems of insurance funds in Germany, Austria, or the Netherlands. In the Czech Republic, the boards of trustees, which consist of representatives of the insured, employers, and the state, are not elected but appointed. The power of the board is rather weak, and therefore management accountability may be questioned.

The initial idea was that funds would compete through the spectrum of reimbursed above-standard services. As insurance contributions are set by law, price competition is not possible. We may consider this an experiment with a type of managed competition. At the beginning, the different above-standard services were offered by funds in competition for new members. Such behavior was necessary for newly established funds to attract customers initially covered by the GHIF. Later, it became evident that many funds did not have sufficient resources to cover basic healthcare services. Subsequently, in 1994 reimbursement of above-standard healthcare was prohibited by law, and the space for competition among funds was narrowed even more by new legislation in 1997. The plurality of funds has not met expectations, and it would take a new legislative framework to prove a benefit from it. Currently, many critics do not see the reason for a pluralistic health insurance system and suggest keeping the GHIF as a single public insurer. The system of insurance funds is at a crossroads, but who knows which way to go?

3.7 Purchasing and Contractual Policy for Health Funds, Cost Containment Measures, Incentives, Resource Allocation, and Remuneration of Providers

3.7.1 1992–1997

After 1989, the integrated system of national health service was not seen as effective, and the separation of purchasing and provision functions was introduced. The responsibility for purchasing lies in the hands of health insurance funds. There are currently nine health insurance funds. The funds (until mid-1997) reimbursed contractual providers according to a fee-for-service scheme (the list of health procedures). This list sets the relative point values of items of services, while monetary values of points were initially set by individual funds. The point value of an item is calculated according to the estimated time required to provide the service. With thousands of items, it is an enormous task to set relative point values without discrepancies. Drugs and medical appliances were reimbursed according to the price list. With practically no regulation of volume of services and contracting with all providers, the fee-for-service system caused over-utilization, redundant medical tests, excessive capacity and cost explosion—unsurprisingly, this led

quickly to financial difficulties. Funds decreased the monetary value of points, which transferred financial problems to providers. In 1996 the GHIF introduced a division of its budget into separate "chapters" for different types of care (ambulatory care, hospital care, dental and medical transport, etc.) which became a standard. In July 1997 the MoH published a new list of health procedures with new corresponding point values. This list met with criticism both from providers convinced that the new point values would not cover the real cost of services, and from the funds, which argued that the collected insurance contributions will not be sufficient to cover the supposed volume of health services. Finally, the list was rejected and budgets were set.

3.7.2 After 1997

July 1997 saw the beginning of strict regulation and budgeting with the introduction of the national negotiation framework. Since then, the level of reimbursement has been negotiated between health insurance funds and organized groups of providers (hospital associations, unions of physicians, dentists, etc.) Total expenditures are divided among different sectors. The usual issues are the monetary values of services and the allowed growth of the expenditure ceiling. Individual funds may offer better reimbursements than agreed, but not less. GPs are paid by a mixed capitation/fee-for-service system (approximately 85-90 percent of their income consist of age- and sex-adjusted capitation payments, the other 10-15 percent is FFS). GPs appear quite satisfied with the capitation system and welcomed its introduction. Ambulatory specialists (AS) are paid by a FFS scheme with tight total time limits and expenditure ceilings, which for many ASs means budgeting. Dental services are reimbursed according to a price list. This is the least regulated sector, as dentists stay only within the total budget for dental services. This probably stems from the fact that dentists earn a significant part of their incomes from private payments for above-standard services and dental materials. Reimbursement for hospital services is based on a simple per-patient charge, with some regard to services provided. The GHIF ensures that hospitals cannot exceed the income from the previous year by more than a negotiated percent—a kind of budgeting device. Other funds use similar strategies; however, the smallest funds usually do not regulate hospitals with a marginal number of treated enrollees. Outpatient services delivered in hospitals are part of the hospital budget with the same reimbursement mechanism—per-patient charge with income ceilings based on the last period and agreed growth. Physicians working in hospitals are salaried employees. Long-term care institutions are paid per day with total expenditure ceilings. The reimbursement system may change every half year according to negotiations. If the negotiation is unsuccessful, as is often the case in the hospital sector, the government is obliged to set the rules.

The changes in the reimbursement scheme culminating in July 1997 formed an essential modification of incentive structure for health providers. The abolishment of the FFS system halted the tendency to over-utilization. On the contrary, with a more regulated reimbursement scheme, the motivation to minimize the volume and cost of services emerged. The negative results of budgeting are the rise of waiting lists in hospitals and at some ASs. This may open the door for corruption, bribery, and under-the-table payment. In spite of all the consequences mentioned here, there has been evidence that the 1997 measures did not have a negative impact on the health status of the population.

Per-patient payment based on DRG has been planned in hospital services since 1997. However, the real introduction of a DRG system was postponed every year for six years, so that expectations for its implementation in the near future have dimmed.

3.7.3 Resource Allocation

The IHIS estimates national health expenditures according to the type of financing (public/private) and type of service provider (see Table 4). These numbers may be a bit misleading, as hospitals provide extensive outpatient services, which are hidden in the chapter on hospital services. The structure of health expenditures and it dynamics are shown on data from the GHIF, which covers about 70 percent of the population. Many experts believe that resource allocation is somewhat biased to specialist and hospital services, whose share of expenditure is growing. Especially, the parallel network of specialists outside hospitals has been criticized. On the other hand, the share of primary care is still relatively low, although it has been suggested on many occasions that a shift towards primary care is needed. The decline in dental expenditures may be attributed to growth in out-of-pocket payments for these services. Probably the main problem in resource allocation is the share for pharmaceuticals. Expenditures on pharmaceuticals increased sharply during economic transition, part explained by the less favorable exchange rate for Czech currency. A rapid increase in the 90s is a consequence of large market liberalization, above all the liberalization of imports from Western countries. On one hand, this has had many positive effects on mortality and morbidity; on the other hand, such developments are seen as an important cause of financial problems. Introduction of the reference price list slowed down drug expenditures but did not solve the problem. On the provider side, the regulatory capacity of the government and health insurance funds has not been fully utilized yet. Controversial decisions by the MoH about reimbursements for certain drugs are regularly questioned by the public. On the consumer side, a 2003 OECD country review recommended the reduction of the number of reimbursed drugs, because many reimbursed drugs are usually paid out-of-pocket in other OECD countries. The current government promised not to increase co-payments, but under financial constraints it is changing its view.

Table 5.
The Structure of Expenditures of the GHIF (%)

Type of Provider	**1998**	**1999**	**2000**	**2001**
General practitioners	5.0	5.0	5.0	4.9
Dentists	6.2	6.1	5.9	5.6
Other outpatient care	10.3	10.2	10.6	10.3
Hospitals (including outpatient and long-term care)	49.3	49.2	49.3	49.9
Balneology	2.4	2.3	2.2	2.1
Transport and emergency services	1.5	1.7	1.7	1.7
Drugs and medical aids	25.3	24.8	24.2	24.3
Other	1.1	0.7	1.2	1.2

Source: General Health Insurance Fund.

As explained in the previous section, health expenditures of funds are divided among different providers' sectors during the negotiation process with providers. This measure might help contain costs in the short term, but it may become a significant barrier to shifting resources between providers' sectors in the long run. Given the power of providers on one side and the lack of leadership on the regulators side, one might expect resource allocation policy, once formulated, to be a very painful reform process. Crucial here is the omission of evidence-based medicine from the resource allocation process.

3.7.4 Health Expenditure and Aging

Health expenditures in developed countries are constantly rising despite cost-containment efforts. One reason is that health systems face the problem of aging populations. Dlouhý and Tuckova (2000) predict public healthcare expenditures in the Czech Republic for the period 1998–2030 by a simple formula: the age structure from the demographic prognosis of the Czech statistical office is multiplied by specific age-related expenditures from the GHIF's annual report. The expected increase in health expenditures due to demographic changes is 6–23 percent, depending on the alternative chosen. This projection is not as dramatic as it may appear. One percent economic growth per year will cover such expenditure increase sufficiently. According to a study, the problem is not thus the fact of an aging population itself, but its possible combination with other factors, which can expand problems exponentially.

3.8 Healthcare Financing and Purchasing—Conclusion

The Czech Republic succeeded relatively in deeply reforming the inflexible state system into a pluralistic health insurance system, albeit with many financial problems. 1990–1996 was the period of major reforms in financing the health system. This period was driven by ideology, naive radicalism, and insufficient experience with regulation. Since 1997, the health sector has been more regulated and to some extent stabilized. The health sector offers better quality and is equitable. Efficiency improvements in healthcare provision are probably less than expected. What is needed now is a clear vision for the 21st century.

The key recommendations from the OECD (2003) are:

- The excessive capacity of beds and ambulatory specialists has to be reduced.
- Many reimbursed drugs should be paid out-of-pocket. User-fees should be introduced in a socially acceptable way.
- The private market for non-core activities must be liberalized.

3.9 Changing Patterns of Service Provision

Delivery of curative health services in the CR is shared among providers of primary healthcare (including home care), specialized ambulatory care, and hospitals. Bed care comprises specialized therapeutic institutes and spas for adults and children. Hygienic stations (public health institutes) and pharmacies complete the system of curative care. The current situation is described by the following table (the structure of healthcare providers and the motion of patients and desirable referrals between different part of the system is shown in Chart 6 in the Appendix) (see Table 6).

Patients are free in their choice of physician and a healthcare facility, regardless if it is a public or private provider. Nevertheless, according to the experience from many developed countries, the patient should enter the healthcare system through a "gate-keeping" GP, but this is not yet ensured by law.

The present network of health facilities is the result of massive decentralization in the 1990s. In the first period (1990–1992), the DINH/RINHs (see chart 1 in the appendix) were dissolved, and health facilities obtained a high degree of legal and economic autonomy. During the second period (1993–1996) decentralization focused mainly on ambulatory services. Many polyclinics were divided into individual practices, most of which were privatized the following year. As well, many physicians established private offices outside former polyclinics. Today's structure has not changed significantly.

In the 1960s, the categorization of hospitals into three types was introduced according to the capacity and range of specialized wards, however, this hierarchical structure was abandoned at the very beginning of the reform in 1991. There is at least one hospital in each district (usually 1–3), and accessibility is considered satisfactory. There may even be a surplus of beds requiring their reduction (or the reduction of hospitals) or

Table 6.
Healthcare Providers and Facilities as of June 2003

Type of Facilities	Number of			
	Facilities	Physicians (FTE*)	Paramedics (FTE*)	Beds
Hospitals (in- and outpatient care)	202	16,087	60,380	67,031
Institutes for long-term patients	76	261	2,140	7,264
Psychiatric institutes	21	463	2,999	10,050
Specialized therapeutic institutes	68	319	1,779	5,859
Spas	67	350	1,997	22,800
Independent ambulatory facilities	23,400	21,252	31,483	*Places*: 313
• Polyclinics, health centers	379	1,932	3,972	
• General practitioners for adults	4,451	4,480	4,304	
• GPs for children and adolescents	2,113	2,101	2,053	
• Independent dentists	5,411	5,710	5,570	
• Independent gynecologists	1,150	1,083	1,199	4
• Independent ambulatory specialists	5,943	5,588	62,918	29
• Other ambulatory facilities	3,953	358	8,267	225
of which home care	477		1,900	
Special health facilities	491	5,182	3,749	6,035
Pharmacies	1,921			
Hygienic services	30	339	1,322	
Health facilities—total	26,613	39,734	110,625	113,005

Note: * Full-time equivalent.
Source: IHIS 2003.

their replacement with beds for long-term patients and/or social aid beds. The problem of bed or/and hospital reduction is that the fixed cost of hospitals is about 75 percent regardless of the number of patients treated.

In 2002, hospital-based bed care consisted of 201 hospitals with 61,500 beds for critical care and 5,200 beds for sustained care (see Chart 6 in the appendix). In critical-care hospitals there are 6.5 beds per 1,000 individuals, down from 8.1 in 1990. Hospital utilization depends on the relation between critical and long-term and/or social beds, which is not yet optimal.

The average length of stay (ALOS) amounted to 8.3 days in 2002 (IHIS 2003). Since 1990, this number decreased by 34 percent, and the trend is to reduce it further, in some cases by appropriate utilization of home care.

A large administrative shift in ownership took place in 2003, based on the last phase of public administration reform (see section 3.3.2). Only those bed-care facilities

managed directly by the MoH are considered state owned. Others, belonging to regions, towns, and municipalities, are regarded as non-state and only the rest, owned by private persons, churches, NGOs etc., are actually private.

Section 3.5 presented the share of privatized facilities in primary, specialized ambulatory, as well as hospital care (in number of beds). In other bed-care facilities, the share is unbalanced (83 percent of all beds in spas are privatized; none in psychiatric institutes are none). In institutes for long-term patients the share of privatized beds is 23 percent, in other specialized therapy institutes the share is 29 percent. Hospice care is exclusively private (unfortunately there are only 210 beds, run predominantly by churches).

Until 1990, home care in the modern sense was an unknown concept. In the last ten years, however, home care has developed rapidly. The 450 agencies currently existing are sufficient to cover the whole territory of the Czech Republic. Autonomous agencies are able to provide a broad range of services often on behalf of GPs.

