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Czechoslovakia's Changing Health Care System

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Synopsis

Before World War II, Czechoslovakia was among the most developed European countries with an excellent health care system. After the Communist coup d'etat in 1948, the country was forced to adapt its existing health care system to the Soviet model. It was planned and managed by the government, financed by general tax money, operated in a highly centralized, bureaucratic fashion, and provided service at no direct charge at the time of service.

In recent years, the health care system had been deteriorating as the health of the people had also been declining. Life expectancy, infant mortality rates, and diseases of the circulatory system are higher than in Western European countries.

In 1989, political changes occurred in Czechoslovakia that made health care reform possible. Now health services are being decentralized, and the ownership of hospitals is expected to be transferred to communities, municipalities, churches, charitable groups, or private entities. Almost all health leaders, including hospital directors and hospital department heads, have been replaced. Physicians will be paid according to the type and amount of work performed.

Perhaps the most important reform is the establishment of an independent General Health Care Insurance Office financed directly by compulsory contributions from workers, employers, and government that will be able to negotiate with hospitals and physicians to determine payment for services.

CZECHOSLOVAKIA IS A LONG, narrow, landlocked country in central Europe, surrounded by Poland, Hungary, Austria, Germany, and a small part in the east by Ukraine. Geographically, there are three regional areas— Bohemia and Moravia in the west and Slovakia in the east—that were combined following World War I to form present Czechoslovakia. Politically, the country was divided into two republics, Bohemia and Moravia forming the Czech Republic and Slovakia forming the Slovak Republic. Of today's total population of 15.6 million, two-thirds live in the Czech Republic and one-third live in the Slovak Republic.

As a result of the Munich Agreement in 1938 between western European powers and Germany, Bohemia and Moravia fell under German protec-

torship and Slovakia became an "independent" state with a pro-German government. This was meant to appease German territorial demands in Europe, but German troops soon occupied all of Czechoslovakia. In 1939, the Germans invaded Poland, touching off World War II that brought devastation to Czechoslovakia. Large segments of the population were wiped out, most material resources were destroyed, malnutrition and disease were widespread, and the medical and sanitation systems disrupted (*1*).

Following World War II, Czechoslovakia came under Soviet influence along with the other countries of eastern Europe. A socialist political structure, economy, and health system were established similar to that of the Soviet Union. For almost 40 years the public health system provided health care with no charge at time of service. It was managed, planned, and financed by the government and operated in a highly centralized, bureaucratic fashion. It was possible, however, to receive preferential treatment by paying generous tips to health care providers. There was also a higher quality health care system for Communist party members and their families.

The country is more industrialized and diversified than neighboring Hungary and Poland. There was rapid economic development from the 1960s, but a combination of rigid central planning and a slowing international economy produced a recession by the 1980s. Since then the economy has declined slowly, but not as much as in most formerly socialist countries. Seriously underfinanced, the quality of the health system deteriorated (*2*). In November 1989, political changes provided the opportunity to reform the health care system and the economy. Government will continue to guarantee "adequate" health care for all, but the organization and financing are changing with the goal of improving medical care and the health of the people.

Health Status

The health status of the people has been declining and is below that of western Europe (*3*). This could be due to a number of factors such as poor nutrition, environmental pollution, widespread smoking and alcohol consumption, inadequate health care, and insufficient health education of the public.

While the mortality rates for most developed countries have decreased since the 1950s, Czechoslovakia's rates have remained about the same for women and increased for men, particularly among middle aged and elderly men (*3,4*). Although life expectancy in western Europe continues to increase, it remained relatively constant in Czechoslovakia and is significantly less than that of western Europe (see table). Infant mortality rates in Czechoslovakia have been steadily declining, from 16.6 per 1,000 live births in 1980 to 11.9 in 1988. Preliminary data for 1989 showed a further decline to 11.3 (10.3 in the Czech Republic and 13.5 in the Slovak Republic) but still higher than in western European countries (see table).

In Czechoslovakia, deaths from diseases of the circulatory system have not declined as they have in most industrialized countries. Diseases of the circulatory system accounted for 56 percent of all deaths in 1989. Although there has been a decrease in mortality among men since 1985, the rate is still higher than the rate in 1975. The rate for women remains about the same. It is disturbing that the incidence of heart disease in younger age groups (35 to 39 years) is increasing (*3a*).

The consumption of alcoholic beverages, both wines and spirits, continues to increase (*3b*). Smoking is prevalent and recognized by health authorities as a contributing factor to the increasing incidence of chronic diseases and death.

