HEALTH CARE REFORMS IN THE SLOVAK AND CZECH REPUBLICS 1989–2011: THE SAME OR DIFFERENT TRACKS?

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Introduction, research questions and methodology

After the Velvet Revolution of November 1989 until the amicable separation of Slovakia from the Czech Republic on 1st January 1993 health policy had been a republic level rather than a federal responsibility. Thus from the start of transition there was the possibility of divergence in this area of social policy, and after the 1993 separation health policy divergence seemed to become more marked and entrenched. The political division thus created an apparent natural experiment in social policy, as the successor states had had identical policies under communism, but responded differently to the challenges of transition.

The goal of this comparative paper is to examine the comparisons and contrasts between the two systems across the two full decades since the end of communism. There are many analyses of processes and results of health care reforms in the Czech Republic and in Slovakia. For example see the recent papers by Maly, Pavlik and Darmopilova [14] for the Czech Republic and by Szalay et al. [21] for Slovakia. However, we are unaware of any recent comparative study of these two systems. Because both systems started reforms from the same point, there is the potential for a really original comparative paper. For example, is path-dependence or other factors still keeping both systems really close to each other, or are significant divergence trends already visible?

The first research question is to examine how the process of health care reform has evolved in the Czech and Slovak Republics from 1989 to the present decade. This is the health policy dimension of the study. It is carried out in section 1, by examining the principles and development of social and economic policy in health care, and how that has been influenced by the political and economic context, including economic ideologies, pressure groups, coalition politics, and funding issues. For both countries the accounts are illustrated by analyses covering the whole post-communist period, but including in-depth studies of two relatively recent comprehensive reform programmes: the Julinek reform in the Czech Republic and the Zajac reform in Slovakia. We start with an analysis of trends in health policy making and implementation because political decisions influence all real changes in policy and resources. The nature of the question and the availability of sources led us to use a mainly qualitative, that is in this case, historical methodology.

Measuring and describing the performance of health systems is a really difficult issue, but there are certain observable current common trends [11]. Most analyses focus on access, costs and cost containment, quality – usually interpreted as outcomes, and less commonly prevention levels. We focus on all three core performance dimensions: access, quality and costs. Thus our second research question is to examine what were the resources available for health care delivery, and what was the impact on costs, quality and access? These related areas are addressed in sections 2, 3 and 4. Although much of the data is quantitative, its limited scope allows only qualitative conclusions. However we are able to deploy comparative data on resources, outcomes and patient perceptions that allows us to place the Czech

and Slovak results in wider Central European and Western European contexts.

Our studies on the two research questions allow us, in the concluding section, to draw some conclusions on whether and to what extent the Czech and Slovak Republics have diverged over the last two decades in this key area of social policy and individual wellbeing. The research was supported the Grant Agency of the Czech Republic, project GACR P403/10/1892.

1. The Development of Health Care Policies

We argued above that in both the Czech and Slovak Republics political instability had important effects on the development and operation of health-care policy. In this section we illustrate this phenomenon in detail, by exploring the development of social policy in this area, and by examining the interest groups that determined or tried to influence policy.

1.1 Czech Experience

In the Czech Republic health care policy was decisively influenced by the first post-separation government of Vaclav Klaus (1993–1997). Despite this administration`s apparent stability there were almost annual changes of health minister and in its final years it governed with only a tiny parliamentary majority. Furthermore, the publically proclaimed market ideology of the prime minister was not always reflected in the more pragmatic and less visible activities of his administration. In short the economy was less market oriented than he claimed, and this underlying hidden pragmatism extended to health-care.

The Czech health-care system under Klaus developed in an intellectual milieu that favoured markets and personal choice. But the government was very strongly influenced by pressure groups, especially doctors and other input suppliers. “After the establishment of professional chambers, their representatives were able to dominate the health policy making and implementation processes, to a significantly greater extent than in other (central European) countries” [7]. The examples of fee-for-service reimbursement schemes for doctors, privatisation and decentralisation clearly favoured key interest groups, but were still consistent with the market principles of the government. In addition the government`s preference for pluralistic insurance funding over direct state budget payments was also consistent with those market principles. The social policy objective was universal coverage and hence access. Whether the equity aspect of Czech social policy was consistent only with only a single level of health insurance policy provision, or whether it should allow a range of more or less expensive insurance policies, remains bitterly contested.

In the initial Czech choice of health-care system there was no evidence of public opinion on health care policy existing, much less exerting influence. The absence of such influences from Czech government choices may simply reflect an accurate political calculation that ordinary citizens had neither the expectation of being consulted, nor the experience to form and express views in ways that politicians might notice.