In the field of ambulatory care the core segment should be GPs, however patients prefer ASs to GPs. Healthcare delivery for Czech citizens beyond insurance (by out-of--pocket payment) is exceptional; only dentists derive approximately 25 percent of their income from direct payment from their patients. Economically, this situation is hardly acceptable, and discussion about other options is ongoing.

3.10 Unintended Consequences of Reform

Ambulatory care is not only sufficient, but clearly exceeds reasonable need. Compared to developed European countries, the number of patient contacts with ambulatory doctors is exceedingly high. Czech patients enjoy an average of 14.8 contacts with ambulatory doctors per year (2.1 with dentists). This frequent contact is mostly with GPs (5.9 contacts for adults and 7.1 for children). These numbers are at least double the Western European average. Six contacts with ASs, especially considering that the price of such a contact is two to ten times higher (according to specialization) than contact with a GP, are particularly high. Even if the health status of the Czech population is worse than other developed European countries, these numbers are exaggerated. Most likely, this is due to the socialist habit of visiting doctors for banal reasons. People are unaccustomed to treat minor health problems themselves.

On the other hand, FFS payments support the AS efforts to provide the maximum volume of care: this also explains the high number of ambulatory specialists. In a number of cases, doctors send patients from one specialist to another in order to increase specialists' income (and no doubt, through kickbacks, their own).

The presence of parallel networks for specialized ambulatory care is also problematic. A private network exists in hospitals, with the same number of doctors. The following conclusions were drawn:

A. The present system disturbs the *ordering of patient's care* ("shopping around"). The central, gate-keeping element of care management—the GP—is absent from the Czech system. Therefore the system can be risky for patients and quality of care may decrease.
B. *Problems of specialized care* and *primary care* cannot be solved independently. It is necessary to define competencies and criteria for training and postgraduate education. Bringing the quality of primary care up to Western European levels would lighten overburdened ASs, who would not have to activate special know-how and experience in fields treatable at lower levels of the system. With the help of standards and rules of best practice, it would be useful to establish GP and AS competencies (see Figure 32 in the appendix).
C. *Competing private (out-of hospital) and hospital-based ambulatory care* create other problems. As we see from the experience of several countries, it is possible to find an acceptable model of cooperation (not competition) on the supply side. This requires *respect for the cultural anchor of national-historic evolution*. An enforced change could lead to unacceptable solutions. As for *parallel practices*, it is necessary to establish limits beyond which fruitful cooperation changes into a heartless struggle for survival. It is also necessary to define clearly, with best practice standards, what is feasible outside the hospital and what is not.
D. The problem of parallel care would probably be solvable in the frame of a cooperative model for hospitals, ASs and GPs. In the interest of better care, hospitals could facilitate GP and possibly AS access to their patients.
E. The system must be decentralized regarding regions and districts, alongside with the gradual introduction of a new regional public administration.
F. Insurance funds (especially the GHIF) should clearly set rules for contracting with ambulatory facilities.

The relevant Czech political forces lack a clear idea about the problems of ambulatory care and specialized care. Politicians do not know how to approach and resolve such issues. Increased awareness is necessary concerning management of the system and its processes.

3.11 Major Domestic Debates Concerning Healthcare

Debates concerning problems with the healthcare system are professional, political, and public.

Until 1989 there was limited space for discussions.

Some professional discussions, nevertheless limited by both censorship and self-censorship, did go on. Published recommendations did not go beyond improving the existing socialist healthcare system.

As to the lay public, the regime declared a high level of general satisfaction with the Czech healthcare system. Public opinion polls were not carried out. The first polls that baffled this conviction were at the end of 1988, showing that the population was worried about problems of health and healthcare (as well as the environment). The results of the polls were published in the press: unimaginable before that.

Debates held *by the political representation* appeared as late as the second half of the 1980s. Not even the political document of the dissident movement Charter 77 about healthcare, dating from the end of 80s, stepped out of the frame of the communist healthcare system. The last communist minister of health ordered an analysis of public opinion and the positions of medical staff for the first time at the beginning of 1989 (Jaroš, Purkrabek, Sevcik 1989) perhaps under the influence of the first public opinion poll (in 1988). Professionals, until then not allowed to work in specialized activities, could for the first time participate in the analysis (results were not published because of the events connected to the Velvet Revolution).

Even healthcare professionals did not step out of the official scheme, as was shown by the results of this unpublished analysis, in spite of a rather critical approach towards the system. The authors defined several organizational insufficiencies and expressed their dissatisfaction with the low level of respect for the work of medical professionals (see section 1.4).

The situation changed radically immediately after the Velvet Revolution in November 1989.

The professional discussions as well as the political decisions of that period were described in previous sections of this study. From the beginning, cooperation between decision makers and professionals (researchers) in the field of health economics, policy, and services has been poor. Political decisions were not usually made on the basis of professional analyses. There are several reasons for that. Findings must be presented in a form comprehensible to legislators. Politicians lack the background to grasp the need for a comprehensive concept of health policy and a vision for its long-term development. This concerns not only the highest level of politicians who change from one election to the next, but also executive officials at all levels of the decision-making process, including insurance companies. The capacity to deal with professional papers and groundwork must still be developed. With some exceptions, top decision makers were unable to formulate a more complex assignment for the professional sphere. The good use of professional results in recommending policy is uncommon.

The abolition of *media* censorship has been significant: e.g. the weekly Health News is read by a broad health public. In the mid-1990s a new health magazine, Czech healthcare, appeared, which deals with problems in the healthcare system—healthcare policy, economics, service research, etc. There is a wide spectrum of public activity and debate on those problems, etc.

A new element has been constituted—*public opinion polls*—some of which have to do with healthcare.

Trade unions, professional associations, hospitals and, of course, customers—through insurance funds, especially the public GHIF—play increasingly important roles, though small compared with their roles in Western nations. All these parties commission or publish, with varying range and scope, their own analyses.

Materials published by the Ministry of Health are another specific source of information. Almost all Czech health ministers since 1990 have published some kind of "concept." From time to time, both chambers of Parliament ask for studies. Today's healthcare legislation is a tangible result of debates spawned by this process. Over the last 14 years, the following principal issues have bee discussed (expressed chronologically):

1. The main question in **insurance** was whether to introduce the neo-Bismarckian system of obligatory insurance (which could be possibly supplemented by a form of voluntary insurance) or to adopt and adapt the British system. The tendency to return to the former Czechoslovak system—from before communism—suggested a system similar to Austria or Holland. The solution was found at the beginning of 1990. What was lacking in this process was a project of mixing obligatory and voluntary insurance. The debate was ongoing during the first half of the 1990s, when the GHIF with its state guarantee and several HIFs were created. Some bankrupted and were abolished. The present structure of insurance funds—one + nine—has existed since 1997.
2. **Privatization** began in mid-1990.[33] At first, the question was whether to privatize or not, while in the next period it was rather what and how to privatize. An agreement was reached that ambulatory services ought to be privatized, and in subsequent years, a majority were. The neo-Bismarckian model of obligatory insurance made this a natural and logical step. Privatization of hospitals and other bed facilities, however, was problematic. Difficulties stemmed from poor access to bank credit and disagreements about the process in general—to privative activities and properties together or separately? This question has not been resolved even now, but debate has not had the intensity it had in the first half of the 1990s. The extent of privatization of different kinds of healthcare facilities was described in sections 3.5 and 3.9.
3. **Remuneration of medical staff**—especially doctors—has been a golden thread the past 14 years. It came out of the underestimation of the value of medical personnel under the previous system and, of course, compared to developed countries. During the first two years of transition, debates were related to new methods of payment (capitation payments, FFS, etc.). The first liberal system, based on an FFS system, was found inappropriate, and in 1997 it was changed (to capitation in primary care, combined payments for ambulatory specialists, budgets in hospitals, etc.). A less than exhaustive debate on waste before and after the change took place. An official document from the MoH admitted that—after the implementation of the changes—healthcare was diminished by

30 percent, without affecting overall health status. At present, when the government is seeking ways to reduce public debt, debates aim at setting amounts of compensation for providers. The main parties in those debates are providers themselves, their trade unions, the MoH, and insurance funds. There was also a debate on the problem of *doctors' rights to strike* in public healthcare.

4. **Reimbursement for services provided from insurance funds** is an issue closely linked to the first. One aspect concerns delaying payments that threaten (particularly) ambulatory doctors with insolvency. Another aspect is the amount of payments. Insurance funds complain about considerable debts, paid tardily, which, in sum, amount to a huge amount of money. Insurance funds consequently delay payments to providers. Hospitals in particular do not pay suppliers, and this leads to crisis in which (for example) distributors refuse to supply hospitals with drugs. The system of reimbursement for hospitals has changed twice; now a system of DRG is being prepared, not without problems (see Figures 28 and 29 in the appendix).
5. With varying intensity, the issue of **patient co-payments** has been debated throughout the period. The beginning of the debate was connected to an alarming finding on the rapid ageing of the population and on a fast increase in the costs of the provided care. A similar debate was taking place in many OECD countries, which published several studies on such topics. The issue of individual saving accounts was suggested—on the model of Singapore. This scheme dominated and several other solutions have been shadowed, such as payments for the direct access to specialized (secondary) ambulatory care without referral from a GP; similarly, payment for "accommodation services" (catering, etc.) and the like. It has to do with necessary changes in obligatory health insurance and with an undefined guaranteed healthcare package, which should not include 95 percent of all care as is the case today. Excluded care could be covered by voluntary insurance or out-of-pocket. Unfortunately, this debate is political. The topic is politically abused—economic analyses and arguments are used very scarcely. Until 1998, liberal governments did not dare to address this problem, although in the first five years after the Velvet Revolution the willingness of the population for massive change was extremely high. The social democratic government continues to promise free care as a core element of their policy. As economic problems erode the current healthcare system, debate will no doubt reopen.
6. A wide range of **economic problems** have been debated over the last 14 years; some discussed here, such as the problem of abuse of ambulatory care, over-consumption of drugs and low levels of compliance with their use (see section 3.9).
7. At the end of the 1990s, a new topic appeared: **the relation between doctors and patients**. Patients began to demand to be active partners and not only

subjects of paternalistic care. The physicians' lobby has shown strong resistance—especially to questions of malpractice—but the situation has been gradually moving toward a Western European model. Obligatory membership in medical chambers—legally required to supervise medical standards and ethics—has significantly affected such issues. Although these professional organizations act as trade unions, there are two strong actual trade unions with voluntary membership: one for all medical professionals, another for physicians only. On the other side, the three organizations representing patients coordinate their activities rather poorly; they are mostly left-wing and tend to constantly raise new, poorly reasoned requirements. The media, especially print, has played a positive role, pointing out the necessity to reduce physicians' autonomy and their paternalistic approach to patients.

8. The absence of a **long-term concept** for the entire healthcare system is the final topic. Most health ministers have submitted ideas on reform, but none have had had time to carry them through. Few concepts were based on sufficient qualified analytical groundwork, not only economic, but legislative, sociological, and technical as well. We are still waiting for a developed and convincing healthcare concept.

4. CONCLUSION: COUNTRY-SPECIFIC EXPERIENCE

4.1 Advantages and Disadvantages of the Highly Decentralized, Pluralistic System

As was presented in section 3.3, redistribution of powers and responsibilities in decision making, administration, and financing was an important feature of reform. Administrative decentralization, devolution, delegation, and provider autonomy touched all parts of the system to a large degree.

Whether all of these types of decentralization in service provision, financing, management, and administration were needed, and what their outcomes were, is another question. To find an answer, we must look at several aspects of the problem.

Many steps toward decentralization in the first period of reform were logical reactions to the centralized and bureaucratic system under the communist regime, either in the health sector itself or in the country as a whole. The general reactive trend was unavoidable and understandable; however, looking back, steps were often poorly considered and less than effective

However, these types of decentralization may have been inseparable from the transformation of the Semashko model into the neo-Bismarckian model. However even in

countries with the English "Lord Beveridge model," similar features of development and reform could be traced to the 1990s, such as the separation of delivery and financing, higher autonomy for providers, decentralization of management, etc.

Undoubted disadvantages of early, rapid, and massive decentralization were (at least in the first years of the new system):

- a lack of a bold responsibility in all parts and dimensions of the system
- no culture of negotiation among the major players
- lack of mandate to promptly "repair" initial faults of the system
- difficulties in implementing "regulation" in a broader sense, i.e. not only cost containment mechanisms but structural and capacity regulation measures, quality control, etc.

On the other side, the system:

- was able to resist short-term political interests and particular concerns
- stimulated development of services and medical technology
- met the health needs of the population and contributed substantially to improving health status.

After several years, major players seemed to learn their roles and cooperate more smoothly than before. From the end of the 1990s to 2002, the system seemed to stabilize. However, it might be at the cost of "frozen reforms" (as many potentially destabilizing factor were not successfully dealt with—more about this in section 4.2).

In 2003 a new destabilizing factor occurred, linked to the transfer of administrative and managerial competencies to new self-governing regions in the frame of the reform of public administration.[34] The focus of attention was on the problem of smaller state hospitals previously run by the central administration in districts, which were transferred from the state to self-governing regions—with huge debts and without appropriate resources to cover them. The most critical situation was treated by contributions from the state budget, but this was only the tip of the iceberg, pointing to many deeper unsolved problems, e.g. the surplus of critical care hospital beds, the sustainability of a dense network of small hospitals, overlapping services, a hospital remuneration scheme and hospital financing in general.

