Health Policy Interests in the Czech Republic: Doctors and the State

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I. Introduction

Seven hundred pharmacists protested outside the Czech Ministry of Health in January 2006, angered by the Ministry’s cost-cutting decision to reduce pharmacists’ profit margin by 3 percent (Proti Rathovi 2006; Většina Českých Lékáren 2006). That was the first time pharmacists took to the streets, but Czech physicians and other medical workers have organized public demonstrations at least five times since 1995 to demand higher pay or protest decisions of the Ministry of Health. These events are interesting because just over 15 years ago they would have been unthinkable under the communist regime and even since the reestablishment of democracy in the Czech lands, national strikes and protests like these have been infrequent. In addition, these confrontational, high-pressure acts occurred in a health system that, on its face, is corporatist. Why are doctors and pharmacists filling the squares and streets of Prague when they have membership in the state-created Medical Chamber associations and guaranteed seats in the corporatist body that deals with health care issues? Doctors have dominated these corporatist structures and are credited with shaping initial Czech health policy reform. What has changed since the early 1990s, that they find it necessary to employ pluralist strategies to publicly air their grievances?

I argue that these incidents reveal the weaknesses of the Czech corporatist governance regime in the healthcare arena. The state dominates these structures and has ignored or even dissolved consultative bodies designed to create a policy process oriented around consensus. This has created incentives for well-organized interests, with doctors being the most mobilized group in the healthcare industry, to seek other channels of influence and employ pluralist strategies. The pharmacists have followed the doctor’s lead and recently organized their own protests and demonstrations. Health policy is a confrontational battle ground, with the best-organized interests exerting the most power.

There are two channels in the Czech health policymaking process, the institutional, corporatist means of policymaking and the pluralist lobbying activities of independent organizations. The Healthcare Tripartite (zdravotnická tripartita) and the legislatively created professional chambers, including the Czech Medical Chamber are the two main avenues of formal interest mediation in the Czech health policymaking process. To date, the weakness of

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the corporatist bodies to reach and enforce satisfactory agreements is exacerbated by the ability of individual professional associations to side-step this formal representation process and use public demonstrations to appeal to the public and put pressure on the Ministry of Health (MoH). Health insurance, pharmaceutical firms, and patients have not adopted these measures to the same extent that medical professional associations have. Since these doctor’s associations use informal lobbying channels, the extent of their influence depends on the willingness of the Minister of Health to defend their cause and the strength of the Minister of Health in the government cabinet as a whole.

The two-track process of policymaking has led to stagnation and the inability of the government to pass comprehensive policy legislation. In the particular case of Czech doctor’s salaries, this has meant that incremental increases have occurred recently but a fundamental reworking of health financing to make these increases economically viable has not occurred. Since the doctor’s had power to push a particular agenda, that complaint was addressed, but not larger problems with the system. The consequences of this health policymaking process have led to piecemeal and sometimes inconsistent reforms.

In the next section I explain why the Czech case is a fruitful case study of health policy and postcommunist interest representation and give a brief overview of Czech health reform in the 1990s. Section III builds on this foundation and maps the Czech health policy process, identifying key actors, their interests and their power. In the conclusion I reflect on the meaning of these results for health policy and interest representation in the Czech Republic.

II. The Czech Health Policy Context

A. Why Health Policy in the Czech Republic?

Health policy is an important case study of postcommunist interest representation because it is an expensive policy for the state and private citizens, the health industry employes a large number of employees involved and healthcare, at some point, touches every citizen’s life, so that everyone in a society has a stake in the debates that surround health policy. In 2003, the total per capita expenditure on healthcare in the Czech Republic was 1,298 USD (PPP). This is well below the OECD average of 2,394 USD (PPP) but higher than per capita spending in the other postcommunist countries of Hungary (1,269 USD), Slovakia (777 USD) and Poland (744
In East Central Europe, only Slovenia (1,405 USD) and Malta (1,709 USD) spent more on health care (Rokosová et al. 2005, 40).

Total Czech healthcare expenditures measured up to 7.5 percent of GDP in 2003, again below the OECD average of 8.8 percent of GDP (OECD 2005, 71), but much higher than the 5.3 percent of GDP spent in the Czech lands in 1991 (Háva et al. 1998, 311) and also well above the 2003 average among central and eastern European countries, which was 5.8 percent of GDP (Rokosová et al. 2005, 36-38). Total healthcare spending as a percentage of GDP ranks near pensions, making it the second most expensive social policy in the Czech Republic (for example, see comparisons in Mácha et al. 1999). Compared to its postcommunist peers, the Czech Republic spends a large amount of money meeting the health care needs of the population.