The basic structure of the Czech health-care system long survived the Klaus government, and has proved very difficult to reform. It combined compulsory health insurance for the whole population, with a mix of public and private provision. Insurance payments are made by firms, individuals and the state, to a group of loosely competing insurance funds. The right to health-care is constitutionally guaranteed. But perhaps most importantly there are bi-annual negotiations between the funds, the providers, both private and public, and professional chambers, to agree reimbursement rates and other issues. As Darmopilova and Spalek [4, pp. 46] note “The government has to ensure that the outcome meets legal requirements and public interest before approving it. The joint negotiations, followed by government approval, might be considered as a backbone of the health care system.” Their paper shows that for over a decade there has been considerable evidence and some agreement that reforms were needed, very little of substance changed. Consequently the focus of attention of the numerous ministers of health, whose average tenure since 1990 has been less than eighteen months, has usually been on the consequences of the lack of reform: chronic financial deficits in both the overall health budget, and in those of the key institutional actors, insurance companies and hospitals.

The proximate source of this failure to reform in the face of clear evidence of its need

lies in the ability of combinations of interest groups to block radical change. But the ultimate cause of the failure is a lack of political will engendered by political instability. The key test of the ability of the Czech political system to overcome this blockage came with the election of a conservative oriented government in 2006. Although the government was a coalition of three parties, with a majority of only two in a two hundred seat chamber, it survived until 2009 and Julinek, its minister of health, had a long-considered reform programme to implement [8]. This programme encapsulated many of the key reforms that numerous observers and participants in health policy debates had come over the previous decade to agree were essential or desirable if the Czech health system was to be efficient. Although the reform was not passed in its entirety many of its ideas were or will be implemented and will be discussed below. It is also worth noting that they bear a strong resemblance to the Slovak reforms of the Dzurinda government`s health minister Zajac, implemented from the beginning of 2005 and also discussed below.

"Julinek Reform"

The original Czech Julinek reform programme was ambitious and detailed, and expected to take two parliaments to implement. The first phase had four objectives. The first was to expand choices and responsibilities by creating individual health-care accounts. These would record a detailed individual health income and expenditure account that would generate data that could be used to check on individual, geographical and inter-temporal access to health-care. To discourage excessive access individuals were to be charged for prescriptions, emergency calls, visits by medical specialists and hospital stays. Analytically such co-payments should improve efficiency, but would have conflicted with any aim to make services free at point of use. Therefore to maintain consistency with the key Czech social policy value of solidarity, total charges per individual were to be capped and allowances made for personal circumstances. Co-payments could also increase the health care system`s resources, and by increasing direct visible patient payments perhaps decrease pressure for informal payments. If informal payments decrease, this would be consistent with the social policy principle of equity, for such payments allow the wealthier to access better care.

The second objective was to widen and strengthen the health insurance companies` ability to make independent decisions, and at the same time to increase inter-company competition. The purpose of such a proposal was to strengthen the hitherto relatively weak financing actors – the health insurance companies – at the expense of other supply actors: specifically medical staff, and especially doctors` unions. This objective was to be achieved by privatising the companies, and allowing them to act as the purchaser of health services for their clients, who in turn, should they wish would be allowed to buy higher than standard access policies. Thus the companies were to be given the opportunity and the incentive to increase profits, while pressuring health providers to control costs. The implications of this policy would have been that access was partly dependent on willingness to pay, and services would no longer be entirely free at point of use: two clear changes to the previously guiding principles of social policy in this area. This change was intended to be the key change to the system of health care, moving it even more clearly away from its state-based pre-1989 origins towards a societal based mixed-type system with state and societal regulation but societal financing and mixed state-societal-private provision [23].

The third objective was to introduce or strengthen competition between the health-care providers, to provide insurers and their clients with lowers costs and a more uniform service, by allowing insurers to contract with suppliers on a similar basis, whether they were private doctors, or public or privately owned hospitals. That would give insurers a very considerable influence over the development of the pattern of provision, and doctors, through their professional chambers have protested the changes vigorously. But as the government`s objective was clearly to reduce the ability of such chambers to determine rewards or to block initiatives, the change has not been reversed. However, and as if to emphasise the need for reform, in the run-up to passing the 2011 legislation, 30 % of doctors threatened to resign their jobs unless they received substantial pay increases: which they did.