Even this step in decentralization could have positive consequences, at least in one aspect. Theoretically, self-governing regions can be successful in rationalizing hospital capacity within their territory; something the central administration was unable to cope with. Currently, a method known as "regional centralization" has been discussed, meaning a single organization for hospital administration and management to be formed in each region. Smaller hospitals would lose some of their autonomy. Interestingly, this idea is close to the pre-reform model, abolished in 1990, of District/Regional Institutes of National Health (see section 2.1 and Chart 1 in the appendix).[35]

4.2 Financial Sustainability

In the mid 1990s, the system of healthcare faced a serious financial crisis due to uncontrolled and spiraling costs. As was explained in section 3.2, this provoked a second round of reforms aimed at optimizing health service provision, financing, and utilization. Although longer term goals and objectives were not reached due to political discontinuity, the hot problem of financial sustainability was successfully addressed. From the economic viewpoint, the system seemed to stabilize until very recently. However, after 6 years it became apparent that the 1996–1997 measures did not address deeper risk factors in the system. Hospitals debts and the increasing deficit of the GHIF has again raised the question of the financial sustainability of the Czech system of healthcare.

First attempts to respond merely involved more money. However, facing an enormous deficit (almost seven percent of GDP in 2003) the government cannot afford other expenditures, and to shift the burden onto insured persons and employers in the form of higher health insurance contributions would have negative political and economic effects.

The system in itself is very costly and still has a tendency to overproduction and over-utilization, because of the large capacity of services and high generosity towards consumers. Therefore it can drain additional resources without being "fed." For the sake of financial sustainability, it is necessary to introduce other reform steps both on the supply side and the demand side:

- On the supply side, rationalize the dense network of services in secondary care, both critical care hospital beds and special ambulatory services through introducing multiplicity and overlapping hospital-based and outpatient care.
- On the demand side, rationalize consumer behavior by rigidly defining the essential guaranteed package of services.

The financial imbalance of 2003 may provoke a third round of reforms, which would mean revitalizing the frozen process and reviewing abandoned and uncompleted plans from the second round.

4.3 The Position of Patients and Professionals in the System

What was the real contribution of the "decade of reform" to citizens' lives and health?

Without a doubt, better health is the major contribution. From patients' perspective benefits include freedom of choice, free access to a wide range of services, and higher quality of care, particularly thanks to advanced medical technology, a wide range of pharmaceuticals from the international market, and increased qualification of doctors and other personnel.

That the first five years of the new system of healthcare stimulated service development was a benefit for both sides, i.e. both for patients, doctors, and other health workers. This changed after 1997 cost-containment measures: different kinds of stimuli influenced care provision since then, and doctors and hospitals are less motivated in treating patients. Consequently, long waits for treatment at ambulatory specialists and for non-acute surgery in hospitals has resulted, leading to the unpleasant return of under-the-table payments so common under communism.

In spite of this, the system is very comfortable for consumers and promotes over-utilization. The average of 14.8 visits to a doctor per citizen per year is far above comparable indicators in developed Europe, and it reflects factors other than real health needs, such as administrative requirements, abuse of illness benefits, and psychosocial habits (poor case management, as well).

In the health sector in general "consumers' voice and choice" is weaker than that of providers. Even after 12 years, patients' position in the system is far from that of well-informed, responsible consumer and respected partner. Freedom of choice is neither based on accessible information about quality and efficiency nor on transparent mechanisms of quality assurance. The reluctance of providers plays the largest role in this.

Although the position of providers' representatives seems quite strong, it is practically impossible to meet their needs. Regulative measures and limits in provision and remuneration for care also promote dissatisfaction among doctors (and other medical personnel). There is a widely shared feeling (articulated also by medical chambers and trade unions in the health sector) that recent developments do not meet the expectations of health workers, who see themselves as forced to "sponsor" the financial difficulties of the healthcare system.

The new system of healthcare in the Czech Republic has brought about many advantages and new opportunities both for patients and medical professionals, but these advantages must be balanced in a financially sustainable system. The current crossroads calling for a third round of reforms also points to the fact that if a third round was taken seriously, it might be painful for both sides.

4.4 Market Principles, Equity, and Efficiency

The introduction of market principles into the system of healthcare provision and financing was a political slogan for many years in the 1990s. It was declared a reform principle by the ruling center-right parties and a public threat by the opposition. In both cases, it was mostly an exaggeration. The market principles really implemented were quite modest, and they did not go beyond the concept of a regulated market described in the scholarship on health economy.

However during the first several years the word "regulated" was not emphasized. Competition among providers, privatization, free FFS contracts between providers and

health funds, as well as other market factors, all stimulated development of services and opened new opportunities both for patients and providers. On the other side, this led to spiraling costs and financial crisis in the mid 1990s. The subsequent discourse emphasized "regulation" more than "market," with the positive and negative consequences mentioned elsewhere in this chapter. Still, not all regulatory measures worked against market principles. The Czech experience may show that the concept of a regulated market is viable, although there are different views about the balance to be struck.

Neither the new system as a whole nor its market elements led to the same equal access to care assured by social health insurance schemes. In general, principles of equity and solidarity were never abandoned or neglected. The reform process has been, from this viewpoint, a dynamic balance between equity and solidarity on one hand and market principles and efficiency on the other. This is not specific to the Czech Republic, as all European systems of healthcare cannot stay removed from each other.

4.5 Stabilization or Continuing Reform?

Professor R. G. Feachem, an eminent WB expert, once called the Czech reform of the health sector reform "a big bang followed by years of stabilization" (Feachem 1994).

More than a decade after the "big bang," there may be evidence that the new system of healthcare has been able to fulfill its central mission: to provide good—and improving—health. However, this conclusion cannot be taken as proof that the reform was the only possible correct path: we may imagine that reforms of another type would have similar positive and negative consequences, perhaps only on a different time-scale.

It is also clear that "stabilization" does not mean an "endstate." If in-built risk factors remain unaddressed, stabilization can be only temporary. Reform should continue, probably not in the form of an another big bang, rather in a process of "incremental reforms," in which the Czech Republic as a new EU member will face and have to solve similar problems as other EU countries.

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NOTES

[1] The contents of the study and its abstract are available online at www.oecd.org.

[2] The sources of all data are: European WHO Health for All Database (at www.hfadb.who.dk/hfa); OECD Health Data, 2003 Edition (at www.oecd.org); Czech Statistical Office—CSO—(at www.czso.cz); Institute of Health Information and Statistics (at www.uzis.cz); General Health Insurance Fund (at www.vzp.cz), and our own calculations (due to scarce space, we do not quote sources of data individually).

[3] Comparison of performances is only tentative.

[4] Major factors connecting political changes and health reforms at the beginning of transition included: (1) the release of data about the health status of the population and other relevant information, which had been blocked by the communist regime; (2) open public debate about key problems in the health sector; (3) the formation of a pro-reform movement inside the health sector, which backed changes and gave a platform for collecting experts capable of formulating them; (4) new, pro-reform political garniture coming into power.

[5] Social policy used experience from abroad in a larger extent, and particularly the reform of social services, launched in 1997 by the social democratic government, was based on a high degree on the international collaboration.

[6] The Ljubljana Charter (1996)—a WHO political document on healthcare reform in the WHO European region.

[7] For more about Czech attitudes to the World Bank and WHO, see section 2.5.

[8] See also Chart 1 in the appendix.

[9] Differently from other principles mentioned, this principle was later abandoned.

[10] Although this principle was never abandoned totally, its implementation met many difficulties and has remained uncompleted.

[11] For more about the different views of major players, see section 3.4. See also Chart 2 in the appendix.

[12] These topics will be discussed further in sections 3.1.1 and 3.4.

[13] Reasons for the rejection were: (1) the prudent financial policy of the government in general: avoiding loans and approaching debts cautiously; (2) underestimation of health sector needs by influential economic ministers in the government; (3) mistrust of "uninformed" views from abroad and consequent reluctance to accept WB expert intervention into national policy—in spite of the fact that the WB philosophy was quite close to Czech reform concepts.

[14] WHO was identified with socialist ideology and was therefore hardly acceptable to the liberal-conservative politicians that dominated during the key period from 1991 to 1997. These ideological attitudes were also the reason for declining to join the Ljubljana Charter in 1996. In spite of this ideological controversy, the WHO principles of equity and solidarity were to a great extent included in the new healthcare system (obligatory health insurance, extensive coverage, etc.).

[15] See organizational Charts 1, 2, and 4 in the appendix.

[16] See Chart 1, 2, and 4 in the appendix.

[17] In May of 1997, the MoH launched a program for the restructuring of the hospital bed fund. The target was to reduce critical-care beds from 7 to 5 per 1,000 individuals and increase long-term beds to 2 per 1,000 individuals. Surplus beds were to be transferred to social services or sold, and there was a plan to transform up to 30 minor hospitals into social institutes. The MoH was to simultaneously support primary care and home care and implement measures halting supply-induced utilization of hospitals. The draft of the rationalization of bed capacities was elaborated based on ALOS analysis and occupancy ratios, and negotiated in several rounds with each district authority. Methodologically, a detailed analysis of the health status of the population and of the technologies abbreviating ALOS was to be performed. However, even the most sophisticated approach could be rejected by the public. The idea of hospital rationalization presents a very sensitive political problem, which has already inspired counter-pressure from politicians, local health administrators and, last but not least, from the affected health personnel.

[18] See Shakarishvili G., Presentation at the OSF Institute meetin, Budapest, 2001

[19] See organizational Chart 4 in the appendix.

[20] Districts are still used for statistical and other specific reasons.

[21] Before 1990, ten regions existed in Czechoslovakia, and regional authorities ran almost all large and university hospitals. In 1990 this regional structure and administration was abolished and all these health facilities were transferred to the MoH, which before had only controlled a handful of similar institutions. Thus, by 2003, after all the reforms, the MoH controlled about 220 institutions—much more than in 1990.

[22] This transfer of former state hospitals to regional governments has been seen rather ironically by many, as facilities were privatized from one day to the next that did not meet requirements of the 1992 Act on Private Provision of Healthcare. This resulted in illegal healthcare and under-the-table payments.

[23] The legal requirement on "non-state" providers of care were in principle as follows: (1) personal license given by the Medical Chamber to a responsible physician regarding his qualification; (2) approval of medical equipment, also by the Medical Chamber; (3) authorization of premises by hygiene service; (4) registration of a "non-state health facility" by the respective District Authority after fulfilling the first three requirements (see Charts 4 and 5 in the appendix).

[24] After the first free parliamentary elections in 1990 the Ministry of Health and Social Affairs was divided into two separate institutions: the Ministry of Health and the Ministry of Labor and Social Affairs. For many reasons this was not a beneficial decision, and it formed many inter-ministerial

problems, e.g. discontinuity of services or missing links between health insurance and illness benefits (see Charts 2 and 3 in the appendix).

[25] Among its strongest critics were the professional associations, other provider representatives (which substantially influenced the public and the media) and the Parliamentary committee for health and social affairs.

[26] The director general of the GHIF was approved by Parliament—particularly in certain periods, the GHIF had broader and more articulated parliamentary backing than the MoH.

[27] In this case the draft of the law originated in Parliament by the constitutional right of legislative initiative of Parliament members.

[28] Note that professional and provider representation in general saw a weaker voice for GPs than for hospitals and medical specialists.

[29] WHO Ljubljana Charter, 1996

[30] Law No. 48/1997 Coll.

[31] There is a marginal subset consisting mainly of specialists and dentists working in Prague and other big cities on a cash payment basis.

[32] Minimum wage increases, usually every year or two, by order of the government, in connection to increasing salaries in the public sector.

[33] Privatization was not mentioned in the first reform paper (the *Yellow Paper*) but played a role in the second draft (the *White Paper*).

[34] Principles of the reform of public administration are presented in section 3.3.

[35] The reform of public administration in itself was poorly prepared and chaotically implemented. The first 9 months of the new regional arrangement displayed many disturbing consequences (in health as well as culture, social services, infrastructure, territorial planning, etc.). The new trend toward "regional centralization" is also appearing in other areas.