Health Services Administration

The Federal Government's responsibility for health was and still is to establish broad policy and standards through legislation; to propose each republic's budget, including the health budget, for approval by the Federal Assembly (parliament); and to disperse funds to each republic. There is no Federal Ministry of Health. The Slovak Republic and the Czech Republic each have a minister of health. At the Federal level, there is a Health Care Council, consisting of the ministers of health of the two republics and their deputies, that coordinates the republics' responses to health problems requiring unified action. The Ministry of Health in each of the two republics is responsible for providing health services and training medical personnel.

For administrative purposes, prior to 1990–91, each republic was divided into regions, and regions into districts. At the regional and district governmental levels, there were health committees that oversaw their departments of health. The departments of health were headed by a medical doctor, who was administratively accountable to the governmental body, but professionally responsible to the next higher department of health. For example,

a district department of health was administratively responsible to the district government, but professionally responsible to the regional department of health (fig. 1).

In 1990, organizational and administrative changes were begun to eliminate the hierarchical structure and government monopoly of health services by decentralizing authority and allowing health care facilities to have more autonomy or to become independent. Each republic is developing its own plans, but they are very similar. The Czech Republic's plan is described subsequently.

The Slovak Republic's plan probably will follow a similar path despite its independence from a Federal authority. The main outlines of reform were developed at the Federal level with participation by the Slovak parliament. The pace of Slovak reform, however, is likely to be slower than that of the Czech Republic because of its weaker financial position, exacerbated by the end of Federal transfer payments as the two republics become independent.

By 1991, regional authorities in the Czech Republic had been eliminated and their responsibilities assumed by districts or, in some cases, by communities or the ministry of health of the republic. Specialized and teaching hospitals were transferred to the republics' ministries of health. Some may become independent. Other facilities were either transferred to districts or became independent (fig. 2). By 1992, more than 500 health facilities such as diagnostic centers, ambulatory clinics, and hospitals had become independent (*5*). District health departments will implement health policy, monitor standards, assure adequate health care for all persons, and regulate undesirable competition. They will also plan and coordinate health services within their geographic areas.

Ultimately, the goal is to eliminate district government control over medical facilities (*6*). They will become independent and may determine their own structure, system of management, and the types of health services they will provide within the framework of general district health policy. They may be owned by the republic, communities, health insurance companies, and charitable or church organizations. During the transition period, almost all health care institutions will be controlled by either the republic's ministry of health or health divisions of the districts. Then, when the reforms have been completed, communities will be responsible for assuring adequate health care. They will own some health care facilities, establish some, and contract with outside entities for other needed services (*7*).

Medical Practice

There is a higher ratio of physicians to population in Czechoslovakia than in western Europe (see table, *8*). Almost all medical doctors in Czechoslovakia are specialists at different levels depending upon their training. Lower level specialists in general practice, pediatrics, gynecology, and stomatology (dentistry) deliver primary care. More than half of practicing physicians are women, and they are concentrated in primary care.

Primary care is usually provided at a community health center by a general practitioner who cares for adults, a pediatrician, a gynecologist, and a stomatologist (dentist). Examinations at community health centers are very basic, and usually there are no facilities on the site for X-rays or laboratory work. Each general practitioner is responsible for about 3,500 persons. Typically, an office visit takes 7 to 10 minutes, with the time equally distributed among talking with the patient, examination, and paper work. Physicians spend a significant amount of time processing sickness leave certificates for workers.