The fourth objective of the first phase of the reform "aims at setting an efficient and

transparent process of determining maximum prices and reimbursements paid from financial resources of public health insurance supervised by the Ministry of Health of the Czech Republic. The objective is the harmonisation of the Czech law with the Transparency directive of the European Union." [3]. This is achieved by creating a system that reimburses the cost of new drugs on the basis of their effectiveness, with where appropriate requires explicit additional co-payments from individuals. To recognise variations in individual circumstances such co-payments were to be subject to individual ceilings.

A limited policy of co-payments was implemented, but privatisation and competition between insurance companies proved too controversial, and little had changed when the centre-right Topolanek government fell in March 2009. After an interregnum government of technocrats an autumn election brought in a new centre-right coalition with a different prime minister, but led by the same party, and with the same programme of public service reform. It finally managed to pass a series of health care bills in the summer of 2011. These bills introduce the two-standard system into health insurance, increase the powers of insurance companies, and confirm the move from citizens as patients of the state to clients of insurance companies.

The motivations for the changes are: an aging population and hence rising health costs, general pressures to limit expenditure, the desire to raise health care productivity, to improve health outcomes, to provide more choice, to switch resources towards preventive activities and away from acute interventions, and to make patients more aware of and so more responsible for their own health.

The policy changes imply a weakening in the influence of two of the three dominant values in Czech social policy: solidarity and equity – the latter normally being interpreted as equality. The third dominant value, plurality, is strengthened by the changes, as the range of providers should expand in response to the reforms. Solidarity is potentially weakened because defining the basic care levels citizens can expect sets the degree of solidarity that can be expected. Over time this base may not rise in proportion to the expected cost escalation caused both by an aging population and technological advances to prolong or improve the quality of life. Likewise equity, interpreted as equality, is reduced as the health insurance system is deliberately tasked with providing products that allow a diversity of treatment levels. In addition some fear that once the principle of co-payments is widely established, their levels could rise and hence reduce both solidarity and equity.

There is a strong chance that at least some of these changes will not be implemented, or if implemented will not last. This is not least because the fiscal savings lie in the future, while the chance to arouse resentment against those who can and choose to pay more lies in the present. The Social Democratic and Communist parties and most health workers oppose the changes, which are likely to figure prominently in future election campaigns. But whatever the eventual fate of this set of reforms all of the ex-communist new EU members will observe the experiment carefully, for almost all have insurance-based health care systems and feel the same pressures to control costs yet improve productivity in the face of aging populations and increasingly expensive treatments.

1.2 Slovak Experience

Slovak social policy in health care is based on free access at the point of delivery for most services, with costs predominantly met from compulsory health insurance entitlements. The ideas of solidarity and equity (equality of access) have a strong resonance with the electorate, as in the Czech Republic, and successive Slovak governments have reconfirmed the aims of universal coverage, high quality treatment for all, and efficient delivery of service. At the same time the reality of provision is the same as in the Czech Republic – fiscal constraints, and in the longer run the need to provide services for an aging population that has rising expectations, in a world where costs are driven upwards by technological innovation.

The composition of Slovak governments has however been noticeably different from their Czech neighbours. While the formative transition years in the Czech Republic were dominated by Vaclav Klaus and the centre-right, the same period in Slovakia saw the dominance of the left-populist-nationalist coalitions of Vladimir Meciar. But the imperative

in both countries in the early transition years was to produce health care systems that were clearly different – and easily seen to be different – from the communist era model. Consequently and largely on the advice of foreign experts, direct state funding was replaced by a pluralistic health insurance model, with indirect state involvement through payments for the health care insurance of minors, retirees and state employees. No subsequent government returned to the state financed system employed under communism, though the 2006–2010 Fico administration would have liked to. Yet at the same time it has been widely recognised that Slovak citizens still have a strong desire for and expectation of state leadership in this and other areas of social policy [2]. Paternalism rather than individual responsibility is both expected and sought, and this is clearly a long lasting legacy of communism. If there has been a similar expectation on the part of Czech citizens, and we would argue that there has been, it has been less prominently discussed.

After Meciar, Slovak governments have alternated between right-wing coalitions under Dzurinda (1998–2006) and Radicova (2010–2012), and the left-wing populist-nationalist regimes of Fico (2006–2010 and 2012 to date). But unlike their Czech equivalents these coalitions have usually commanded clear majorities in parliament. So in principle they have enjoyed more freedom to select and implement their preferred policies. Their rhetoric on access and equity has been similar, but there have been genuine differences about whether or how much privatisation to aim for, and what the effects of it would be.

