A Prague Winter for Public Health

ANTHONY ROBBINS, MD

Dr. Robbins is the Editor of *Public Health Reports*. Tearsheet requests to him at U.S. Public Health Service, Room 1826 JFK Building, Boston, MA 02203; tel. 617-565-1442; FAX 617-565-4260; Internet AROBBINS@PHBOS.SSW.DHHS.GOV.

IN MAY 1967, E. RICHARD WEINERMAN, MD, visited Prague for his study of social medicine in Eastern Europe (*1*). I had been his student at Yale Medical School and remembered his enthusiasm for Czech efforts to create a workable health system. So when I received an invitation to Prague in February 1995, I dug out Weinerman's thin, now dusty, 1969 book. While reading it, I kept in mind that a year after Weinerman had left Prague, a period of growing liberty and innovation came to an abrupt end as Soviet troops reentered the city.

Now, 5 years after the Velvet Revolution lifted the siege of Soviet Communism, I was part of a small group of Americans—Daniel Callahan, PhD, President of the Hastings Center, Briarcliff Manor, NY, and Phyllis Freeman, JD, Professor of Law and Public Policy, University of Massachusetts, Boston—who visited Prague at the invitation of Dr. Petr Struk, Director of the Health Policy Department in the Ministry of Health of the Czech Republic. As a principal advisor to Dr. Ludec Rubás, the Health Minister, he had invited the three of us to join a larger group of Czech professionals in a seminar on "Public Health and Market Forces." Could public health advances of the past be preserved in the market economy?

The Czech participants came from the fields of social medicine and of hygiene. Social medicine, as defined in the pre-Communist university-based German tradition, had functioned during the Communist era to impose standards of medical care, top down, holding every practitioner to the example set by the professor at the top of the hierarchy. The hygiene departments, at every level of government, had linked medical practitioners and polyclinics to its system of disease surveillance and control of hazards in the environment. It performed the police function in sanitation and public health.

Finding the Czech experience since World War II impressive, Weinerman still had his doubts (*1a*):

> Soviet influence was an overriding factor, traditional trade relationships with Western Europe were curtailed, and military claims on the national budgets remained high. Yet the new programs of social welfare were suddenly required to provide expensive benefits to vast and previously ignored segments of the population. The difficulties besetting the developing health services systems were immense: limited economic resources, inadequate personnel, inability to assign high priority to research and development, and the need to concentrate on basic services for large numbers of people, with the attendant postponement of quality goals.
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> To some extent, these negative economic factors were mitigated by the ability of the new governments to centralize control of their limited resources and to undertake unified and disciplined program planning. This made it possible, for example, to assign high priority to community sanitation, maternal and child health, and industrial hygiene, as well as avoid maldistribution of essential resources.

"Command and control" came from the Soviet Union, but in 1967 the degree to which the Soviet blueprint was appropriate to the varying conditions then prevailing in Czechoslovakia, Hungary, and Poland remains a matter of intense debate within these countries.

As Eastern European countries imposed the Soviet design, the Czech system was "the most systematically organized, the most uniform, the most solid in terms of material and personnel resources, and the most advanced with respect to technical standards" (*1b*). Czechoslovakia had reduced infant mortality to 25.5 per 1,000 live births in 1965 from 113.4 in 1938 and 77.7 in 1950, and in 1965, life expectancy had reached 67.8 years for men and 73.6 for women (*1c*).

At the mention of Weinerman's name in my opening remarks, one Czech participant beamed with pride. Dr. Frank Osanec, who had turned 80 years old the day before, recalled that Weinerman's visit to Prague had been a high point during the long Communist era. (Weinerman (*1d*) described Dr.

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Osanec in 1967 as being part of the Department of Foreign Health Services, Institute for Research into the Organization of Health Services.) Weinerman had come when the Czechs felt most included in the world of medical care, sharing their experience and learning from Western Europe and America. The Czechs were bending the Soviet model into something that would work.

Osanec's recollection was unusual. For most of the 25 Czech physicians who sat facing a formal dais throughout our meeting, real opportunities had begun only in 1989. The Communist period had been uniformly repressive and gloomy. Low pay for physicians, deteriorating facilities, strict health standards without enforcement, and the rigid Communist command and control system separated them from progress in the rest of the world.

Today privatization is in full swing. Reform started with health services, and by the end of 1990 there was a draft plan for the Czech Republic and the parliamentary action. Payroll deductions now buy private health insurance that covers basic physician and hospital services. Twenty-two private insurance companies, founded with minimal reserves established with large bank loans, make fee-for-service payments to all physicians who care for their policy holders.