ANNEX 1: Health Indicators

Table A1.
Crude Death Rate per 1,000 Individuals

Male	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
• CR	13.7	13.4	13.2	12.7	12.3	11.8	11.7	11.7	11.3	11.3	11.0	11.0	11.0	10.8	11.0
• EU avg.	11.0	10.9	10.4	10.4	10.2	10.4	10.1	10.2	10.2	10.0	10.0	10.0	9.8		
• CSEC avg.	11.5	11.8	11.8	12.0	12.1	12.1	12.1	12.2	12.1	12.1	11.9	11.8	11.5	11.6	11.7
Female															
• CR	12.6	12.0	11.8	11.5	11.0	11.1	11.1	11.1	10.6	10.6	10.3	10.4	10.3	10.3	10.3
• EU avg.	10.0	10.1	9.9	9.9	9.8	10.0	9.7	9.9	9.9	9.8	9.8	9.9	9.7		
• CSEC avg.	9.8	10.1	9.8	10.0	9.9	10.0	10.0	10.0	10.1	10.0	9.9	9.9	9.7	9.7	9.8

Figure A1.
Crude Death Rate per 1,000 Individuals

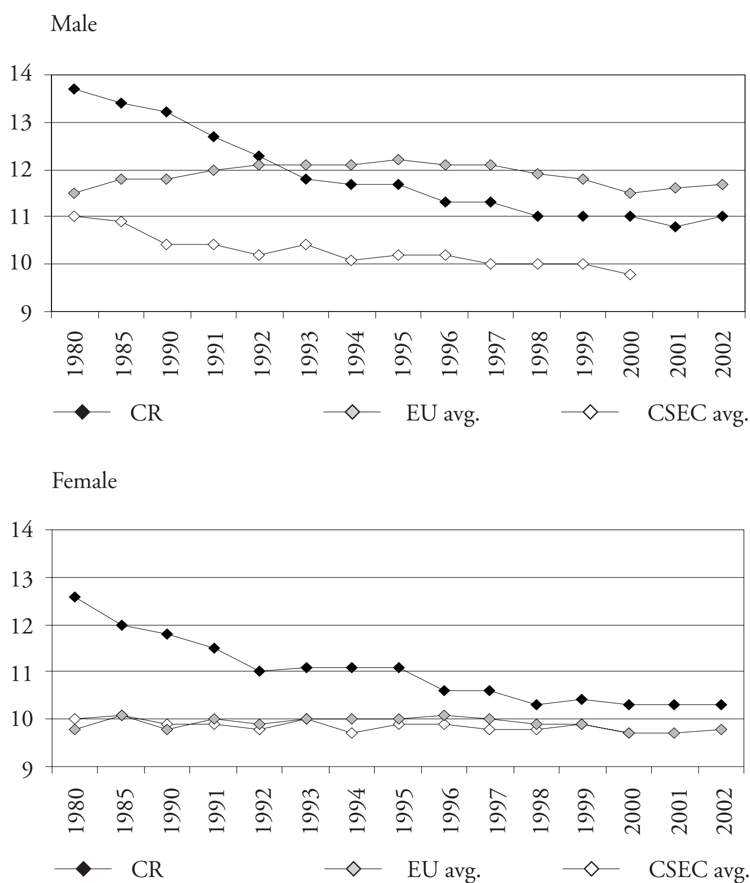


Table A2.
SDR Cerebro-vascular Diseases per 100,000 Individuals

Male	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
• CR	253.0	252.2	237.4	221.8	205.1	192.2	187.4	176.4	163.3	145.2	150.4	151.3	156.5	148.6	144.7
• EU avg.	135.0	119.6	96.7	97.8	92.5	90.0	85.5	82.9	80.0	76.7	75.5	72.3	69.0		
• CSEC avg.	170.9	169.9	165.0	165.3	163.5	176.7	173.2	170.3	172.8	172.2	175.0	172.9	167.9	165.4	
Female															
• CR	203.7	203.5	179.4	163.8	154.1	151.2	145.6	134.8	124.4	111.0	123.4	123.6	121.9	122.5	119.5
• EU avg.	110.0	97.2	79.5	79.6	75.5	73.5	70.4	67.4	65.0	62.3	61.0	58.9	56.3		
• CSEC avg.	145.2	141.6	131.4	131.2	127.6	137.6	134.1	133.7	134.9	133.6	137.3	136.3	131.6	129.3	

Figure A2.
SDR Cerebro-vascular Diseases per 100,000 Individuals

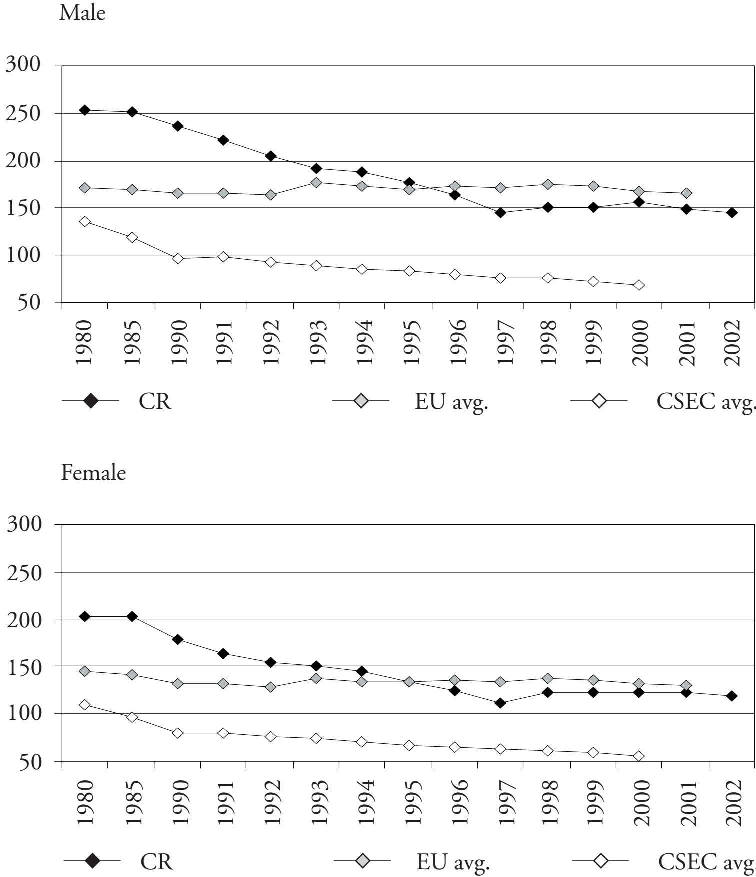


Table A3.
Live Births per 1,000 Individuals

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR	14.9	13.1	12.6	12.6	11.8	11.7	10.3	9.3	8.8	8.8	8.8	8.7	8.9	8.9	9.1
EU avg.	13.0	11.9	12.0	11.7	11.5	11.2	10.9	10.8	10.8	10.8	10.7	10.7	10.7		
CSEC avg.	17.2	16.3	14.0	13.5	12.8	12.3	11.3	11.2	11.0	10.6	10.4	10.2	10.2	10.9	

Table A4.
Annual Population Growth (Difference Between Crude Death and Live Births)

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR death	13.1	12.7	12.5	12.1	11.7	11.4	11.4	11.4	10.9	10.9	10.6	10.7	10.6	10.5	10.6
Live births	14.9	13.1	12.6	12.6	11.8	11.7	10.3	9.3	8.8	8.8	8.8	8.7	8.9	8.9	9.1
An. Growth	1.8	0.4	0.1	0.5	0.1	0.3	–1.1	–2.1	–2.1	–2.1	–1.8	–2.0	–1.7	–1.6	–1.5

Figure A3.
Live Births per 1,000 Individuals

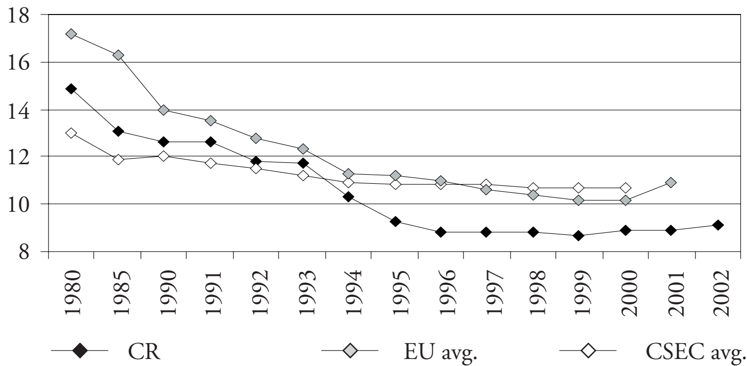


Figure A4.
Annual Population Growth

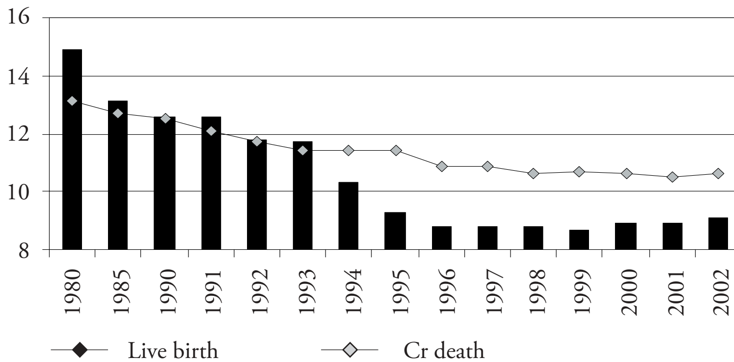


Table A5.
Total Fertility Rate

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR	2.1	2.0	1.9	1.9	1.7	1.7	1.4	1.3	1.2	1.2	1.2	1.1	1.2	1.2	1.2
EU avg.	1.8	1.6	1.6	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	
CSEC avg.	2.2	2.2	1.9	1.9	1.8	1.7	1.7	1.6	1.5	1.4	1.4	1.4	1.4	1.3	

Table A6.
Maternal Deaths per 100,000 Live Births

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR	10.0	10.0	8.4	17.8	12.3	12.4	15.0	6.2	7.7	5.5	6.6	10.1	9.9	3.3	3.2
EU avg.	13.1	8.6	7.8	7.3	7.4	5.8	6.6	6.1	7.1	5.8	6.6	5.2	5.6		
CSEC avg.	37.4	37.1	26.8	23.1	21.1	21.4	22.3	19.6	15.3	16.9	15.2	15.6	14.5	13.0	

Figure A5.
Total Fertility Rate

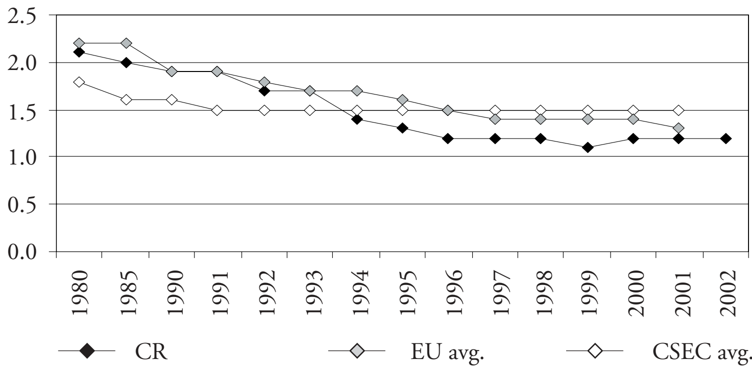


Figure A6.
Maternal Deaths per 100,000 Live Births

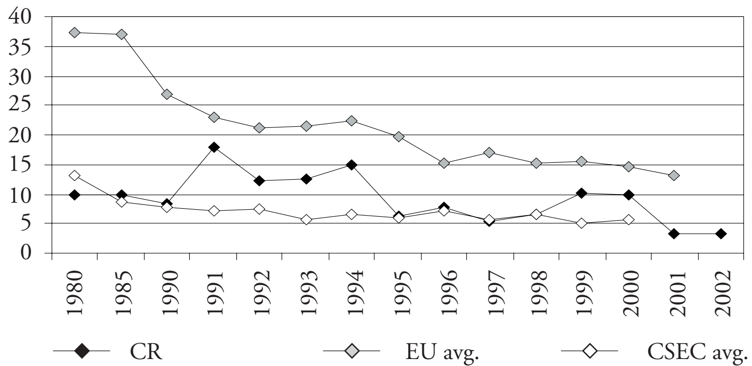


Table A7.
SDR Ischaemic Heart Disease, All Ages per 100,000 Individuals

Male	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
• CR	410.3	438.8	439.1	413.8	402.0	383.3	364.2	355.4	318.1	298.5	274.3	270.2	256.0	252.5	242.5
• EU avg.	225.9	215.1	185.6	185.7	179.8	180.0	169.5	168.0	162.3	155.4	153.4	147.3	139.8		
• CSEC avg.	243.1	262.4	269.5	274.8	275.5	281.6	275.7	270.6	265.4	267.0	266.3	265.2	252.1	247.7	
Female															
• CR	218.7	224.1	219.9	216.0	199.5	201.0	195.2	191.9	174.2	160.5	143.5	146.9	137.0	135.6	133.9
• EU avg.	100.3	96.2	86.4	86.8	84.3	84.8	80.3	79.4	76.9	74.2	73.4	70.6	66.9		
• CSEC avg.	126.9	138.6	139.7	142.5	139.8	146.4	145.3	142.8	141.8	144.0	146.6	147.9	142.4	139.0	