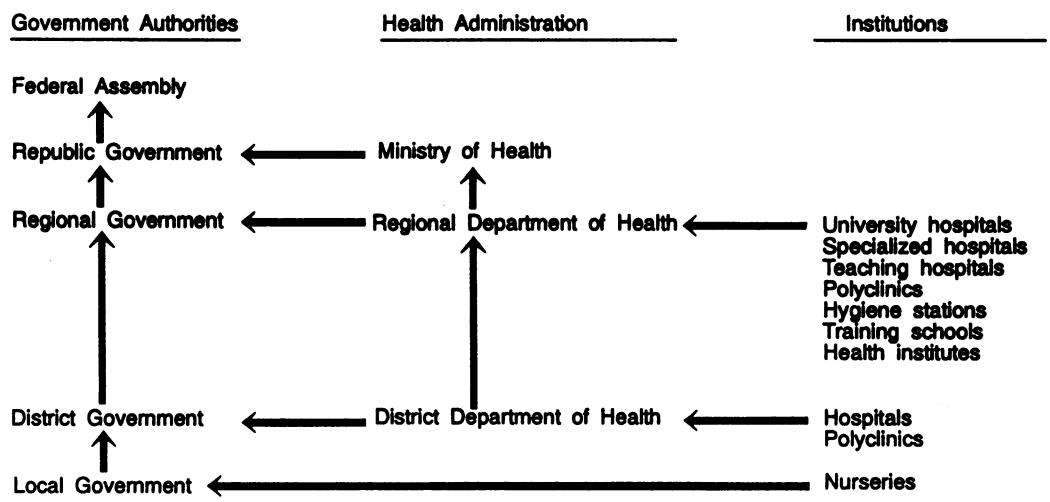
Patients have direct access to all of the primary care specialists as well as to ophthalmologists and dermatologists, but usually they must be referred to other specialists. Specialists either at a polyclinic (multi-specialty ambulatory clinics) or at a hospital are responsible for providing consultation. Under the new changes, in certain cases patients may have limited direct access to specialists without being referred.

Industrial plants have physicians who are responsible for prevention and screening programs as well as for treating minor accidents or illnesses.

Physicians are still employed by the government and are paid a monthly wage depending upon length of service and specialty level. Their salary is the same if they treat 5 patients a day or 50. In the future, the method of payment will be based on the number of patients treated, the type of treatment, and other factors. Plans call for a relative value scale to determine the amount paid for each type of service (*5*). Although physicians just out of medical school earn less than the average worker, specialists can earn about twice that. There has been growing dissatisfaction because of the low pay and because pay is not related to the amount of work done. "Tipping" or gratuities is illegal, but the practice is widespread and provides a significant supplement to a physician's income, especially in fields such as surgery.

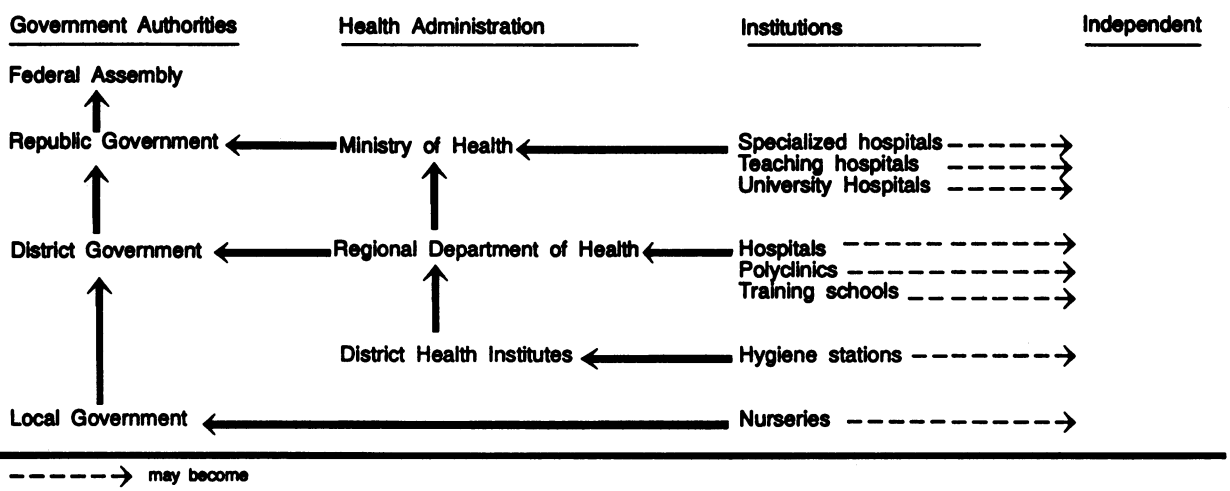
The influence of physicians was diminished un-

Figure 1. Health services in Czechoslovakia prior to their reorganization in 1989, indicating by arrow entity to which each component is responsible



SOURCE: Ministry of Health, Slovak Republic

Figure 2. Health services in Czechoslovakia after their reorganization in 1989, indicating by arrow entity to which each component is responsible



der the Soviet model of health care by placing all types of health workers in one union. One of the first things physicians did after the political changes of 1989 was to secure parliamentary legislation reestablishing the Medical Chamber (medical association). Parliament legitimized at the same time other professional bodies, specifically the Stomatological (Dentistry) Chamber and the Pharmaceutical Chamber.