For example the Dzurinda government argued that privatisation of health insurance companies and hospitals would improve efficiency and raise the quality of health care, and the government`s health minister Zajac`s reforms discussed below, which as noted have strong similarities to the Czech Julinek reforms, reflect this position. But as there is little general evidence, and certainly no Slovak evidence to support this view [17] it seems to have reflected an ideological preference of the policymakers, or possibly the private interests of some significant government supporters.

"Zajac Reform"

This in part radical shift towards the marketization of the Slovak health care system was concluded in June 2004, when Parliament passed health minister Zajac`s proposals, set out in a suite of laws that came into force on January 1st 2005.

The Law on emergency service stipulated that every citizen has the right to a rapid emergency service response within fifteen minutes. The service can be delivered by any form of licensed legal person. This meets the public-private-civil sector mix principle for social policy delivery. The Law on health care and other health related services and the Law on the scope and scale of health care financed by compulsory social health insurance and on financing of health related services need to be evaluated together. The first is the basic law; the second sets the rules of implementation. This new legislation explicitly details rationing: distinguishing between what would and would not be available to all free at the point of use. The division is:

A: Emergency health care – available free to all.
B: Health care services – split into two groups: a basic package fully covered by compulsory social health insurance; and other services subject to a co-payment from the patient.
C: Heath related services (e.g. accommodation and catering in hospitals), delivered for a fee.

The Law on health insurance created a new two-tier system; a compulsory social health insurance in line with the above laws; and an individual health insurance in accordance with the Business Code. The second tier provision was never implemented. The social health insurance system was still broadly defined to guarantee citizens` access to a basic package of health services, financed by contributions from employers, employees, and from the state for the economically inactive citizens. The Law on health insurance companies transformed them into public share-issuing companies, with the state wholly owning two of them; the General Health Insurance Company, and the Joint Health Insurance Company. The rights and responsibilities of the insurance companies increased significantly, allowing them to function as real regulators of the health care system, for, most importantly, they became formally co-responsible for securing the

minimum network of health facilities in their areas, and for contracting health providers. The Law on health providers – health professionals and their professional bodies – enlarged the list of types of health providers; for example by including home care, and same day care. It set out the principles for basic provision, and transformed all health providers into non-profit or shareholders companies.

Such radical reform changes were electorally unpopular. To reflect this opposition the incoming 2006 left wing Fico government tried to alter several important elements of the reform, less than two years after their introduction, replacing market with more paternalistic approaches. Thus the only obvious permanent impact of the Zajac reforms has been the considerable increase in private payments by patients. These are now widely thought to be too prominent from an equality perspective.

Sometimes policies have been designed to reflect differences in coalition partners` preferences, and this may have limited reform. But the most obvious limitation on radical change has been the perception that reforms are contentious, and may be reversed under the next government. For example in 2006 the incoming Fico government stopped the then in progress privatisation of teaching hospitals, and in addition, reflecting their own ideology, forbade private health insurance companies to operate on a for profit basis. This radical policy clearly reflected statist preferences in his coalition, but it also triggered EU interventions on the companies` behalf, and eventually in 2010, after the defeat of the Fico coalition, Slovakia`s Constitutional Court struck down the law. Nevertheless this dispute damaged the interests of for-profit insurance companies, and may have set back reforms in health care finances by discouraging new entrants into health insurance, so reducing competition. Such a result may have been anticipated and indeed sought by the policy`s supporters.

The upshot of this ideological tussle between supporters of the market and of state control has in fact been a highly decentralised health care administration. For example in 2009 of 172 hospitals, 67 were state owned, 22 were run by regional or local governments, and 83 were privatively owned and run on either profit or not-for-profit lines. Most of the privatisation of hospitals happened under the second period of Dzurinda government (2002–2006), but in other areas of health care delivery, for example in ambulatory care, the state has only a minor direct role. In general there is wide acceptance of the principle that a plurality of providers – public, private and civil sector – should be encouraged and sustained, though different political parties have distinct preferences about the relative size of the different sectors and whether or not profit is an acceptable motive for engaging in the supply of a service.

1.3 Conclusions: Health Policies

In both countries left and right wing coalitions alternate in power – and these changes are clearly connected to important policy reversals, switching between more pro-market and more pro-state orientations. Frequent policy reversals, based on behavioural norms or on populist strategies, but not on evidence, limit any chance to realise needed effective reforms – both countries pay dearly for providing health politics and not health policy.

Although shifts between right and left are common features of both systems, it is unlikely that there will be a reversion to the direct state financed and managed delivery system last seen under communism. However, there is a limited probability that pluralistic health insurance system might be abolished in Slovakia.