Figure A7.
SDR Ischaemic Heart Disease per 100,000 Individuals

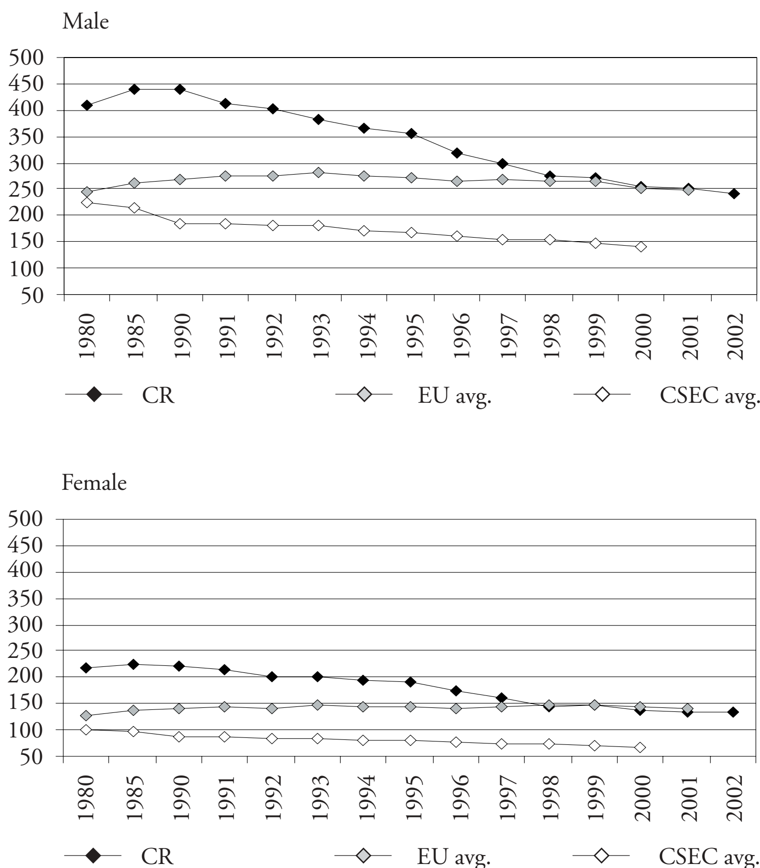


Table A8.
SDR Chronic Liver Disease and Cirrhosis per 100,000 Individuals

Male	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
• CR	27.5	26.4	34.7	32.5	29.1	25.7	25.3	25.5	24.6	24.7	26.3	26.2	25.2	25.7	25.5
• EU avg.	33.1	28.2	23.8	23.9	23.2	22.7	22.1	21.4	20.9	20.4	19.9	19.3	19.3		
• CSEC avg.	29.8	33.0	33.9	35.5	37.7	39.9	41.5	42.5	40.5	41.6	42.5	40.4	39.0	38.8	
Female															
• CR	9.1	8.7	9.6	9.7	9.5	8.6	8.6	8.6	8.2	8.9	9.6	8.5	9.2	9.0	9.4
• EU avg.	11.9	10.6	9.7	9.7	9.4	9.4	9.2	8.9	8.7	8.5	8.2	8.2	8.1		
• CSEC avg.	12.5	13.4	13.2	13.8	14.2	15.4	15.4	15.9	14.8	15.4	15.8	14.8	14.3	15.0	

Figure A8.
SDR Chronic Liver Disease and Cirrhosis per 100,000 Individuals

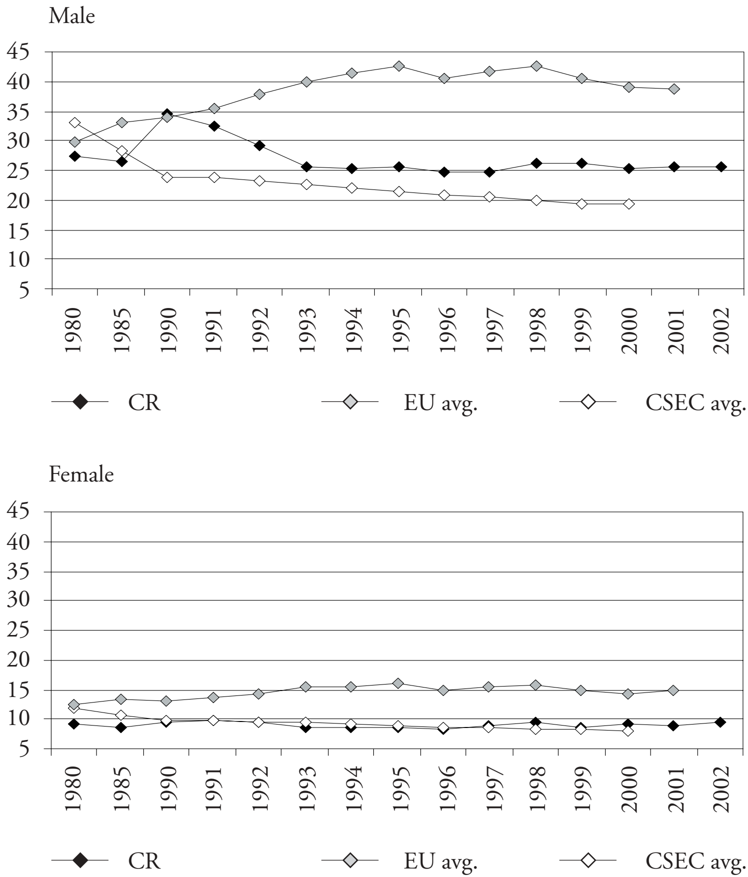


Table A9.
Viral Hepatitis Incidence per 100,000 Individuals—Both Sexes

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR	107.9	50.4	28.3	20.7	21.7	18.1	18.4	19.6	30.3	20.6	19.7	22.4	19.3	16.8	15.1
EU avg.	25.6	27.7	31.4	29.2	28.2	25.4	23.9	23.8	24.9	24.5	22.0	20.7			
CSEC avg.	148.3	119.0	133.2	110.4	84.0	81.6	84.6	77.0	54.7	46.1	42.5	46.8	46.8		

Figure A9.
Viral Hepatitis

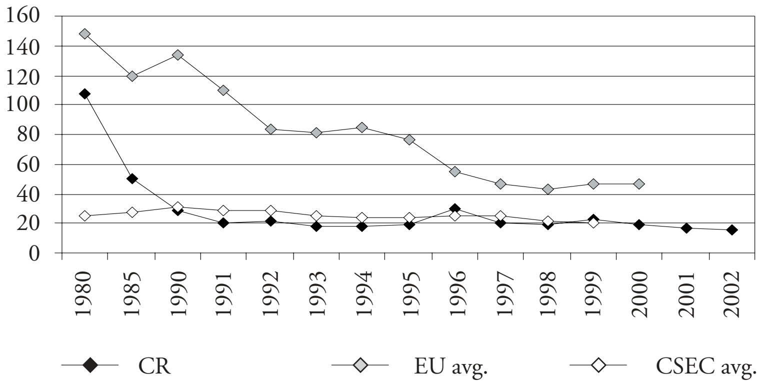


Figure A10.
TB Indicidence

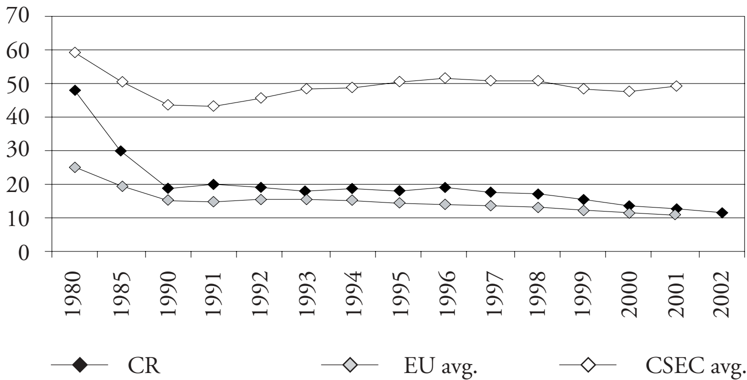


Table A10.
Percent of Regular Daily Smokers, Age 15+

	1993	1994	1996	1999	2000	2001	2002
Male	32.2	43.0	32.8	30.1	36.2	26.4	30.9
Female	21.3	31.0	20.2	17.3	22.0	20.4	18.1

Table A11.
Pure Alcohol Consumed per Capita, Age 15+

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR	16.0	15.7	16.3	15.6	16.5	15.7	15.9	15.8	16.1	16.5	16.4	16.5	16.3	16.2	
EU avg.	15.4	13.6	12.7	12.3	12.1	11.8	11.7	11.5	11.2	11.4	11.1	11.1	11.1		
CSEC avg.	12.6	11.6	10.3	10.1	10.0	10.0	9.9	9.8	9.7	9.9	9.4	9.5	9.5	9.4	

Figure A11.
Daily Smokers

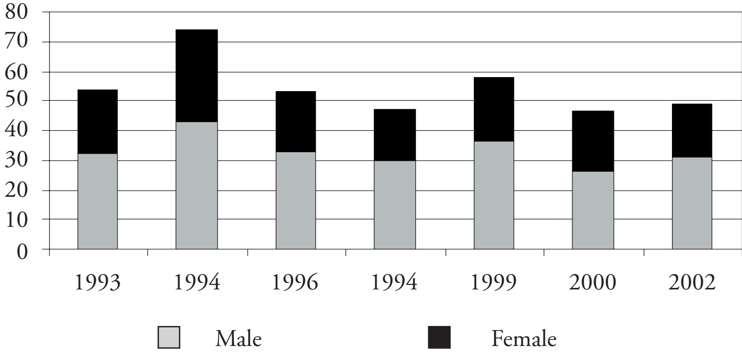


Figure A12.
Alcohol Consumed

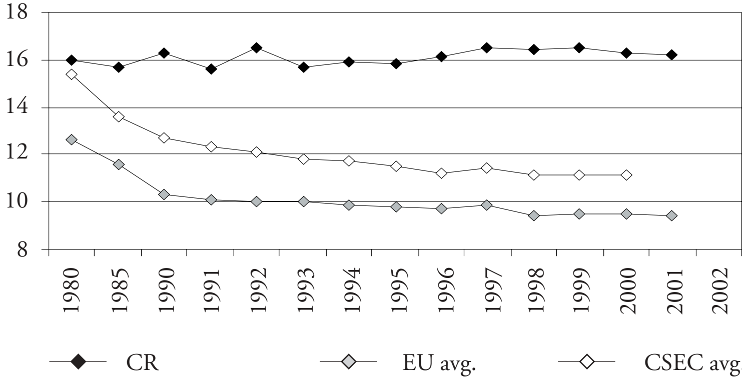


Table A12.
Physicians per 100,000 Individuals

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR	225.7	257.7	270.6	267.5	267.9	286.4	293.2	299.5	298.4	311.2	303.0	307.8	336.9	344.5	389.8
EU avg.	217.6	266.6	291.4	299.6	305.9	315.8	324.1	327.6	334.7	338.3	338.2	344.5	348.5	350.8	
CSEC avg.	200.5	222.6	236.8	236.3	238.4	238.9	240.9	244.3	247.9	249.1	249.4	250.2	250.2	250.6	

Table A13.
GPs per 100,000 Individuals

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR	68.2	72.3	72.6	69.8	69.6	68.2	69.2	70.0	68.3	67.8	67.9	68.2	71.9	72.3	72.2
EU avg.	86.3	92.1	100.3	100.2	101.1	101.5	100.4	102.9	102.0	101.7	101.8	101.2	101.0		
CSEC avg.	51.8	57.7	67.5	60.3	65.8	65.9	65.6	65.8	64.8	65.8	67.5	67.7	68.5	69.6	

Figure A13.
Physicians per 100,000 Individuals

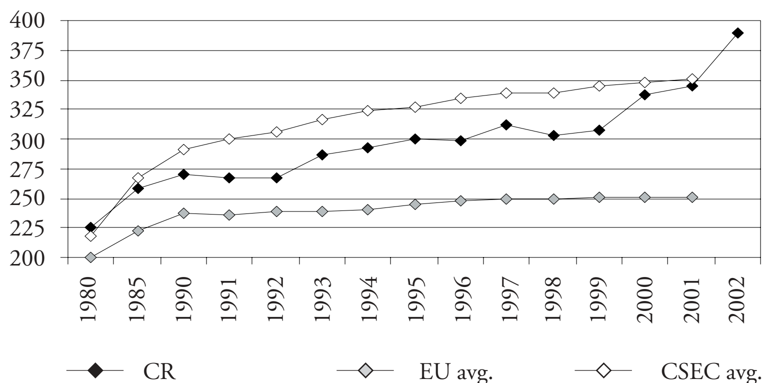


Figure A14.
GPs per 100,000 Individuals

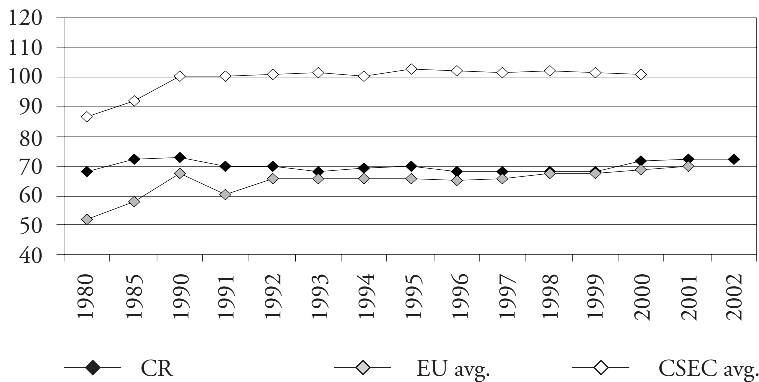


Table A14.
Bed Occupancy Rate in Acute Care Hospitals (%)

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR	81.8	80.8	69.6	69.0	70.2	71.6	73.0	72.6	74.1	71.8	70.8	67.7	70.7	70.5	72.1
EU avg.	76.5	76.8	77.0	77.2	77.4	77.3	77.1	77.5	77.2	76.9	77.9				
CSEC avg.	83.7	82.2	76.0	72.9	73.2	71.8	73.9	74.5	75.6	75.5	74.5	71.3	71.5	72.0	