The Medical Chamber is an independent, professional body composed of physicians that will register practicing physicians and establish professional and ethical standards. It will have disciplinary powers and is expected to protect both the rights of patients and physicians. The Medical Chamber will nominate delegates for the Minister of Health's Advisory Council and for other professional bodies. A very important function will be negotiating with health insurance companies about wages and services. Membership is compulsory for practicing physicians. Physicians interviewed by the authors expected that the Medical Chamber will work to increase their wages and change the way physicians are paid to reflect the amount of work they do.

One of the important changes in medical practice is the right of people to select their own physicians.

It is hoped that some competition among physicians will improve the quality of medical care and make physicians more responsive to patients because their incomes will be affected by their number of patients. Although physicians are employed by the State, some had been seeing patients privately but illegally. Private practice is now legal.

Health Institutions

Hospitals in Czechoslovakia have a high bed to population ratio, average length of stay, and occupancy rate when compared with western Europe (see table).

There are three types of hospitals. At the lowest level are local and community hospitals that are classified as Type I. They have an average of 200 to 300 beds, a minimum of four departments—medical, surgical, pediatric, and gynecological-obstetric—and they provide treatment for patients not requiring highly specialized diagnostic and treatment procedures. Each serve a population of about 50,000.

Type II hospitals are at the district level and serve a population of 150,000 to 200,000. They provide basic services for those who live in the surrounding area as well as for patients referred for special services from Type I hospitals. There are 10 to 12 specialities among their staff members and an emergency department.

Type III hospitals provide highly skilled care for a population of about 1 million, although they typically provide more routine services for the population in their immediate geographic area. These are also usually teaching hospitals. Most of their patients are referred from Type I and II hospitals. Formerly at the regional level, they are now at either the republic or the district level. The plan is that eventually all Type III hospitals will be turned over to communities, churches, charitable groups, or private entities. They will be independent legal entities that will determine their own type of management and services. The owners will appoint an administrative council for the institution to which the hospital director will be responsible.

Previously, hospital directors were required to be physicians, but 1990 legislation allows nonmedical personnel to occupy that position. Also, hospital directors were required to have the proper political standing. That resulted in the replacement of virtually all of them since 1989. The new hospital directors have been elected by the hospital personnel and have had little experience in management. Another change likely to have a great impact on hospitals is the introduction of competition by allowing patients to choose the hospital to which they are admitted.

Polyclinics are classified into three types just as hospitals are. Type I polyclinics include community and factory ambulatory facilities and have 8–10 departments serving the same geographic areas as Type I hospitals. Type II polyclinics may have as many as 16 departments or specialities and Type III, even more. Hospitals and polyclinics are in a single organizational unit, but polyclinics often have not received their full share of resources. Because of the new emphasis on outpatient care, polyclinics will become separate entities.

Financing

For almost 40 years, Czechoslovakia's health care system has been financed by general tax revenue from the Federal Government. Funds were then allocated to the republics and in turn to the regions as "block grants" that combined health care, education, transportation, and social services. Regions distributed the money, again as a block grant, to districts. The districts decided on the percentage to be used for health care and for other services.

Although both districts and local authorities had elected bodies with health committees, the real power was in the hands of the local political party organizations that made key health policy decisions and important appointments (*6*). Health institutions had little ability to influence resource allocations or to respond to local needs. There was insufficient incentive to provide services efficiently. In part, the hospital's allocation was based on its percentage of occupancy. This led to long stays and full hospitals. There was no incentive to economize because unused allocations were returned to the government and the next year's budget was reduced by the amount returned.

With the end of Soviet influence, one of the highest priorities for the health sector was changing the method of finance. Czechoslovakia had a sickness insurance system that covered medical care prior to the period of Soviet domination, and it is now reestablishing health insurance as a system to finance care, drawing on its previous experience and the experiences of Europe and the United States. Both republics are committed to a new system of financing health care based on health insurance with multiple sources of funding and the possibility of additional private health insurance companies. The Czech Republic has moved quickly

and has a detailed plan that it is beginning to implement.

In December 1991, the Czech Republic's parliament passed the General Health Care Insurance Act that provides for the establishment of an independent, nonprofit General Health Care Insurance Office (*7*), scheduled to begin operation in 1993. At the same time, changes will occur in the system of taxation. Significant consumer participation is assured in the structure of governance for the first time.

