Health policy reforms in the Czech and Slovak Republics as a political process

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Martin Potůček
Institute of Sociological Studies, Faculty of Social Sciences
Celetná 20, 116 36 Prague 1, the Czech Republic
tel. +(4202)24491492
secretary +(4202)24210505
fax +(4202)24227950
e-mail potucek@s.fsv.cuni.cz

Summary

In both the Czech and Slovak republics, the concept of health care reform was based on the principle of compulsory health insurance, pluralisation of the provision and financing of health care (mostly by means of privatisation) which represented the abolishment of previous highly centralised health care system run by the state. The birth of the new system was full of complications: especially, it faced growing fiscal tensions and dissatisfaction of the health professionals with their position and salaries. The Czech approach favoured market-conform approaches, especially fast privatisation. Strong multinational pharmaceutical firms entered the market with medicaments; the state proved to be too weak to execute an effective regulation of prices there. The privatisation was slower in Slovakia. Unlike in Slovakian case, the Czech medical profession was able to use the newly established corporatist institutions (e.g. Chambers of Physicians, Dentist and Pharmacists) to „capture“ the governmental policy and pursue their, especially economic, interests. The Slovak approach relied more on the state regulatory functions, such as a locally and regionally specific description of basic necessary health services, cross-sectional programmes, regulation of the market with medicaments and the reform of public health sector. Non-profit organizations represent emerging, potentially important, but until now not impressively strong agents of health care delivery in both the Czech Republic and Slovakia.

Czech and Slovak health care systems compared[1]

Marrée and Groenewegen (1997: 21) pointed out recently: „.. the general tendency in the reform of health care systems of Central and Eastern Europe is a Bismarckian type of health and social insurance system". This is the valid and at the same time also the most important characteristic of health reform efforts in both countries in question.

After 1989, the reform programs relating to health care, and the first steps in their implementation, contained many common features in the Czech Republic and Slovakia, in particular:

- the introduction of compulsory health insurance (with the contribution of employees, employers and the state)
- broad changes in the forms of ownership of health care units, represented by transfer of state ownership to municipal ownership and/or privatisation of state property, esp. in ambulatory care, spa treatment, pharmaceutical facilities [2]
- the abolishment of highly centralised health care system and increase of the scope for free decision making of health care units, including their financial independence and responsibility[3]
- free choice of a physician and/or health care unit.
- the intent to improve the social and economic status of physicians and other health care personnel (not yet realised).

In both countries, first comprehensive reform proposals were elaborated and accepted as soon as in the Autumn 1990. General similarity of health reform programs allowed for some differences in their institutional framework, political processes of their realisation (or postponement) and effects. These divergent trends gained additional momentum after the June 1992 general elections.

[1] For more detail, see Háva et al. (1997), Háva-Kružík (1997), Nemec-Mikundová (1997) and Radičová - Potůček (1997). The paper couldn´t have been prepared without the support of the IWM Vienna which sponsored the SOCO Research Project „Comparative Analysis of the Czech and Slovak Social Policies since 1989" as its exclusive sponsor.

[2] The privatization of hospitals proved to be a very difficult and long-term task. Even in the Czech Republic, where privatization enjoyed full governmental support, only 6,7% of all hospital beds belonged to the private sector in 1995.

[3] At the end of 1989, there were only 116 legally autonomous health care units, mostly Regional and District Institutes of National Health in the Czech Republic. At the end of 1991, there were 430 such autonomous units, at the end of 1992, 3,965 units, and on 1 June 1993, 6,449 units.