The underlying problems of both countries` health care systems are very similar and for the moment seemingly intractable, in part because of the limitations interest groups and divided political preferences place on change. However the power of actors seems to be different in the Czech Republic and Slovakia – see for example Maly, Pavlik and Darmopilova [14].

2. Resources, Costs and Cost Containment

The resources available to the Czech and Slovak health care systems are set out in tables 1–4. The table 5 includes selected comparative data for Poland, Hungary and the European Union (EU) taken as a whole as the benchmark.

Tab. 1: Health resources Czech Republic: financial data (bil. CZK, current prices)

	1990	1995	2000	2005	2007
Health insurance	x	77,402	115,792	170,093	183,713
Total public expenditures	30,052	92,478	132,962	191,356	206,565
Direct payments	NA	7,366	13,873	23,110	31,491
Total health expenditures	30,052	100,675	146,835	218,774	241,935
Percent of GDP	4.7	7.0	6.7	7.3	6.8

Source: [14]

Tab. 2: Health resources Czech Republic: natural units

	1990	1995	2000	2005	2007
Physicians	28,036	30,942	34,604	36,381	36,815
Physicians/100,000 population	271	300	337	355	357
Other health professionals (nurses, pharmacists, midwives)	99,267	100,967	104,268	97,234	97,096
Other health professionals/ /100,000	958	977	1,015	950	941
Hospital beds	113,204	95,217	87,820	85,723	83,667
Hospital beds /100,000 population	1,092	922	855	838	811

Source: [14]

Tab. 3: Health resources Slovakia: financial data (bil. SKK/EUR, current prices)

Expenditures	**1995**	**2000**	**2005**	**2008**	**2010**
Health Insurance	SK 20.1	SK 35.1	SK 72.2	SK 99.3	SK 102.3
			€ 2.4	€ 3.3	€ 3.4
General Taxation	SK 11.2	SK 15.7	SK 12.0	SK 3.0	SK 6.0
			€ 0.4	€ 0.1	€ 0.2
Direct Payments	SK 1.8	SK 5.9	SK 21.1	SK 30.1	SK 33.1
			€ 0.7	€ 1.0	€ 1.1
Total	**SK 33.1**	**SK 56.7**	**SK 105.3**	**SK 132.4**	**SK 141.5**
			€ 3.5	**€ 4.4**	**€ 4.7**
Percent of GDP	**5.7**	**6.1**	**7.2**	**6.5**	**7.3**

Sources: [24] – data for 1995 and 2000, WHO 2011

Tab 4: Health Resources Slovakia: natural units

	1995	2000	2005	2008	2010
Total work-places health establishments	77,137	71,605	98,829	109,874	106,233
Physicians (total)	10,567	9,761	19,237	20,866	20,431
Nurses (total)	30,334	28,037	32,319	33,778	34,477
Other medical staff (total)	13,036	12,644	21,918	24,508	23,053
Administrative and service staff	21,329	19,982	23,191	28,552	26,072
Other staff	1,871	1,181	2,164	2,170	2,200
Hospital beds (total)			48,622	46,742	46,878
Hospital beds per 1,000 inhabitants	7.5	6.5	9.0	8.7	8.8

Sources: [24] (data 1995 and 2000), Zdravotnicka Rocenka 2010

The snapshot aggregate data (Table 5) hide some significant trends and characteristics. For example the ratio, per 1000 population, of general practitioners to specialists in OECD countries in 2007 was 0.9/1.8. In the Czech Republic it was 0.7/2.9, and in Slovakia 0.4/2.3. These figures reflect the strong hospital bias of health care delivery in Czechoslovakia and in its successor states. They suggest a system that is arguably over-focussed on acute rather than preventive services. They also reflect the post-communist fee per intervention reimbursement system in the Czech Republic, which led to chronic overspending and excess interventions and because of effective medical pressure groups is still retained for specialist services.

Tab. 5: Resources for health care in Central Europe (2008)

	Czech Republic	Slovakia	Hungary	Poland	EU
Doctors (1)	3.6	3.0	3.1	2.2	3.3
Nurses (2)	9.7	6.3	8.7	5.2	9.8
Hospital beds (3)	7.3	6.6	7.0	6.6	5.7
Average hospital stay (4)	7.5	7.7	5.9	5.6	7.2
Per capita GDP (5)	21.5	19.0	16.9	14.8	25.4
Average expenditure (6)	1.5	1.5	1.2	1.0	2.2
Public share (%)	82.6	69.0	71.0	72.2	73.6
Drugs share (%)	21.1	28.2	31.5	22.9	20.5

Source: [20].

Notes: (1), (2), (3). Per 1000 population.
(4) In days.
(5), (6). In thousands of euros at PPP per capita.