Table A15.
Private Inpatient Hospital Beds as Percent of All Beds

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR	0.3	1.7	3.8	6.5	8.3	9.4	9.6	9.8	10.4	10.4	31.4
EU avg.	20.1	20.8	21.7	22.5	22.4	22.2					
CSEC avg.	0.1	0.2	0.5	0.8	1.1	1.2	1.4	1.5	1.7	1.6	

Figure A15.
Bed Occupancy Rate

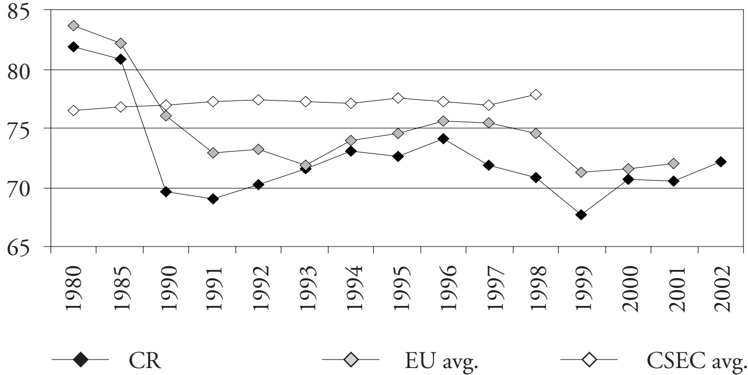


Figure A16.
Private Hospital Beds

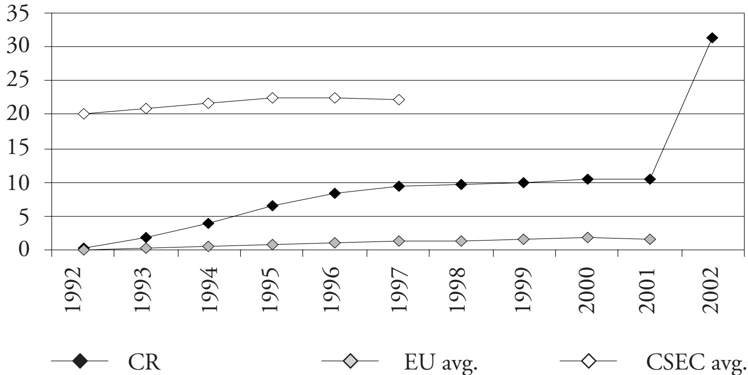


Table A16.
Hospital Beds per 100,000 Individuals

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CR	1,085	1,099	1,092	1,069	1,035	1,005	982	922	897	877	862	847	855	858	831
EU avg.	964	917	799	748	724	702	687	673	664	648	640	629	622		
CSEC avg.	801	810	811	803	770	766	749	732	727	706	684	669	663	657	

Figure A17.
Hospital Beds per 100,000 Individuals

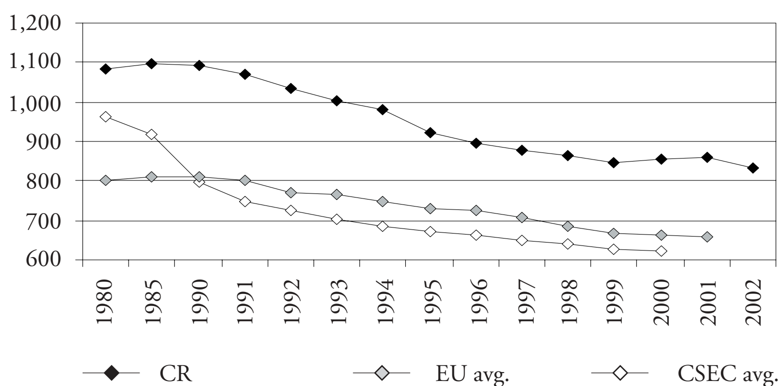


Table A17.
Percent of Population Aged 0–14 Years

Male	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
• CR	24.6	24.6	22.6	22.0	21.4	20.8	20.2	19.6	19.1	18.6	18.2	17.7	17.3	16.9	16.6
• EU aver.	22.7	20.4	19.1	18.9	18.8	18.6	18.5	18.3	18.1	17.9	17.9	17.8	17.7		
• CSEC aver.	25.6	25.4	24.6	24.2	23.8	23.3	22.9	22.4	22.0	21.5	21.0	20.5	19.9	19.2	
Female															
• CR	22.1	22.1	20.4	19.8	19.2	18.7	18.2	17.6	17.2	16.8	16.3	16.0	15.6	15.3	14.9
• EU aver.	20.4	18.3	17.2	17.1	17.0	16.9	16.8	16.6	16.4	16.3	16.3	16.1	16.0		
• CSEC aver.	23.4	23.2	22.4	22.0	21.6	21.1	20.7	20.2	19.8	19.3	18.9	18.4	17.9	17.3	

Figure A18.
Percent of Population Aged 0–14 Years

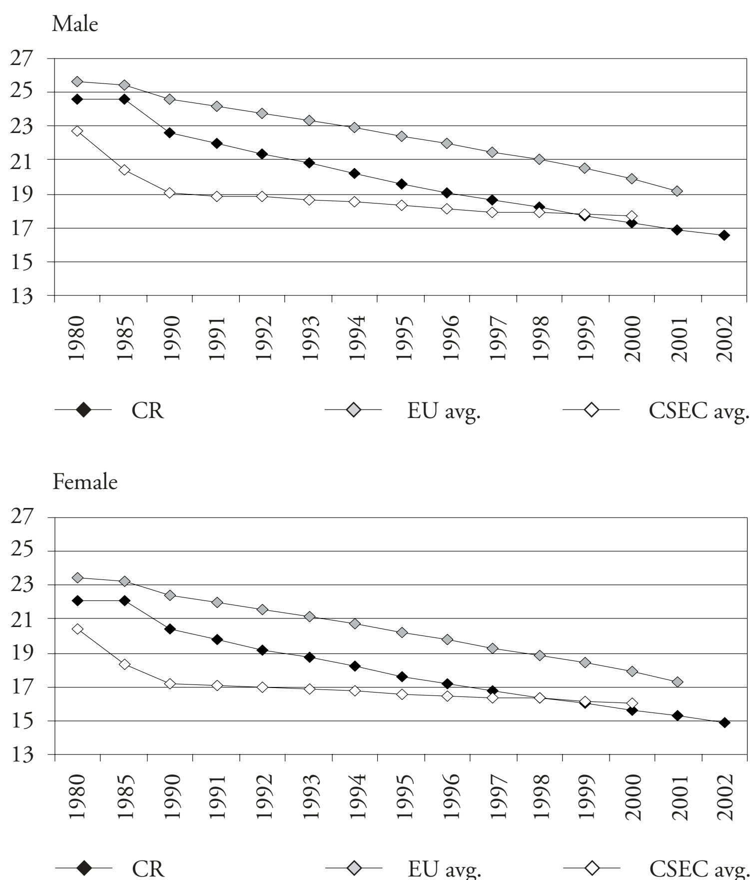


Table A18.
Percent of Population Aged 65+

Male	**1980**	**1985**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
• CR	10.8	9.2	9.7	9.9	9.9	10.0	10.2	10.3	10.5	10.6	10.8	10.9	10.9	10.9	11.0
• EU aver.	11.3	10.9	11.6	11.8	12.0	12.2	12.4	12.7	12.9	13.1	13.1	13.3	13.5		
• CSEC aver.	8.8	8.0	8.5	8.7	8.9	9.1	9.2	9.4	9.6	9.8	10.0	10.1	10.3	10.6	
Female															
• CR	16.0	14.4	15.2	15.4	15.5	15.7	15.8	16.0	16.2	16.3	16.4	16.5	16.6	16.6	16.6
• EU aver.	16.5	16.4	17.5	17.7	17.9	18.0	18.2	18.3	18.5	18.6	18.7	18.9	18.9		
• CSEC aver.	12.5	11.9	12.8	13.0	13.4	13.6	13.8	14.0	14.3	14.5	14.7	14.9	15.1	15.6	

Figure A19.
Percent of Population 65+

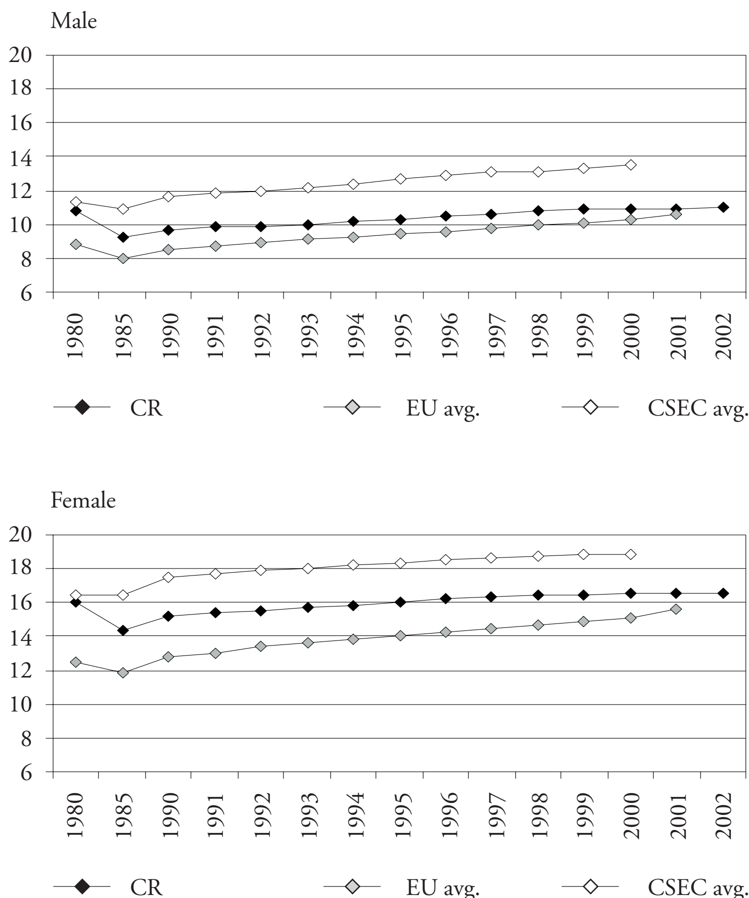


Table A19.
Live Births per 1,000 Individuals

Male	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
• CR	15.9	13.9	13.3	13.3	12.5	12.4	10.9	9.8	9.3	9.3	9.3	9.2	9.4	9.4	9.6
• EU aver.	13.8	12.6	12.7	12.3	12.2	11.8	11.5	11.3	11.4	11.4	11.3	11.2	11.2		
• CSEC ave.	18.0	16.8	14.7	14.2	13.4	13.0	12.5	11.8	11.6	11.3	11.0	10.8	10.8	10.5	
Female															
• CR	14.0	12.4	11.9	11.8	11.1	11.1	9.8	8.8	8.3	8.3	8.3	8.3	8.3	8.4	8.6
• EU aver.	12.3	11.3	11.4	11.1	11.0	10.7	10.4	10.3	10.3	10.3	10.2	10.1	10.2		
• CSEC aver.	16.3	15.2	13.3	12.8	12.1	11.6	11.3	10.6	10.4	10.0	9.8	9.6	9.6	9.3	

Figure A20.
Live Births per 1,000 Individuals

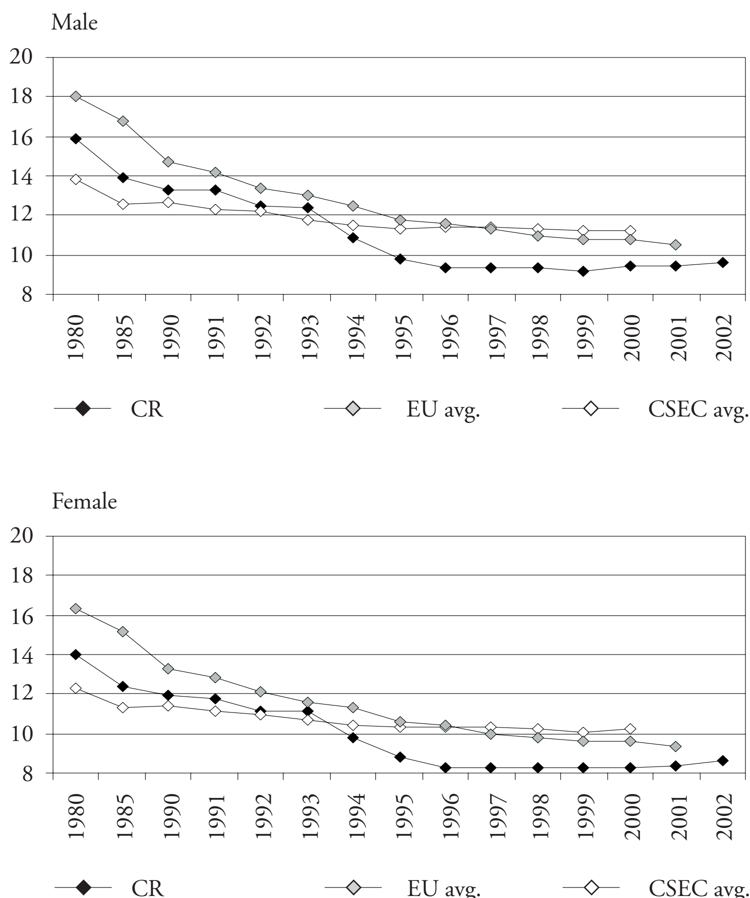
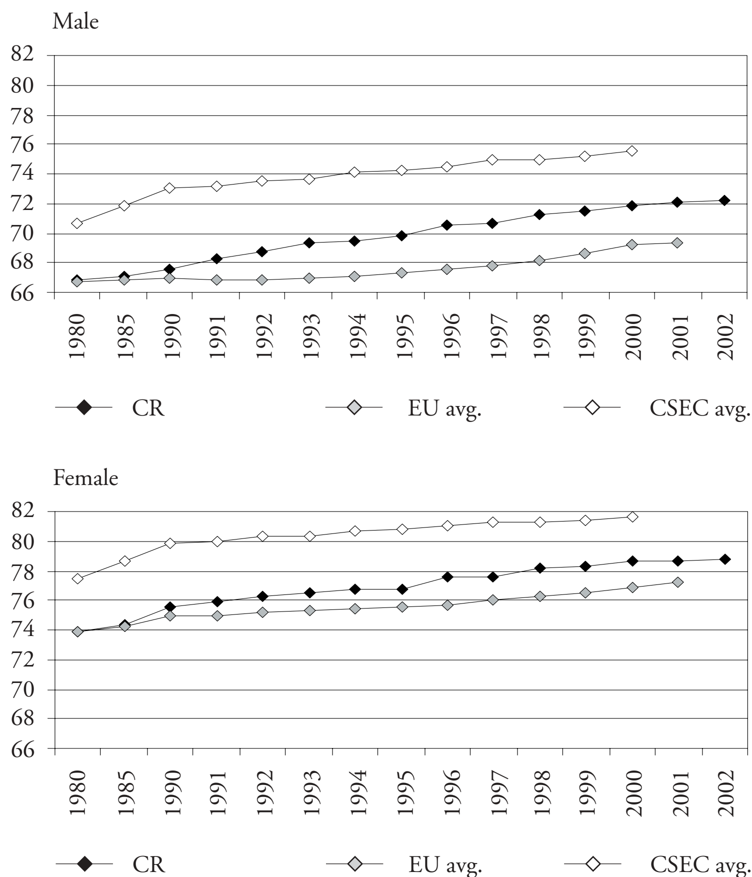


