

Health Care Privatization in the Czech Republic: Ten Years of Reform

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After a decade of reform efforts in the health care sector, the Czech Republic has experienced both successes and failures in its transition from a Soviet-imposed system of public financing and provision of care under a centralized command-and-control structure to a decentralized, market-driven system of compulsory health insurance and fee-for-service reimbursement. On the positive side, Czech health care reform has brought increased access to new medical technology, updated medical protocols and guidelines, and higher quality of care, all of which have translated to greater clinical efficacy, as indicated by the dramatic improvements in population health status measures such as male and female life expectancy, rate of infant mortality, and rate of premature death from cardiovascular disease (“Chaotic Growth Period . . .,” 1997; Robbins, 1995). Reform has also elevated the voice and stature of consumers with respect to choice of providers and treatments. On the negative side, inefficiencies and misallocations of resources wrought in part from poor management practices and excess capacity in physicians and hospital beds—all legacies of the Soviet model—continue to plague the Czech health care system (Lewis, 1999; Massaro, Nemec, and Kalman, 1994; Scheffler, 1999; Uldrichov, 1996; Vyborna, 1995). These old problems, coupled with reform-based disincentives to control the volume and costs of services, have rendered the system vulnerable to rapid inflation. In this article, we provide a thumbnail sketch of the core elements of the reforms and the underpinning national policies as initiated in 1989, the major outcomes of these efforts to date, and the key challenges that lie ahead for Czech policymakers as they develop and implement further midcourse corrections in the financing and delivery of health care.

Core Elements of Czech Health Care Reform

The reforms were designed to achieve solidarity, decentralization, and privatization through three major elements: (1) mandatory health insurance for all citizens, financed by a national health

insurance fund to which the government and, via a payroll tax, workers and employers contribute; (2) creation of and promotion of competition among nonprofit, employment-based health insurance plans in the private sector; and (3) movement of physicians and other health care workers into private practice and the transfer of some hospitals to decentralized private control (Scheffler, 1999). Under the reform plan, workers contribute 4.5 percent of gross wages and employers contribute 9.0 percent of gross wages, and the self-employed pay the full tax of 13.5 percent of annual income, to the national health insurance fund. The government pays for the elderly, children, military personnel, and the unemployed.

The motivation for the privatization of the Czech health care system was to transfer the centralized power of the state-run health system to private individuals and institutions. This motivation was the same one that was driving the privatization of the Czech economy overall. What is noteworthy is that a key part of the social support system—health care—was privatized so rapidly and without a clear idea of the role of the private sector (Massaro, Nemeč, and Kalman, 1994; Uldrichov, 1996; Vyborna, 1995).

Health care was ripe for privatization, in part because it was in a state of excess supply. By international standards the Czech Republic has a dramatically high level of physicians and facilities. The Czech Republic has over 50 percent more physicians and hospital beds per capita than the United States, which is also in a situation of oversupply. This oversupply, coupled with the Marxist philosophy of surplus value, meant that wages of physicians were quite low: on average, 6,000 korunas (approximately, U.S. \$180) a month, a figure only slightly higher than the overall average wage.

The motivation among physicians, as well as dentists, for the privatization of practice was that of higher incomes and clinical autonomy. They would no longer have to be state employees but rather would be able to practice independently and receive fees from the government-run health insurance system or from patients directly. Over 95 percent of Czech physicians are now in private practice. As the reform plan was originally conceived and implemented, providers were paid solely on a fee-for-service point system for services covered by the health insurance system. This point system is similar to the relative value scale used in the United States,

Germany, and Canada. In theory, it is based loosely on the cost of providing a service. Costs include professional time, supplies, and capital equipment. In reality, however, the point value in Czech health care was somewhat arbitrary and subject to political influence. The value of the billing point was then subject to budgetary limits. The funds available to the insurance companies were divided by the total points billed for by providers to calculate the value of each point (a zero-sum game). Point values were subject to changes in the volume of service points billed for. The value of a point was about .5 koruna (approximately 34 korunas to 1 U.S. dollar).

Privatization of facilities involved a different motivation. At the outset of reform, the Czech government understood that it had an oversupplied, inefficient system. Moreover, much of the system was in disrepair and badly in need of capital. Thus, the motivation was to move these facilities out of the government's budget. However, here the conceptualization of privatization was not as clear. Many of the hospitals were public goods. Some were teaching hospitals that trained physicians and other health professionals, and many were involved in clinical and biomedical research. These public functions were not fit for privatization, hence these hospitals were taken off the list. They would not be privatized, though they could become involved in private joint investments with the private sector.

By the end of 1991, 56 facilities out of a total of 199 (inpatient and outpatient) were privatized. This represents about 28 percent of the facilities, but 9,389 beds out of a total of 80,321 beds are just under 12 percent of the beds. Some hospitals were given to charities at token prices, while others were sold, usually at less than the book value of the facilities. Hospitals near spas that were attractive to foreign visitors were easily privatized. Others in rural communities were simply transferred to local authorities upon request. Various routes of privatization for facilities were much debated, but the actual process pursued by the government lacked clear, established guidelines or principles. As a result, the privatization process was undercut.