The Czech Republic	The Slovak Republic
privatisation of ambulatory units as well as hospitals has been encouraged since 1991	privatisation of ambulatory units has been allowed; privatisation of hospitals has been postponed
many Health Insurance Companies were established as soon as in 1991 - 1992. In 1993, they started to collect contributions. Later on some of them collapsed.	only one Health Insurance Fund was created - as part of a unified National Insurance Company. In 1993, it was dependent on the state budget. Since 1994, an independent General Health Insurance Fund originated, and other Health Insurance Funds have been established as well
a fee-for-service scheme was chosen as the principal way of financing health care units from insurance funds. Only in 1996 there started serious preparatory activities to replace it by a more sophisticated ones. Some of them were implemented in 1997	a combination of financing schemes, incl. fee-for- service, capitation, budgeting and lump sum payments was chosen as the way of financing health care units
Ministry of Health has not applied any effective regulatory device to preserve satisfactory health care capacities at the local and regional level	Ministry of Health has applied a locally and regionally specific description of basic necessary health services
cross-sectional programmes have not been favoured by government. Nevertheless, some of them were - more or less formally - accepted	cross-sectional programmes (such as a National Programme of Health Promotion and various more specific programs) have been supported
transformation of previous system of hygienic stations into a network of State Health Institutes has not been realised	transformation of previous system of hygienic stations into a network of State Health Institutes has been realised
pharmaceutical firms entered the market with only a very loose governmental regulation	government regulated the market with medicaments in order to reduce expenditures, especially in 1993-1997
after the introduction of compulsory health insurance scheme in 1993, state has not been able to regulate health care expenditures effectively	after the introduction of compulsory health insurance scheme in 1993, state preserved quite effective means how to regulate health care expenditures, esp. by keeping state contributions for economically inactive individuals at a low level

If we are to analyse the path of health care reform as a political process, we can identify two significant differences.

1. In the Czech Republic, professionals have been quite successful in „capturing“ government, especially the Ministry of Health, in order to protect their interests. They used for this purpose the corporatist institutions - the Czech Chambers of Physicians, Dentists and Pharmacists, Trade

Unions (the more moderate one - the Union of Workers in Health and Social Care, and the more radical Physicians Trade Union Club). In Slovakia, physicians and other professionals were not able to organise influential lobbies even if they established similar „corporatist" institutions as their Czech counterparts. The scope of their responsibility is narrower as defined by law as well. Thus, the dominant force of decision-making remained the government there.

2. The Slovak government was more active in health legislation and in programming. The second comprehensive health care reform document was accepted by Slovakian authorities in 1995. In the Czech Republic, there has not been accepted any similar document since 1990. In the Czech Republic, the old Law on Health Care from 1966 is still valid, though with many amendments. In Slovakia, a series of new laws has been passed during last couple of years, including the new Law on Health Care (1994), the Law on Health Protection (1994) and the Law on Conditions of Treatment (1995).

There is one common feature of the health policy in both countries: the striking deficiency of civil involvement in health policy making. One of deficiencies is the lack of an efficient public debate about the direction and speed of the reform. The other one stems from the fact that the institutions of self-management (e.g. Supervisory Boards of Health Insurance Funds and hospitals) resemble empty shelves - they failed in performing their steering functions.

In both countries, the system of compulsory health insurance is facing budgetary crisis: increasing number of hospitals, ambulatory units, and Health Insurance Funds are in debt. The common reason of this situation is the inefficient allocation of financial resources.

More generous spending on health care in the Czech Republic can be understood as a result of better economic situation there[4].

Table: Health expenditures as the % of GNP

Year	1991	1992	1993	1994	1995	1996
the Czech Republic	5,5	5,7	7,4	8,1	8,1	8,7
the Slovak Republic	6,4	6,4	5,3	5,5	6,1	n.a.

Source: Radičová - Potůček (1997)

Table: Expenditures on medicaments as the % of GNP

Year	1991	1992	1993	1994	1995	1996
the Czech Republic	1.07	1,53	1,56	1,93	2,05	1,98
the Slovak Republic	1,17	1,46	1,85	1,58	1,66	n.a.

Source: Radičová - Potůček (1997)

4 The Slovak currency was devaluated by 10% relative to the Czech currency in the Spring 1993; by 1 July 1993 the state budget was in a slight surplus in the Czech Republic, the Slovak state budget was in a huge deficit of about 13 billion Slovak crowns (approximately 0,4 billion US$).