The Czech Republic ranks very high in the number of health professionals it employs. The total number of physicians and nurses per 1,000 people is 13.2, which is higher than any other East Central European state (Rokosová et al. 2005, 63). Even among OECD countries, the Czech Republic ranks sixth in number of practicing physicians per 1,000 population and is well above the OECD average (OECD 2005, 39). In 2002, the Czech Republic had 6.5 acute hospital beds per 1,000 population, a rate higher than all other OECD countries except Japan and Germany (OECD 2005, 45). To meet all the demands generated by these hospitals and other health care facilities, the Czech health system employed 241,983 people at the end of 2004 (Institute of Health Information and Statistics of the Czech Republic 2005, 151). This constitutes about 5 percent of the employed Czech labor force (Czech Statistical Office 2005). The sheer number of employees and employers affected by the policy area make it a promising area in which to study interest representation and mediation.

The Czech Republic is an excellent case in which to study interest politics in the health sector because it was one of the first countries in the postcommunist region to decentralize the financing and provision of health care. Only Hungary moved away from the Soviet model to the social insurance system before the Czech Republic. Hungary separated its Social Insurance Fund, which covered health costs, from the government budget in 1988 and removed limits on private provision of health care in the same year. The Czech Republic passed its social insurance health care scheme in December 1990, long before reform passed in the neighboring countries of Poland (1999) or even Slovakia (1994) (Gaál 2004, 7; Kornai and Eggleston 2001, 146). Since
its social insurance system has been in place for 15 years, there’s been sufficient time for new interest groups, power structures and policy processes to develop.

There are two types of policy decisions that the interest groups can participate in. First, there is the fundamental structural reforms to the system which require new legal frameworks enacted through legislative acts of parliament. Second, and more common, are the many policy-implementing acts that are officially supervised by the MoH and do not require any action on the part of parliament. These include the classification of pharmaceuticals as 1) medications fully covered by health insurance or 2) drugs that require an out-of-pocket payment. Controversial decisions about the list of services covered by health insurance and the reimbursement rates for doctors who provide those services also fall under the supervisory role of the MoH (Rokosová et al. 2005, 33). I focus on policy-implementing decisions rather than on fundamental reform. Although debates regularly emerge over fundamentally restructuring the Czech health policy system, a lot of policy energy is focused on simply implementing and maintaining the existing system. Even after a decade of working with the new system, new challenges and questions arise for the current health policy stakeholders to address.

B. The Czech Health System: Past and Present

The 1990 Health Care Reform was a significant break with the communist system and in many ways a return to the structure of health care provision that existed prior to the communist era. The Interwar Czechoslovak government instituted obligatory health insurance for the entire wage-earning population, extending an insurance program that had started in 1888 for industrial workers only. Employers and employees contributed to one of about 300 insurance funds and private doctors and public hospitals provided care. After the Communist Party takeover in 1948, the insurance funds were consolidated into one Central National Insurance Fund, which received contributions only from employers. Three years later, the government established a full-fledged Soviet health system: healthcare was funded entirely through taxes paid to the state, not separate health insurance contributions, and all health care providers were nationalized under the Regional and District Institutes of National Health (Jaroš and Kalina 1999, 1-2). This system enabled the Communist Party-State to meet its legislated guarantee to provide all citizens access to free (at point of service) healthcare (Kornai and Eggleston 2001, 141, footnote 4).
In December 1990, the new, democratically-elected Czechoslovak government passed a Draft of the New Health Care System, which committed the state to returning the system to its Interwar roots. The new system followed the German pattern of compulsory insurance offered by multiple and independent health insurance funds, state-collection of insurance contributions, and mixed state (usually hospitals) and private providers (most primary care physicians and dentists). Although financing health care costs now relied on contributions, the state was still actively involved in health care financing. The state pays the contributions for the unemployed, the elderly, children, women on maternity leave, men in the military, prisoners and people on social welfare programs. This means that about 56 percent of the population is currently insured by the state (Rokosová et al. 2005, 29). In addition, taxes (not insurance contributions) fund capital improvements in healthcare facilities, public health programs, and a portion of the cost of medical training (Rokosová et al. 2005, 34).

The original Draft of the New Health Care System was followed in 1991 and 1992 by several pieces of legislation creating the legal framework for the new system. These new bills elaborated the specific functioning of the health system, such as laws on the health insurance funds, privatization of health provision and professional associations. All the major legislation creating health insurance funds and allowing privatization of provision was put in place and operating by the beginning of 1993.