Table A20.
Life Expectancy at Birth, in Years

Male	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
• CR	66.8	67.1	67.6	68.3	68.8	69.3	69.5	69.8	70.5	70.6	71.2	71.5	71.8	72.1	72.2
• EU aver.	70.7	71.9	73.1	73.2	73.5	73.6	74.1	74.2	74.5	74.9	75.0	75.2	75.5		
• CSEC aver.	66.7	66.8	67.0	66.8	66.8	67.0	67.1	67.3	67.6	67.8	68.2	68.6	69.2	69.4	
Female															
• CR	73.9	74.4	75.5	75.9	76.3	76.5	76.7	76.8	77.6	77.6	78.2	78.3	78.6	78.7	78.8
• EU aver.	77.5	78.6	79.8	80.0	80.3	80.3	80.7	80.8	81.0	81.3	81.3	81.4	81.7		
• CSEC aver.	73.9	74.2	75.0	75.0	75.2	75.3	75.4	75.6	75.7	76.0	76.3	76.5	76.9	77.2	

Figure A21.
Life Expectancy at Birth, in Years



ANNEX 2: Socio-economic Indicators

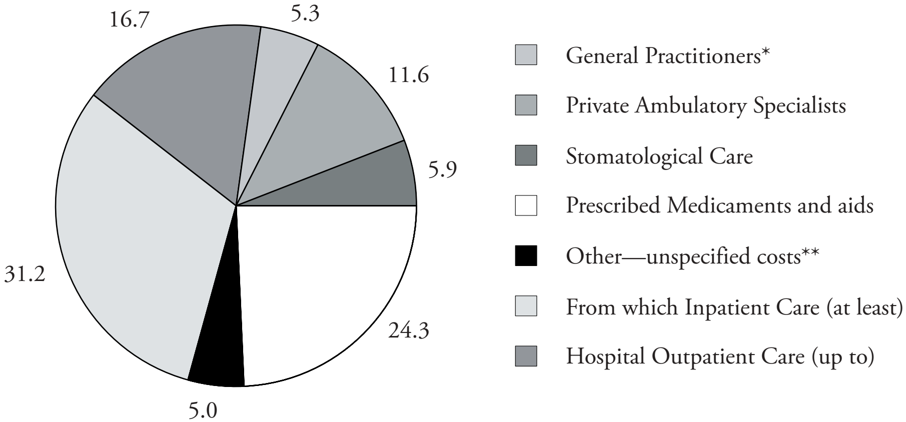
Table A21.
Healthcare Costs of Health Insurance Funds in 2001

	in %
Total Healthcare Costs	**100.0**
• General Practitioners*	5.3
• Private Ambulatory Specialists	11.6
• Stomatological Care	5.9
• Prescribed Medicaments and aids	24.3
Other—not specified costs**	5.0
Hospitals and other bed-facilities	**48.0**
• From which Inpatient Care (at least)	31.2
• Hospital Outpatient Care (up to)	16.7

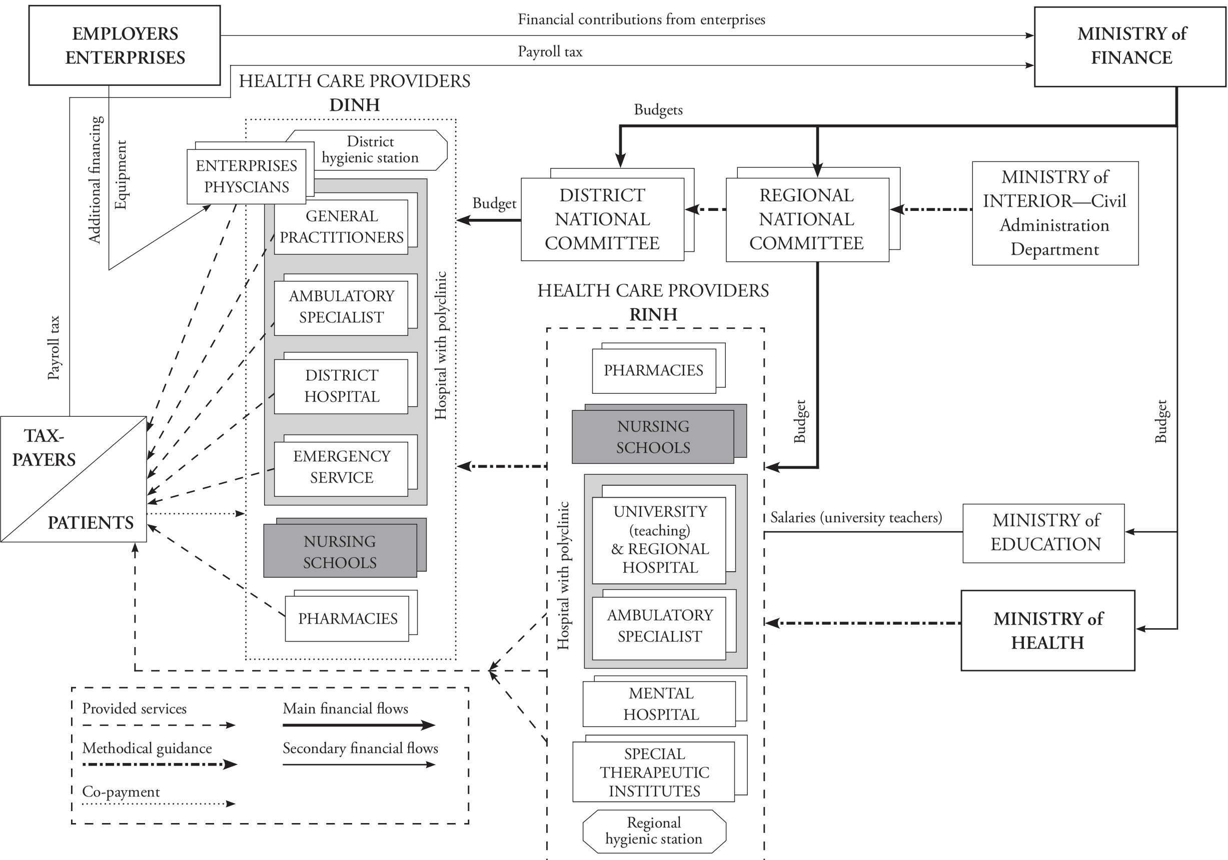
Notes: * GP for adults + children + gynecologists.

** Including spas, treatment abroad, transport, etc.

Figure A22.
Healthcare Costs of Health Insurance Funds in 2001

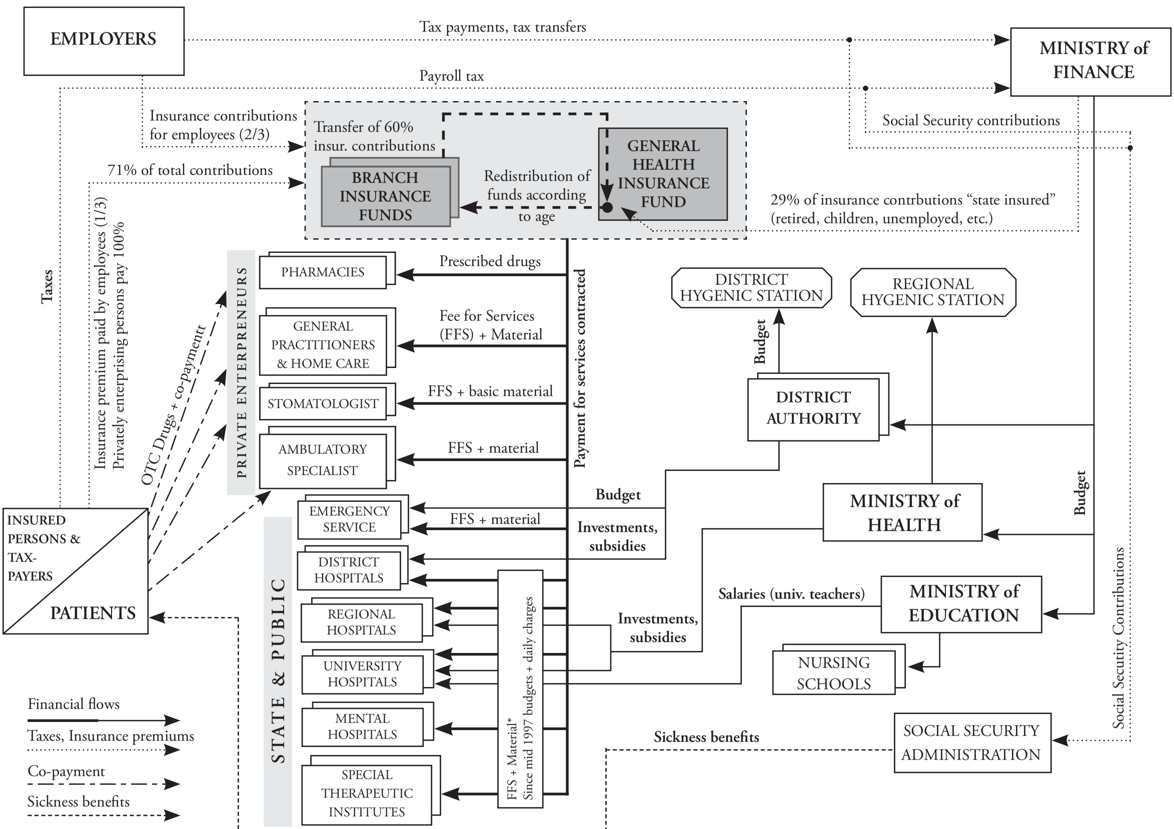


ANNEX 3: Healthcare Financing before 1992



Source: © Czech Association for Health Services Research, 2003.

ANNEX 4: Healthcare Financing 1993–2000



Source: © Czech Association for Health Services Research, 2003.

ANNEX 5: Healthcare Financing after 2003

EMPLOYERS

Tax payments, tax transfers

MINISTRY of FINANCE

Payroll tax

Insurance contributions for employees (2/3)

Transfer of 60% insur. contributions

Social Security contributions

77% of total contributions

BRANCH INSURANCE FUNDS

Redistribution of funds according to age

GENERAL HEALTH INSURANCE FUND

23% of insurance contrbutions "state insured" (retired, children, unemployed, etc.)