Traditional functional indicators of health care - number of inhabitants per one physician and number of hospital beds per 10 000 inhabitants - have not changed too much during the first phase of reforms.

Table: Number of inhabitants per one physician

Year	1991	1992	1993	1994	1995
Czech Republic	290,6	293,0	278,8	273,1	268,4
Slovak Republic	272	281	279	290	n.a.

Source: Radičová - Potůček (1997)

The ratio of salaries in the health care sector, especially physicians ones, are still much lower than in developed countries.

Table: Number of hospital beds per 10 000 inhabitants

Year	1991	1992	1993	1994	1995
Czech Republic	128,9	126,2	122,5	121,0	113,6
Slovak Republic	76,0	76,0	79,0	71,0	75,2

Source: Radičová - Potůček (1997)

There has been a boom in the number of high-tech operations in the Czech Republic. There were undertaken 189 transplantations in 1991 and 493 in 1995, 1657 cardiosurgeries in 1991 and 4008 in 1995. I have no corresponding figures for Slovakia.

The role of the civic sector

The social function of the civic sector is by Frič et al. (1996:29n.) divided into the service function (the own output and providing special services), and the participation function (meeting the need to associate, actively contribute to activities of given organization and influence it). The civic sector offers to people possibility to freely choose forms of own participation at life of larger communities, it opens room for their self-realization in immediate, not estranged and non-formalized shapes of social contacts and cooperation, and all this as an opposite pole to superficial, formal forms of human contact which prevail much in life of current society.

After its formation in 1918, the independent Czechoslovak state linked up to quite rich traditions of volunteerism inherited from the Austria-Hungarian empire. Higher emphasise than before was put to activities in caring for the poor and the youth. Some clubs had a semi-official nature (for instance The Land and the District Care for the Youth, Masaryk´s League against tuberculosis, and others). Between the two world wars, for instance, the membership rate in national organization of the Red Cross was 7%, by which Czechoslovakia ranked the second world-wide, just after the USA (with 11%).

The civic society institutionally mediated expression of the citizens interests independently of the state, was for the totalitarian system, which took over power in 1948, the public enemy number one. That is because the communist system required social atomization as an inevitable condition for its survival and reproduction. Therefore it made everything imaginable to destroy those forms of social, political and economic relations which could support individual and group independence, and give content and sense to activities and

relations among people... (and, at the same time) it maximized power monopoly of the party. (Schöpflin 1991). The number of nonprofit organizations got drastically declined: from about 60 000 before the Communist coup d´état to mere 683 after it. This poor rest was put into totalitarian corporate system of so called National Front. It was an embodiment of the so called "mobilized participation" which became a tool of the central supervision of the leading communist party over all forms of associating people. (Weigle-Butterfield 1993) According to accessible data, there were only slightly above 2,000 civic associations registered in 1989 (including their organizational units, chambers, interest groups and foundations).

Such political circumstances influenced human behavior for two generations. Not surprisingly, the Czech and Slovak public still do not attach high importance to existence of nonprofit organizations.

From the seventeen fields of public interest, the Czech citizens addressed in our research, support for the nonprofit organizations took the last position.

Table: Importance of civic sector in eyes of the Czech citizens and representatives of local government (answers in %)

I consider support for independent and nonprofit organizations for myself and my friends as:	Citizens	Representatives of local governments
decisively important	8	13
rather important	16	22
half by half - in something important, in something not	32	34
rather unimportant	13	14
decisively unimportant	7	4
don't-know	24	13

Source: Purkrábek et al. (1996)

Now let's look at the table comparing present and potential participation of citizens in activities of various organizations of the civic sector which may have connection to health and social care.