The core financial problem of both the Czech and Slovak health care systems (Table 6 for Slovakia) are chronic and often acute deficits caused by inadequate cost containment systems. This weakness is especially prominent during left of centre administrations. Apart from the Czech problems with fee for service reimbursement schemes the two other most pressing cost control issues in health care are drugs and hospital solvency [10]. Both are acute in Slovakia, where hospitals are currently being recapitalised for at least the third time since independence. There is a domestic pharmaceutical industry in both countries, but the cost of medicines, both absolute and relative to other central European comparators are especially high in Slovakia. In fact Slovakia has one of the highest shares of pharmaceutical costs to total health expenditure in any OECD country. Financing in the Czech Republic is heavily reliant on public funds, with only 20 % of the bill coming directly from patients [9].

Tab. 6: Economic Performance of the Slovak Health Care System (billions of SKK, 2009 in EUR million, 1EUR=30 SKK), selected years

	1995	1998	2000	2001	2002	2005	2009[1]
Primary care costs	1.3	4.2	4.7	4.9			
Secondary ambulatory care costs	0.0	1.5	1.9	2.1	7.3	13.3	776
In-patient care costs	25.3	25.6	26.0	28.1	20.5	27.1	1298
Medicaments and health aids costs	2.0	16.1	20.6	22.8	32.2	34.2	1075
Other costs	0.9	5.0	6.9	7.7	12.0	17.3	167
Ministry of Health costs	4.1	4.7	4.5	4.9	4.7	4.1	x
Total costs	**33.6**	**57.1**	**64.6**	**70.5**	**76.7**	**96.0**	**x**
Balance	**-0.5**	**-5.6**	**-7.9**	**-8.6**	**-6.6**	**-2.0**	**x**
Debt settlement	0.5	5.6	7.9	8.6	119	0	199
External debt	0.5	5.6	4.4	5.2	5.0	1.6	n.a.
Privatization grants	0.0	0.0	3.5	3.4	0	0	0

Source: [24] (for 2002 and 2005), [21] for 2009

1: Only expenditures paid by insurance companies

The challenge is to preserve the widespread accessibility and availability of drugs yet reduce the overall pharmaceuticals bill whose excessive size has pre-empted other reforms, such as placing hospital financing on a more sustainable basis. Yet the OECD study concluded that "…incentives for generic substitution are weak (for patients) and misaligned (for pharmacists)." In addition "When deciding whether a drug will be reimbursed through the social insurance scheme, the cost-effectiveness of new pharmaceuticals is not assessed" [9, pp. 4].

There are several obstacles to achieving significantly lower drugs costs without reducing their effectiveness or availability. First is the general lack of capacity to make the sort of judgements that populous EU members with their extensive medical and economic research capabilities take for granted. In assessing the clinical and economic effectiveness of treatments no central European country has any significant independent capability. Where such judgements are used they rely on other countries, especially Germany`s assessments. The lack of clinical assessment capacity is probably of little consequence, the lack of economic assessment capacity is a problem.

But the key obstacle to lower drug bills is the prescription patterns. This is partly a problem of pharmaceutical companies` influence over doctors, and partly a problem of doctors not following or not knowing best practice. In both Czech and Slovak cases the companies are foreign multinationals whose Czech and Slovak markets, while profitable, may not be of prime importance. The companies are also experienced and tough negotiators. For example in 2011 a Slovak plan to reduce the reference price for drugs, and

to try to limit the opportunities of companies to corrupt doctors, elicited a joint letter of protest to Prime Minister Radicova from the ambassadors of the companies` countries. She characterised the lobbying as the hardest she had had on any issue, and described it as exceeding the bounds of "political decency" (The Daily News – Slovakia, 09.06.2011).

To summarise the conclusion of this section: the "economic" performance of the Czech and Slovak systems is very similar and no important divergence trends are visible. From the beginning the Czech Republic spent a bit more and so has used a greater volume of physical inputs to deliver the care. The core common problem is that neither country has been very successful in managing a balanced health care system and in implementing effective cost-containment policies.

3. Quality-outcomes

We assess the quality dimension of the selected health care systems using two key indicators – health outcomes and patient/ /customer satisfaction.

Over the period of transition (1989–2011) the life expectancy of Czech and Slovak citizens has increased by between four and five years (Tables 7–8), due to a combination of "external" factors such as rising incomes and healthier life styles, and "internal" factors like rising expenditures on health care, and improvements in medical practices, equipment and drugs. The slightly faster progress of the Czech Republic reflects a variety of influences, including higher living standard and especially the fact that the Roma population, which has a life expectancy of perhaps ten years less than the non-Roma population [22] accounts for about ten per cent of the Slovak population but only perhaps two per cent of the Czech population. Perhaps unsurprisingly the Czech Roma population is thought to have a higher life expectancy than its Slovak equivalent.