Taxes

Insurance premium paid by employees (1/3)
Privately enterprising persons pay 100%

OTC Drugs + co-payment

PRIVATE ENTERPRENEURS

PHARMACIES

Prescribed drugs

GENERAL PRACTITIONERS & HOME CARE

Capitation fee+FFS
85–90 : 15–10%

STOMATOLOGIST

Price list + co-payment
70 : 30%

AMBULATORY SPECIALIST

FFS + Total time limit and Expenditure ceiling

Payment for services contracted

DISTRICT HYGENIC STATION

REGIONAL HYGENIC STATION

Budgets

Defined part of all taxes from the region

REGIONAL AUTHORITY

Budgets

INSURED PERSONS & TAX-PAYERS

PATIENTS

STATE & PUBLIC

EMERGENCY SERVICE

FFS + material

Budget

Investments, subsidies

MINISTRY of HEALTH

DISTRICT HOSPITALS

REGIONAL HOSPITALS

UNIVERSITY HOSPITALS

MENTAL HOSPITALS

SPECIAL THERAPEUTIC INSTITUTES

Budgets + daily charges per case

Salaries (professors)

Investments, subsidies

MINISTRY of EDUCATION

NURSING SCHOOLS

Social Security contributions

SOCIAL SECURITY ADMINISTRATION

Sickness benefits

Financial flows

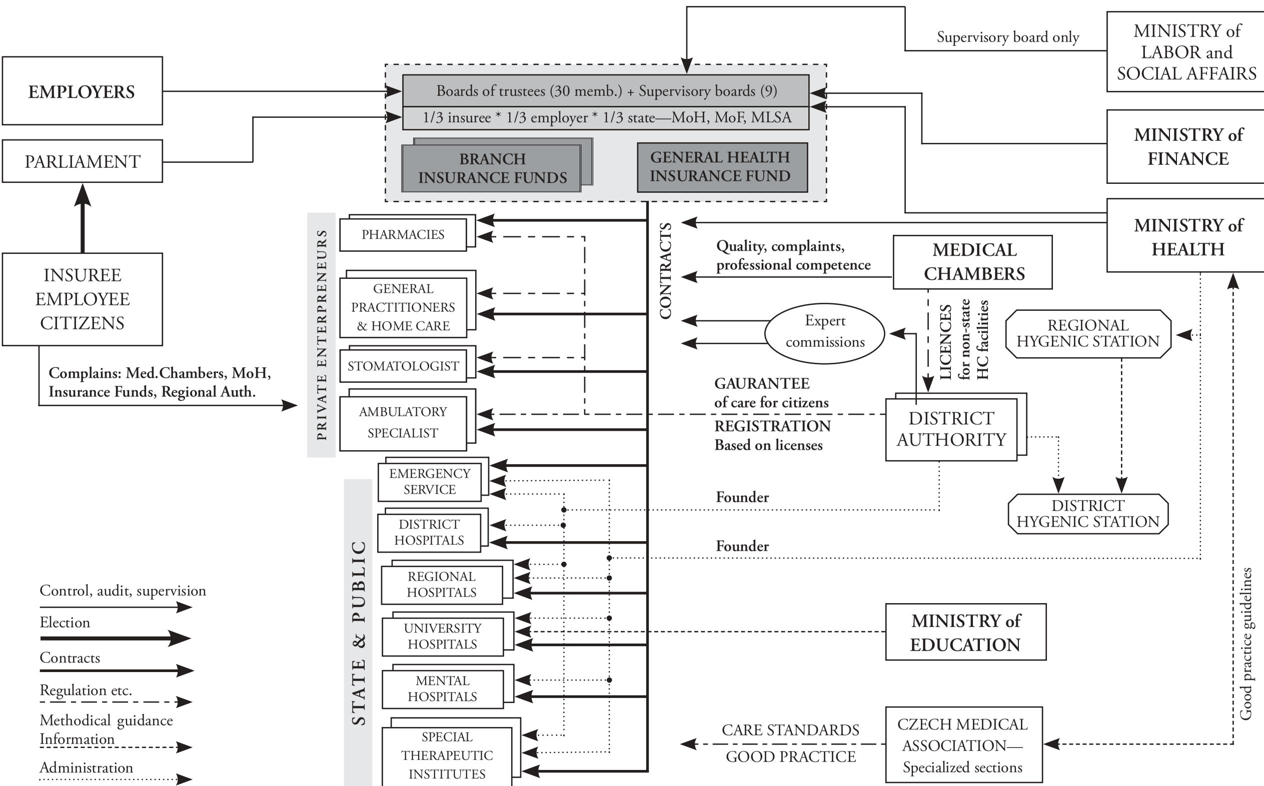
Taxes, Insurance premiums

Co-payment

Sickness benefits

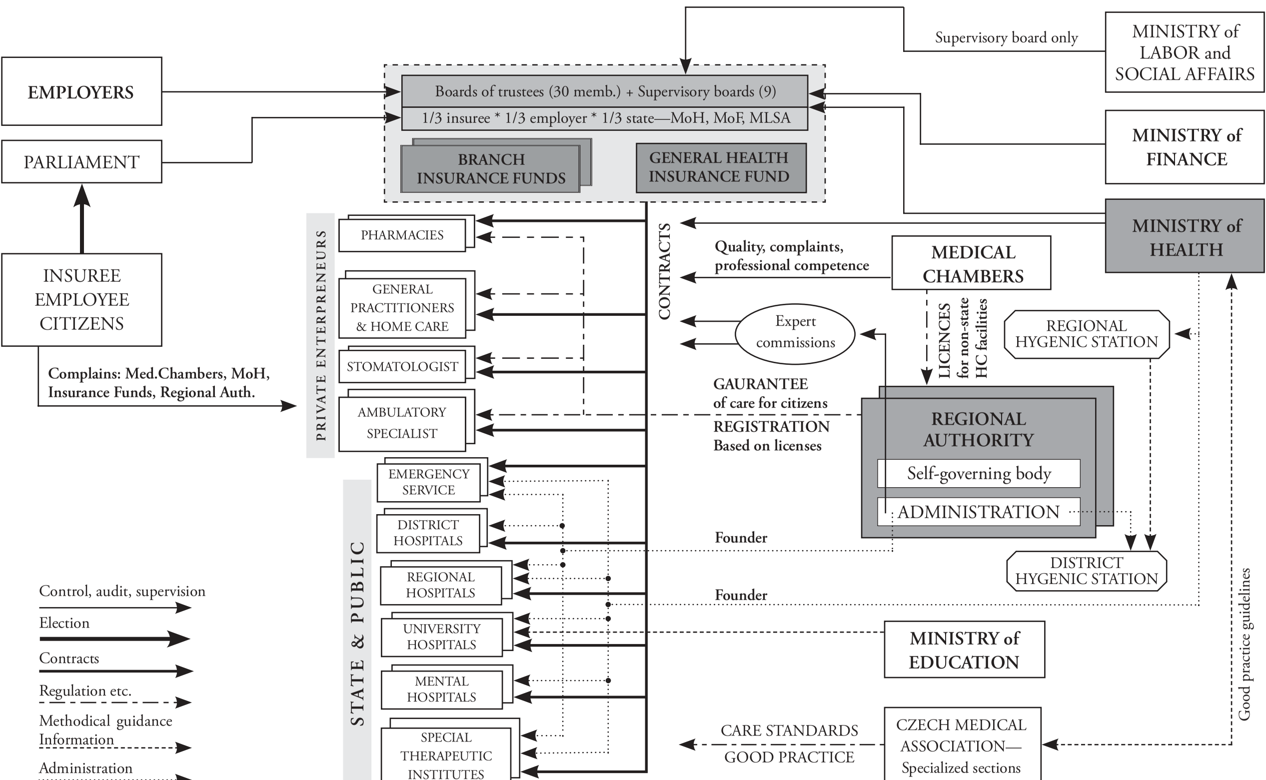
Source: © Czech Association for Health Services Research, 2003.

ANNEX 6: Administrative Competencies 1993–2002



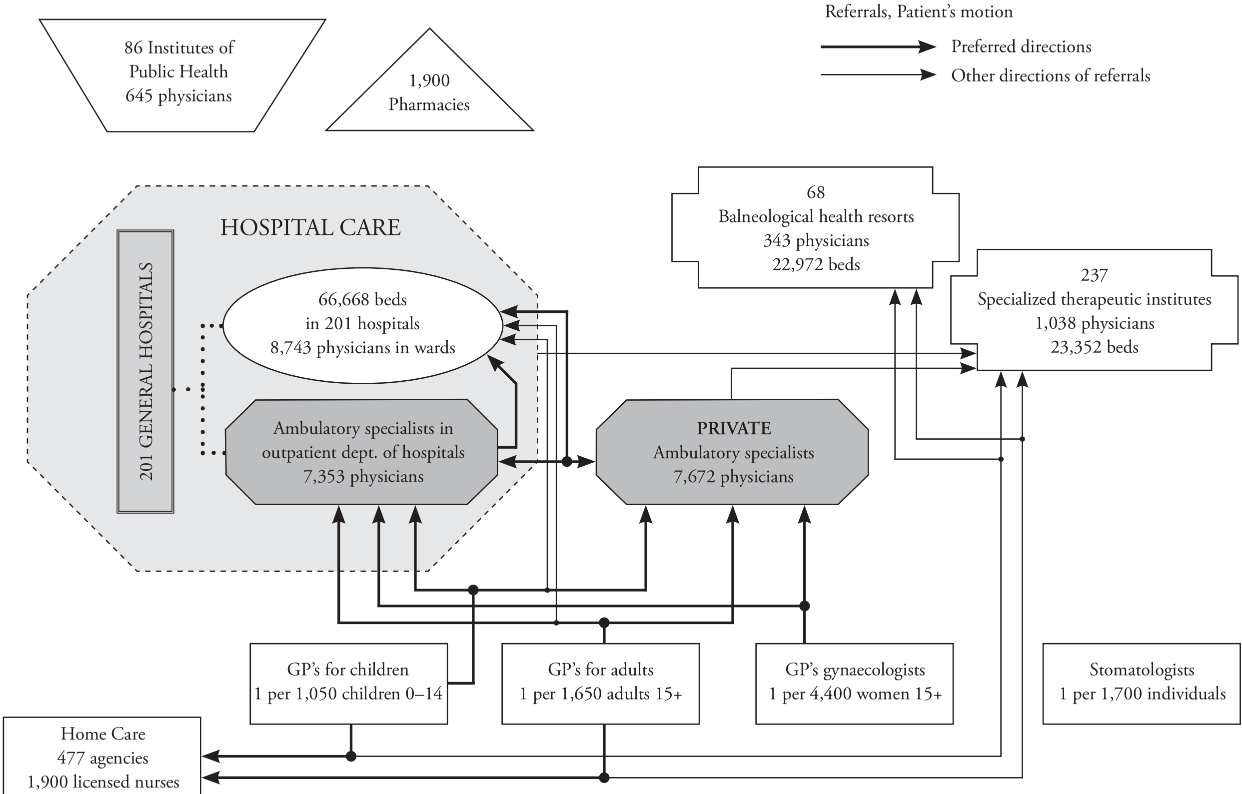
Source: © Czech Association for Health Services Research, 2003.

ANNEX 7: Administrative Competencies in 2003



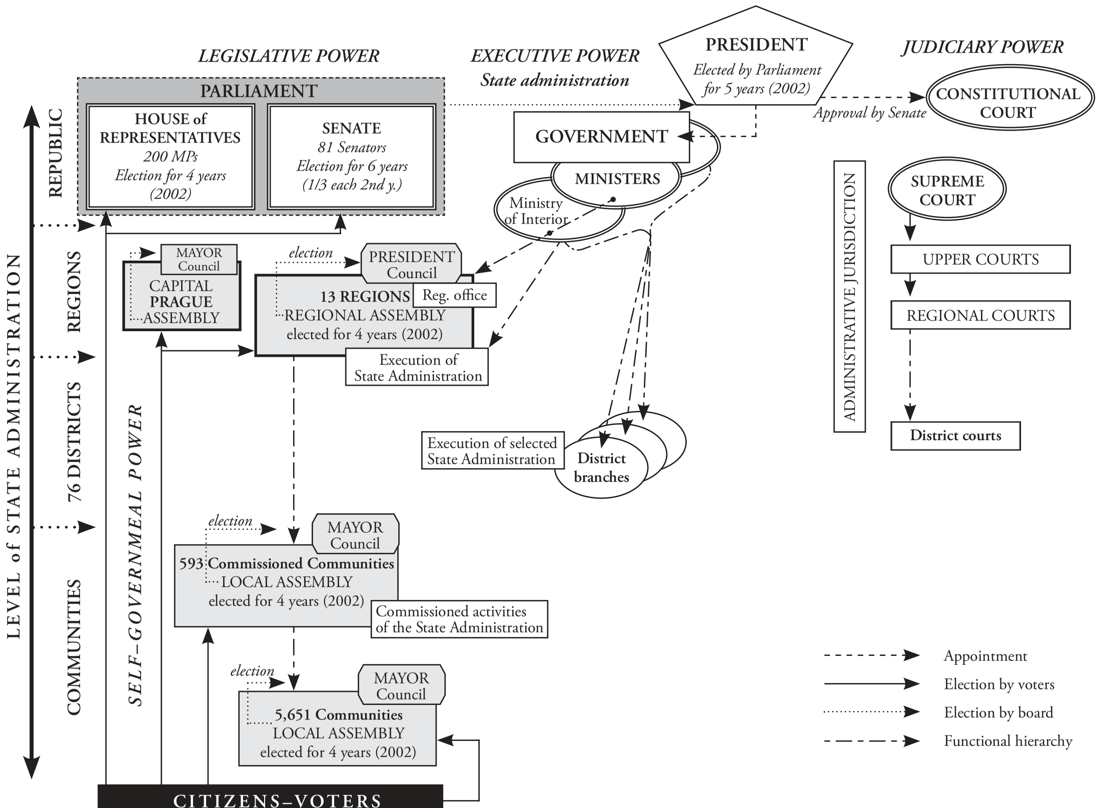
Source: © Czech Association for Health Services Research, 2003.

ANNEX 8: Organization of Healthcare Providers as of 2003



Source: © Czech Association for Health Services Research, 2003.

ANNEX 9: Public Administration and Local Government as of 2003



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