Under the new health insurance system, medical care will be provided without regard to the patient's social status and income. It will be financed by compulsory contributions from citizens, employers, and the government. Citizens required to make contributions are all those who are employed, including the self-employed, and those who are not in paid employment voluntarily, such as housewives. Employers will contribute for their employees and for women employees on maternity leave. The government will contribute on behalf of children, students, pensioners, persons receiving social welfare, women on prolonged maternity leave, and the unemployed. It has been proposed that each employee pay one-third and employer two-thirds of a person's premium. Employees will thus contribute approximately 5–10 percent of their gross wages and should be able to afford the health insurance premiums because of the proposed tax decrease at the time that premium payments begin.

The General Health Care Insurance Office will pay for "adequate" outpatient care, hospital care, medications, convalescent homes, spas and sanatoriums if necessary for treatment, prevention programs, some transportation costs related to treatment, and income while sick. The government, not the insurance company, will define what constitutes "adequate" health care, and the definition will depend upon the financial resources available (*9*). Insurance payments will cover almost all operating costs of health facilities and some equipment costs up to a certain price. Construction costs probably will not be covered but will be paid by the owners of the facility. The amount of payment for health services will be negotiated periodically by the insurance company and representatives of general practitioners, the Medical Chamber, polyclinics, hospitals, and other health institutions. The same rate will be paid for the same procedure to all hospitals and physicians, except that the hospital rates may vary according to the type of institution.

In Czechoslovakia, prescription drugs are paid for by the government; only a token amount is paid by the patient for each outpatient prescription. Medication expenses are increasing more rapidly than other health care costs and now constitute about 20 percent of all medical expenditures. Efforts will be made to control the cost of medications by establishing a price range. If a patient wants a higher priced medicine that is therapeutically comparable to one within the determined price range, the patient will pay the difference (*9*). Also, some steps are being taken to privatize outpatient pharmacies (*9,10*)

Health outcomes and physician and hospital rates, Czechoslovakia compared with other nations, 1988

Outcomes, rates	Czechoslovakia	Western Europe average[1]	U.S.
Percent of GDP for health, 1989	5.5	7.4	11.7
Life expectancy at birth (years)	67.7	72.4	71.5
Infant mortality per 1,000 live births	11.9	8.3	10.1
Physicians per 1,000 inhabitants	3.3	2.5	2.3
Hospital beds per 1,000 inhabitants	7.9	5.3	3.8
Average length of hospital stay (days)	12.8	9.6	7.2
Percent of hospital occupancy	81.7	79.1	65.5

[1] Average of Austria, Belgium, Denmark, Finland, France, Greece, Iceland, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, and Western Germany.
NOTE: GDP = Gross domestic product.
SOURCES: References *3,4,8*.

The Slovak Republic is developing its own plan for a compulsory health insurance system with multi-source funding to provide comprehensive medical care according to the Federal Government's requirements. Although management details may differ, the Slovak Health Insurance Agency's functions will be similar to the Czech Republic's plan with contributions from employers, employees, other citizens, and the government. It will negotiate with providers to set fees for health services and supervise the appropriateness and quality of health services and provide the opportunity to establish additional private health insurance companies (*11*).

Education of Health Personnel

The goal of health education reform in Czechoslovakia is to raise the quality of education for health workers to that of western Europe. Medical school is to consist of a 6-year program following high school. There are examinations at the end of

each subject and a final examination that includes an oral and a practical part.

Until 1990, there were three types of medical schools open to medical students—adult medicine, pediatric medicine, and hygiene and epidemiology. In 1990, these different types of schools were abandoned, and the schools now resemble those of western Europe and come under the supervision of the Ministry of Education. Tuition and books are free, but medical students must pay for lodging and food. Graduates are awarded the title of MUDr (Medicinae Universae Doctor) and can practice under supervision. They must pass a first-degree specialty examination in 1 of 20 specialties before they can practice without supervision.

Despite low salaries, young people have been eager to become physicians. Influence was often exerted to get applicants admitted. Reform efforts include revising the curriculum, improving the quality of teaching, and the adoption of western medical teaching methods. However, there is a severe shortage of texts translated into the Czech language.

At present, there are two levels of specialization. The first level, lasting 2 years, provides important practical experience for independent practice and is taken by all graduates. The second level takes 5 years. These two levels will be combined and the curriculum revised. Also, there will be a greater emphasis on the specialty of general medicine.

In the Czech Republic, additional centers for training in specific specialties are being established, and competition is being introduced to improve the quality of training. The first two training institutes are in radiology and anesthesiology. Improved continuing education is a high priority, and new weekend programs for updating physicians have begun in the Czech Republic.