Table: Willingness to personal participation in activities of the following organizations, the Czech Republic, 1995 (% of answers)

Organization	I participate	I would like to participate	I want to participate but I cannot	I don't want to participate
Voluntary organization providing services for the public	6	16	29	49
Church, religious organizations	7	5	7	81

Source: Purkrábek et al.(1996)

Lesser participation and lower potential for taking part we notice at church, religious organizations. On the other hand, the research discovered currently low participation but extreme interest in contingent future participation in voluntary institutions providing health and social care.

The extent of Slovakia citizens´ participation in voluntary activities associated with health and social care is mirrored in the following table.

Table: Respondents involved in selected voluntary activities, the Slovak Republic, 1995 (% of answers)

NGOs assisting hospitals, health care and social welfare institutes	5.4
NGOs assisting people with health problems and the disabled	3.9
NGOs assisting needy people	1.9
NGOs promoting drug prevention and treatment	0.9

Source: Bútora - Hunčík (1997:227)

There was recorded a slight increase of the number of Slovakian residents providing voluntary and unpaid work to NGOs between 1993 and 1995.

Table: Answer to the question „Did you work last year freely and without pay for some NGO? The Slovak Republic, (% of answers)

Year	1993	1995
Yes	11	13
No	85	82
Don't know	4	5

Source: Bútora - Hunčík (1997:227)

Health status of inhabitants in both countries

The health of the population is not predominantly influenced by health care. It is improving in both countries if measured by the life expectancy at birth; we believe that the key factors which play their role in this positive development can be found especially in the sphere of life style; many people also have greater space for self-fulfilment due to the political and economic changes after 1989.

Table: Life expectancy at birth (CR - Czech Republic, SR - Slovak Republic)

Year	1990	1991	1992	1993	1994	1995	1996
Men - CR	67,5	68,2	68,5	69,3	69,5	70,0	70,4
Men - SR	66,6	66,7	67,6	68,4	68,3	68,4	68,8
Women - CR	76,1	75,7	76,1	76,4	76,6	76,9	77,3
Women - SR	75,4	75,4	76,2	76,7	76,5	76,3	76,6

Source: Radičová - Potůček (1997)

One of the rare indicators of the quality of health care are figures concerning infant mortality.

Table: Children's mortality at birth, ‰

Year	1990	1991	1992	1993	1994	1995	1996
CR	7,7	7,0	6,2	5,7	4,7	4,9	3,8
SR	8,4	8,9	8,3	7,5	7,4	7,9	n.a.

Source: Radičová - Potůček (1997)

Conclusion

The health care reforms in both countries in question have preserved similar goals as well as means. Nevertheless, there were identified important differences, too. One of them is the structure of political decision-making: the sovereign and the key agent of the Slovakian health care reform is government, whereas in the Czech Republic there has developed a more „corporatist" structure, with a sort of a dead-lock situation: professionals are able to influence many governmental decisions, but the government is not able to develop and realise an overall vision of reform. Thus, professionals can pursue their interests only in marginal decisions which hardly contribute to the overall efficiency of the system. The Czech way of health care transformation is no doubt more liberal, with a lack of efficient governmental steering; the system has not effective cost-containment instruments; it failed to gather necessary data about the real performance of health care system; as a consequence, we can see an increasing indebtedness of many health care units and health insurance funds, lack of rationing and dissatisfaction of health professionals. On the other hand, the Czech system is more generous and allows for innovations, whereas the Slovakian health care system is less flexible. The Slovakian approach is stronger and faster where the state has to play its role: in implementation of legislative changes, in the transformation of public health institutions, in optimising the network of health care facilities at the regional and district level, in preventing excessive overspending, in initiating various cross-sectional programs and actions. The Czech approach is stronger and faster where the market can play its role: in privatisation, in pluralization of health care provision and financing etc.[5] Non-profit organizations represent emerging, potentially important, but until now not impressively strong agents of health care delivery in both countries.

[5] After 1996 general election, the Czech governmental program became more balanced; it was too obvious, that the market couldn't regulate health care provision properly without parallel governmental checks and stimuli.

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