As the United States moves toward managed care and carefully structured incentives to make medical practice efficient, why did the Czech Republic choose private insurance companies and fee-for-service? Part of the answer is that the new system seemed furthest from the old command and control and closest to pure market economics. However, no one seems to take responsibility for the decision to replace a Canadian-style fee-for-service system using a single insurance carrier that was in the original plan with 22 independent carriers. Moreover, no one seems to know how much money is taken out of the health insurance contributions to reward investors and managers. A rumor we heard on several occasions suggests that an American computer company made payments to assure that fee-for-service, which requires far more hardware and more complex software, would be the only permitted payment method.

"At least our system did not collapse as Russia's, Romania's, and Poland's did when they privatized," remarked one Czech participant. Physician disappointment with continuing low pay—physicians and health workers in general are in the low and mid income brackets, earning about $240 per month—emerged in every conversation we had with Czechs. Both a pediatrician and a gerontologist sounded a complaint that seemed familiar to us—a few procedure-oriented specialists were the only ones doing better financially in the new system.

Czech insurance companies compete for subscribers by offering certain extra services within the standard payment, such as dentistry. In addition, supplemental payments can secure "over standard" coverage from any of the companies. Yet there is only a single fee schedule for the whole country, negotiated by the physicians, the insurers, and the government. Each item of service has a price in points. At the start, physicians were to receive 1.0 Czech Crowns per point, but a rising volume of services and a limit on collections has reduced payment to 0.52 Crowns per point, with a few insurance companies paying slightly more.

The Ministry of Health is quick to note that health care has less influence on the health of the Czech people's lifestyles, environmental exposures, or genetic factors (*2*). And although life expectancy at birth has continued to increase through 1992, reaching 76.3 years for women and 68.5 years for men and infant mortality has declined to 9.893 per 1,000 live births, the Czech Republic remains behind all of Western Europe and ahead of all of the remainder of Eastern Europe (*3*). "Health status in the Czech Republic is characterized by an extremely high incidence of cardiovascular diseases, primarily ischemic heart disease, stroke, and cancer. Due to the frequent occurence of these diseases, life expectancy in our country is 6 to 7 years lower than in well-developed European countries" (*2a*).

Reform in public health trails behind privatization of health services. At this writing, no plan or legislation has been approved by parliament. From the tenor of the seminar, however, there is little doubt that the Ministry of Health would like to have a plan for public health. Our visit was an occasion to assemble the key players for a discussion of public health under privatization.

The seminar on "Public Health and Market Forces" had assembled protagonists from social medicine and hygiene, the two groups who had been left out of privatization. With the demolition of

command and control, these two disciplines that had maintained links between medical services and public health had no assigned role. During our long afternoon together, they grappled with how to fulfill their historic roles and protect the health of the Czech people. It will not be easy.

Under the Communist system and the standards imposed on all practitioners, every pediatrician, responsible for all children in her district, completed every immunization on schedule. "Today," one practitioner announced, "vaccination is crumbling," and high rates of coverage will continue only as long as pediatricians maintain the standards of practice learned in the past, for there is no longer an incentive to vaccinate all children. Private insurance has all but ended reporting and disease surveillance because the private insurance companies do not collect information beyond a diagnostic code and an item of service code. They are not required to do so.

The prevailing view holds that before 1989 everything government did was bad. Thus, the new constitution, which still grants a right to health care to all, is truly minimalist. As in our legal tradition, laws may be written to restrict individual rights and liberties when necessary to protect the public health. But we were told that there was no expectation that laws would be needed for positive and programmatic interventions. This view conveniently conforms with the severe fiscal limits faced by an impoverished government. No laws should be needed to promote public health. The market shall govern; thus health promotion, for example, would be an inappropriate function for government, and many regulatory functions of government would be left to private sector entities.

At the day's end, Daniel Callahan observed that the marriage the Czechs were trying to arrange—between medicine (inherently and historically a philanthropic activity) and the market (inherently profit oriented)—hardly sounded like it was made in heaven. Market economics was pervasive. But before the hyperbole of market rhetoric could make us totally incredulous, practicality returned. Traditions of protecting the whole population emerged in the discussion. Surely, everyone seemed to agree, health insurance must be provided for all. Surely, public health would not perish under privatization. Everyone agreed, but how to make sure.

At the center of the effort to enlist support for public health from both hygiene and social medicine professionals is the Ministry of Health. Perhaps it is merely seeking a useful role for itself. But I like to think that, as Weinerman used to say that the Czechs had made the greatest possible success out of dogmatic Soviet command and control, maybe, under the leadership of a creative and practical Ministry of Health, they will make the greatest possible success as they face the danger of dogmatic and doctrinaire market ideology.

References

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