The third element of privatization was implemented in the government-run insurance sector, beginning in 1991. Originally, the plan was to subject the government-run national health insurance fund to private competition through the creation of private, employment-based health insurance companies, each catering to the specific health care needs of the enrollees, such as

miners, teachers, or transportation workers. Each group was required to cover the government's list of health benefits and to pay for services using the point system. Competition among them and the social insurance fund was to be based on quality of services and perhaps additional benefits if they could find a way to provide them with the same funds. In principle, they could derive savings if they were able to negotiate lower point prices with physicians and hospitals. This strategy proved untenable, however, because the value of the point was already low and continued to decline as the number of points billed increased dramatically under the fee-for-service reimbursement system. By 1995, most of these privatized insurance companies had severe financial problems and had to be taken over by the General Health Care Insurance Office, which administers the national health insurance fund. By all accounts, especially as measured in terms of the substantial debts left unpaid to public and private providers by the bankruptcies of the private sector companies, this element of privatization was a major failure of the reform efforts (Robbins, 1995; Lewis, 1999; "Chaotic Growth Period . . .," 1997).

Health Care Financing and Expenditures in the Czech Republic: 1990–1995 Trends

The Organization for Economic Cooperation and Development 1997 database on public sources of financing and health care expenditures in the Czech Republic includes both nominal and real values, percentage of gross domestic product (GDP), and percentage of total government expenditures. Health revenues, expressed in one-million-koruna units, show an overall nominal value increase of 60,946—a real value increase of 5,710—between 1990 and 1995. The state budget accounts for the bulk of these funds from 1990 through 1992; the breakthrough year is 1993 for the national health insurance fund, when government funding continuously and dramatically decreases through 1995 and the health insurance fund increases through the same period. The figures for percentage of GDP parallel this trend: The state budget revenues average around 5.42 percent for 1990–1992 and then decline to 2.05 percent in 1993, down to 1.12 percent in 1995. In 1993, the national health insurance fund represents 5.56 percent of the GDP, up to 6.19 percent in 1995.

The pattern of overall health expenditures matches the trend in health revenues: rapid growth between 1990 and 1995, as can be expected in a system of fee-for-service reimbursement where there are no incentives to contain volume and costs of services. In the area of personal health services, these steady increases include the categories of worker wages and benefits, drugs, other consumables and supplies, and maintenance. Expenditures on public health activities also increased. The percentages of GDP as well as percentages of total government expenditures over this period follow suit, though there is a dip between 1994 and 1995: from 7.82 percent to 7.31 percent of GDP and, correspondingly, from 15.85 percent to 15.60 percent of total expenditures. Capital expenditures show a reverse trend over the 1990–1995 period; for example, expressed in one-million-koruna units, real value expenditures dropped from 2,355 in 1990 to 1,279 in 1995.

Compared to its eastern European neighbors, the Czech Republic shows the steadiest increases in public sector health expenditures from 1991 to 1994, as percentage of GDP. With respect to the evolution of real spending, the Czech Republic significantly outpaced these other countries in total health expenditures from 1992 to 1994 but lagged in drug expenditures over this same period.

Conclusion

There is little doubt that the privatization of medical practice, combined with an open-ended fee-for-service point system of reimbursement, has had a profound impact on the Czech health care system. Health care expenditures grew rapidly. Since privatization, physicians' incomes have more than tripled and nurses' have doubled. Although these increases are substantial, they were for physicians 30 percent more than the increase in average wage. The true income position of physicians is hard to discern, since those in private practice do not report all earnings as income and there are no official data on their incomes available at this time.

Privatization and the fee-for-service point system have had a predictable and major impact on costs. It is common for physicians to bill for more than one hundred hours per week,

which is hardly a realistic work schedule. Surgeons who privatized billed for over 25 percent more points than those in government hospitals. A similar pattern was also found for charging of supplies. For example, orthopedists billed over twice as much for supplies when they were in private practice.

It is not surprising that privatization without an economic and organizational structure increased costs dramatically. The actual rate was not anticipated by the government. Hospitals and physicians with lower historical costs were the economic winners, and the losers were teaching hospitals and physician specialists. This was an intended consequence of the point system coupled with privatization.

The process of privatization of facilities in health care is quite complicated and should be done in an orderly open way. The actual value of facilities based on historical costs is hard to estimate. Because of this, windfall profits can be made. Privatization also requires time so that the actors in the health system can understand the nature of privatization and respond appropriately.

Rapid privatization can also be disruptive to patients seeking care. Well-established networks of primary care and public health are important components of the health system. They should be guarded during the privatization process. The role of the consumer in a private system needs to be developed and supported with public information on the health care system so that informed choices can be made.

The role of the incentive system also must be carefully considered. A fee-for-service system with privatization will increase volume and costs. Therefore, a complete vision of privatization needs to include a mechanism for controlling costs and improving the quality of care. Indeed, the government is already moving in the direction of cost containment by incorporating capitation into the payment system for general practitioners (Lewis, 1999).

Overall, the lessons learned from the reform efforts to date make one point especially clear: Privatization remains the all-encompassing challenge of the Czech health care system into the next decade and beyond as the government moves to stabilize the financing and delivery mechanisms and to formulate and implement coherent regulatory policies.

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