There are in Czechoslovakia three postgraduate institutes for medical personnel. These institutes, along with the Medical Chamber and other medical professional associations, are responsible for specialty training and examinations as well as continuing education for medical doctors, pharmacists, and other university level technicians. In 1991, 9,000 physicians participated in educational activities organized by the Czech Postgraduate Medical and Pharmaceutical Institute, which is one of the three postgraduate institutes in the country.

Nursing Education

There is a shortage of nurses in Czechoslovakia. They are poorly trained by western standards and poorly paid. At present, nurses are trained in specialized high schools where students receive a general education along with nursing subjects and practical training. Most nurse training finishes at this basic level. A few graduates attend institutes for post-basic training for 1½-2 years to specialize in adult care for head nurses, operating room service, anesthesiology, intensive care, psychiatric nursing, and other areas. Nursing faculty and nurse managers are prepared by a 5-year course at the university level. The graduate receives a university degree, but also must pass a government examination. Although the high school level training will continue, more nurses will be encouraged to take specialized training.

Discussion

The political events that enabled Czechoslovakia to pursue a democratic, market-oriented economy also provided the opportunity to reshape the health care system by changing the organization, financing, and ownership of facilities and by introducing partial privatization. The reforms are occurring within a poorly functioning health system with outdated equipment, very little money, and very little experience with innovation. A wide array of consultants, mostly from Europe, have proposed strategies and stimulated thinking so that plans have been developed and are being implemented, especially in the Czech Republic. The health care system is changing to a decentralized, public-private financed system with consumer input, controlled competition, and more autonomy for health care providers. These reforms are occurring without any additional funding and in the face of increasing impatience by consumers and health professionals over the rate of change.

To facilitate change, almost all health administrators, hospital directors, and most hospital clinical department heads have been replaced because their appointments had been made largely because of their political affiliations. Their replacements will have flexibility in management and in deciding which services their hospitals will provide, but they will also have a greater chance for failure because they have had little experience in making management decisions, creating budgets, and being held responsible for their performance. The new hospital directors in particular need immediate help in management techniques and new ways of thinking to solve problems if they are to succeed. Democratic enthusiasm for reform is illustrated in the political necessity for workers to elect new hospital

directors rather than hiring the best qualified person. There is a risk to this process in that it could result in less capable directors and thus delay hospital improvement.

Prevention of chronic conditions like cardiac disease and cancer have been given a high priority because of their increasing prevalence and cost to the health care system. A few preventive programs exist that try to create a new awareness that each person should be responsible for maintaining his or her own health by improving their lifestyles. The success of these prevention efforts is doubtful, however, when consumers are increasing their consumption of meat and alcohol (fruits and vegetables are very costly), when smoking is widespread and acceptable, and when environmental pollution is at unacceptable levels.

The introduction of an independent health insurance system with the cost shared by the employer, employee, and the government is the change that will have the most far-reaching impact on health care. For the first time, employees and employers will be aware of the amount of their contribution for health care rather than have it hidden in general tax collections. The authority of the health insurance office to negotiate types and levels of payment and to monitor use of resources and outcomes will provide more flexibility in determining the cost of health care. It may also make hospitals and physicians defensive, however, because until now there has been no monitoring of either resources or outcomes. A great deal of effort is being made to improve the existing data system that will be needed to determine appropriate payments.

Private sector medicine will be encouraged to grow and will stimulate further competition. Two-tier health care may develop with compulsory insurance paying for "adequate" care and additional private insurance providing improved amenities and medical treatment not covered by the compulsory system.

Of all of the opportunities to increase consumer participation in the health care system, the one that interests people the most is being able to choose their own physician and hospital. It gives consumers a new sense of control over their health care and should make the system more responsive to consumer concerns, although it is also likely to make physicians and institutions wary as competition emerges and their security is threatened for the first time. Notwithstanding, competition is viewed by many in Czechoslovakia as the solution for improving efficiency even though its success in the United States is often questioned.

The percentage of Czechoslovakia's gross domestic product allocated for health is not likely to increase in the near future. The challenge is to make the desired changes while maintaining the current level of care and do it quickly enough to satisfy consumers and health professionals within the economic constraints. The political commitment is there, but reforming the economy often takes precedence and may slow or alter health reforms. Regardless of the difficulties, Czechoslovakia's health care system is likely to emerge as a partially privatized system with controlled competition that, over a period of years, will provide improved services for its people.

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