III. Czech Healthcare Governance

The new health care system intentionally dismantled the Soviet centralized, monopolistic system and created a host of new potential participants with a stake in health policy decisions. The first task I take up is to map this new system of Czech health governance. The two most common governance models in democracies are the corporatist and pluralist systems. In a corporatist governance regime, states “delegate authority to a limited number of functional interest groups or professional associations to implement policy on its behalf” (Giaimo 2002, 9). Major actors have guaranteed access to policy discussions and often a voice in final policy decisions. In a pluralist governance regime, there is a competition of ideas of among any group of interests that may organize. Dialogue between these groups is not formally structured, but each interest group may participate in the formulation of policy to the extent that it is successful in attracting the attention of decision makers.
The postcommunist context and the Czech Republic’s adaptation of the German model of health insurance both would suggest the likelihood of a corporatist governance model in Czech healthcare. Due to the habits formed under communism, the state in postcommunist countries “plays a prominent role in the management of day-to-day politics and, therefore, corporatist arrangements have become the norm” (Pérez-Solórzano Borragán 2004, 249). The corporatist trend in East Central European often manifested itself in tripartite bodies, which brought together employers, employees and the state (Myant, Slocock, and Smith 2000, 723). Corporatism also fits well with the healthcare system adopted by the Czech Republic in the early 1990s. The Czech system borrows heavily from the Czech historical experience, but also from its German neighbor, best characterized as a corporatist system. In Germany, the state works with insurance funds and the medical profession to formulate policy and depends on these bodies to implement the government’s legislation (Giaimo 2002, 14-15). The Czech health insurance model of health care combined with the trend of corporatist structures in postcommunist Europe are conditions likely to create a Czech corporatist health policy regime.

Two additional factors, however, work against these expectations. First, the tripartite structures in East Central Europe are typically weak versions of corporatist governance. Corporatist bodies usually do not have the power to make binding decisions on issues like wages. Instead, they serve a social consultative mechanism and provide for the exchange of information between employers, workers and the state (Myant, Slocock, and Smith 2000, 724). This is especially true in the Czech case, where the agreements negotiated by the tripartite body do not carry any legal weight but are rather “‘gentlemen’s agreements” and the Conservative ODS government worked to limit even this power in the mid 1990s (Hála et al. 2002, 10). The weakness of corporatist structures in general, might mitigate against the success and strength of corporatist institutions in the health policy arena.

The second factor is the fact that health policymaking has historically been dominated by the medical professions, especially doctors’ associations. This power comes from physician’s essential role in healthcare provision, the social prestige of their position and their ability to organize politically (Moran and Wood 1993, 124-125). Sometimes, doctors exert this power by capturing corporatist structures and using their privileged position with the state to exert their preferences on policy (Giaimo 2002, 11). In order to ensure the outcomes they desire doctors’ associations operating in corporatist structures may also function as pressure groups, employing
pluralist strategies, especially during times of structural healthcare reform, (Day and Klein 1992 as discussed in; De Voe and Short 2003, 344). This expectation of strong doctor’s associations exercising influence through lobbying conflicts with the postcommunist reality of relatively weak civil society organizations (Howard 2002) and weak union organization (Crowley and Ost 2001). The dominant position of doctors’ associations may facilitate pluralist models of governance or this may be hampered by the postcommunist context.

These counterveiling expectations each explain part of the complex reality of Czech health policy governance. The Czech system does have a corporatist system and doctors have managed to capture these institutions in the past. However, the independent union of Czech doctors, organized entirely outside the corporatist structures in order to better advance their policy agenda. This may be either an attempt on the part of physicians to compensate for the new weakness of their position in corporatist structures due to other new and increasingly influential actors. The fact that doctors have employed pluralist strategies may also contribute to the further decline of the importance of tripartite discussions on healthcare issues.

This complex scenario has several consequences for health policy governance in the Czech Republic. First, the Ministry of Health continues to determine which interest groups have access to the policy process. This does not mean, however, that the Ministry of Health operates entirely independent of interest groups. Which interests are successful in getting this power depends to some extent on who is currently running the Ministry of Health. This leads to an unpredictable process, which changes with every new Minister of Health, of which there have been many.