Slovakia`s health care industry also seems to be slightly less successful than its Czech counterpart when judged by other health outcome indicators, but relative to its neighbours the results are comparable.

Tab. 7: Health Status Indicators Czech Republic

	1985	1990	1995	2000	2005	2008
Life expectancy (male)	67.2	67.6	70.0	71.7	72.9	73.9
Life expectancy (female)	74.6	75.5	76.6	78.4	79.1	80.1
Death/1000 inhabitants	13.1	12.1	11.2	10.5	10.4	10.1
Infant mortality rate	14.2	10.8	7.7	4.1	3.4	2.8

Source: Czech Statistical Office; European Health for All Database

Tab. 8: Health Status Indicators Slovakia

	1985	1990	1995	2000	2005	2010
Life expectancy (male)	66.9	66.6	68.4	69.2	70.1	71.6
Life expectancy (female)	74.7	75.4	76.3	77.2	77.9	78.8
Death/1000 inhabitants	10.2	10.2	9.8	9.8	9.9	9.7
Infant mortality	16.3	12.0	11.0	8.6	7.2	5.6

Source: www.statistics.sk

Tab. 9: Health outcomes in Central Europe 2008

	Czech Republic	Slovakia	Hungary	Poland	EU
Life Expectancy Male	73.4	70.4	69.1	70.9	74.3
Life Expectancy Female	79.8	78.3	77.6	79.6	80.8
Decline in mortality 1994-2008. Age Standardised per 100,000	38	15	36	31	30
Infant mortality 2008 per 1000 live births	2.8	5.9	5.6	5.6	4.6
Adults self-reported health status 2008 (%) "Good or very good"	62	60	55	58	67
"Chronic illness"	28	30	38	31	30

Source: [20]

Tab. 10: Patient health care experience, perceptions and preferences: 2010

	Czech Republic	Slovakia	Hungary	Poland	Western Europe (1)
% Satisfied respondents (2)	66	64	59	62	80
% Change from 2006 survey	+6	+7	+9	+16	n.a.
% Prevalence of unofficial payments (3)	11	22	42	8	3
Health as 1st priority for extra spending (4)	n.a.	49	40	43	n.a.

Source: EBRD, 2010.

(1) Average of responses for France, Germany, Italy, Sweden, and the United Kingdom.
(2) % of respondents who were satisfied or strongly satisfied with public health care services.
(3) % reporting that unofficial payments were always or usually needed to access services.
(4) % selecting health as the first priority for any extra public spending, over spending on education, housing, pensions, assisting the poor, the environment, or public infrastructure.

Table 10 shows some selective results from the second Life in Transition survey carried out by the European bank for Reconstruction and Development (EBRD) in collaboration with the World Bank. The survey covered 1000 respondents drawn at random from 27 transition states, along with some comparative data from five western European countries. The first Life in Transition survey was conducted in 2006, which allows us to draw some longitudinal conclusions.

The four central European countries show average (Hungary) or above average levels of satisfaction with public health care delivery compared to the average of the 27 transition countries in the survey. Interestingly the level of satisfaction has risen since the 2006 survey, despite the impact the Great Recession on the most recent survey. The second survey highlights the gap in satisfaction with health care between western and central Europe, and the importance transition states` citizens accord to additional health spending. It also shows considerable variation in the prevalence of unofficial payments across countries. Looking at the motives for such payments in health care across the whole EBRD survey, about a third of payments reflected patients` gratitude, a fifth

were directly solicited, the same proportion were made to speed up service delivery, and the remainder, while unsolicited, reflected patients` awareness that they were expected.

To summarise this section: the Czech system is slightly more successful in improving health outcomes, but the main indicators do not exhibit noticeably different trends. The level of citizens` satisfaction with the quality of health care is similar in the two countries, though below the western European average. The only visible difference is the larger scale of the shadow economy in Slovakia, though this is not a recent development and was noted by Miller et al. [16].

4. Access

As noted above health policies were a national responsibility in the federal Czecho-Slovakia, and after 1989 both countries independently decided to switch from a general taxation model of financing health care to a social insurance system. Typically this change was bolstered by arguments about plurality, independence and competition, which were viewed as the main positive features of the new system [13]. The motivation to switch from the previous "socialist" taxation-based system to a "modern" (but perhaps not better) insurance-based system of health care financing was to large extent a political one – to show a willingness to change.

The switch to pluralistic health insurance systems did not impact the level of access to health care by citizens – in both systems universal coverage is legally guaranteed and also practically implemented. Both countries are also very reluctant to formally introduce a "two-speed" system allowing rich people to opt to pay for better services. Although co-insurance schemes exist, they do not provide a significantly better quality of clinical care.

Thus where there are observable differences in actual access to the health care system, for example shorter waiting times, these are mainly the result of shadow economy payments or reflect the special status of the patient, for example senior bureaucrats or politicians.

The core difference between the selected systems lies in the share of public and private expenditures. In both countries important co-payment schemes were introduced by liberal governments, though with different results. Arguably co-payments are already comparatively too high in Slovakia, where between a third and 40 % of health care spending is covered from private pockets.

Conclusions

This paper has explored the development of Czech and Slovak social policy in health care across the past two decades. We have argued that the initial post-Velvet Revolution reforms showed no sign of popular influences, but that a desire by the new elite to mark a clean break with the past, plus some foreign advice, led to the choice of the health insurance model. Both countries have substantially increased their expenditures on health care both absolutely and as a proportion of GDP, though they are still a long way from EU expenditure levels. Health policy and practice in both countries has become the target of interest groups rather than popular campaigns. Doctors and other health workers, hospital administrators, health bureaucrats and insurance funds have vied with politicians to mould the development of both countries` systems, neither of which have any significant research capability to make clinical or economic decisions on the basis of domestic analyses. So medical decisions tend to rely on foreign research and practice and economic decisions are influenced by local interest groups, ideologies or coalition politics.

The comparisons and contrasts between the two systems throw up an interesting and somewhat unexpected result: after more than twenty years of independent policymaking the systems are still very close. The main similarities are chronic financial imbalances; an inability to fashion an effective prescription policy; limitations in insurance companies` regulatory performance, stemming from, especially in the Slovak case, an unwillingness by left populist governments to delegate authority; the primacy of politics over health policy; improving health outcomes, due to more resources, improved technologies, and better life styles; the maintenance of largely universal access; the inability of left wing governments to implement consistently even widely agreed reforms.

For the Czech Republic the main differences lie in the greater power of their

doctors` lobby: (see for example the different results of salary-increase-based "strikes" by medical doctors in the two countries); the baleful influence of fee-for-service caused financial indiscipline; the inability to cut excessive hospital and bed provision; and of course in the timing of the reforms. For Slovakia they lie in relatively weaker health improvements; much higher co-payments for services; the maintenance of a single level health service, despite the legality of a two-level system; and the achievement of cutting excessive bed provision in 2010–2011.

From a social policy perspective this natural experiment in social policy points to the difficulties of changing the delivery policies or institutions of health care, following change instigated by a major political rupture with the past. This is especially true when governments are finely balanced coalitions – even those under the constraints of fiscal austerity and an aging population. Neither country gives a strong impression of being able to direct social policy and expenditure in a clearly agreed, or recognised to be necessary new direction, as opposed to managing an existing programme whose general direction is driven more by circumstance than design. The next few years will show if this is too harsh a judgement.

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Abstract

HEALTH CARE REFORMS IN THE SLOVAK AND CZECH REPUBLICS 1989–2011: THE SAME OR DIFFERENT TRACKS?

Colin Lawson, Juraj Nemec, Vladimír Šagát

For 20 years the successor states of the former Czechoslovakia have tried to improve health outcomes in an efficient or at least effective manner. Slovakia and the Czech Republic chose partly different policies, different health delivery and finance systems, and different payment and incentive structures. And yet in both countries better health outcomes emerged, but at great cost, as efficiency proved elusive. The goal of the paper is to examine processes and results of health care reforms in the Czech Republic and Slovakia – are both countries after 20 years of changes still on the same track? The paper has four sections. Following the first section of background and introduction, we examine the principles and development of social policy in health care, how political instability neutered reform, yet politicised health issues, sometimes resulting in policy reversals. The third section explores the outcomes of the transition health care policies and how voters have perceived them. A summary of findings concludes, indicating that both systems are still very close, but some important differences emerged during the reforms process. Although there has been progress towards western European outcome standards, there is much to be done. While the costs of health care will continue to rise, it is unclear that the present political, policy-making and implementation systems can deliver either efficiency or a responsiveness to patients` views.

Key Words: *health care, efficiency, Czech and Slovak Republics, pressure groups, corruption.*

JEL Classification: *I113, I118.*