International actors have been left out of my argument and analysis because of the weak role they play in Czech domestic health policy. The World Bank did issue recommendations for Czech healthcare reform in 1991, but due to the Czech Republic’s relatively sound economic standing at the time, the Bank had relatively little leverage with which to enforce these recommendations and they were ignored (Roberts 2003, 10). Among international actors, the European Union has the greatest potential to shape postcommunist domestic policy (Vachudova 2005), but in the area of healthcare the EU has relatively few tools. Aside from a few requirements about public health, any other regulations affecting healthcare are “spillover” from other policy areas such as agriculture or employment and social policy. The EU has not attempted to intervene in the wide variety of healthcare governance systems found across Europe.
nor has it directly shaped governance systems among its new postcommunist members (Jacoby 2004, 60-62).

A. Weak Corporatism

The main corporatist body in the Czech Republic is the Council for Economic and Social Agreements (RHSD), established in October 1990. The RHSD is a tripartite body, so named because it represents three sets of interests: employers, employees and the state. The interests of healthcare employers and workers are represented in the large plenary sessions of the RHSD and a special healthcare working group was added to the RHSD in 2001 to focus on complex health issues. The MoH also organizes committees of ministry officials and interest representatives to make decisions about doctor reimbursement rates and drug pricing schedules. Although not part of the official tripartite structures, these committees also create space for information sharing and consensus building among the different interests in the healthcare sector.

The fragmented nature of health policy interests represented in these structures works against their consensus-building goals. In addition, the dominant role of the state in these bodies and in final policy decisions has limited corporatism’s power and potential effectiveness. Groups that participate in these bodies can not be assured that their preferences will be accounted for or, sometimes, even heard.

1. RHSD and the Healthcare Tripartite: Fragmented Interests

The Council for Economic and Social Agreements holds large plenary sessions with representatives from the state, employers and workers. Issues related to the healthcare industry could be raised at these larger plenary sessions, but often the complexity of health policy meant that they could not be sufficiently addressed in the crowded agenda of the full Tripartite meetings. So around 2001, the Healthcare Tripartite (zdavotnická tripartite) was formed to deal specifically with health-related issues (Schlanger Interview 2005).

The agenda of the healthcare working group is established by the concerns of the representatives. In addition, the Ministry of Health sends copies of its draft legislation to this tripartite body for discussion and comments. Because the normal Czech legislative process requires that the government send draft legislation to appropriate government and social entities, most of the employer associations and unions represented in the tripartite also have been allowed

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2 This is referred to as the commenting period (připomínkové zařízení) of the Czech legislative process.
to view and offer comments on earlier versions of the bill. When it comes to the health tripartite agenda, this is usually the second time most groups have seen the legislation (Schlanger Interview 2005). If the smaller health care working team can reach consensus on issues, then there is no discussion of the issues in the larger plenary session. However, in cases where the smaller health care working group does not reach agreement, they refer the issues to the full plenary session (Schlanger Interview 2005). Both the RHSD plenary sessions and the smaller healthcare tripartite gatherings face the challenge of coordinating fragmented interests.

At the RHSD plenary sessions, members of the Government Cabinet serve as representatives, although the Minister of Health is not a regular delegate to the RHSD. Government representatives at the Healthcare Tripartite meetings include the Minister of Health, the Minister of Finance and the Minister of Labor and Social Affairs, although other government representatives may be called as their expertise is needed.

Healthcare employers are directly represented in RHSD meetings. One of the seven employer representatives is the Union of Employers’ Associations of the Czech Republic, which also sits in on healthcare tripartite meetings. This membership of this Employers’ Union is made up of a number of smaller employer’s associations, including, in the health field: the Association of Czech and Moravian Hospitals, Association of Hospitals of the Czech Republic, the Association of Private Hospitals, the Coalition of Private Physicians, Czech Association of Pharmaceutical Firms, Association of Large Distributors of Drugs, International Association of Pharmaceutical Companies, the Committee of Owners of Pharmacies, The Association of Health Insurance Funds of the Czech Republic, and the General Health Insurance Fund (Unie Zaměstnavatelských Svazů ČR).

This list of “employers” suggests one difficulty facing healthcare interests in the tripartite body: fragmentation. The hospital associations include large and small hospitals, private and public. Each of these facilities could have different interests on issues like pay, budgets, and labor practices, given their unique position and location within the healthcare market. In addition, private physicians are included as employers, because they run their own private practices and employ the small staff they need to run their offices. The needs and demands of hospitals versus small, private practice doctors are great and discourage a lot of extensive cooperation. The pharmaceutical companies obviously employ many workers, but in the health policy sector they are as much suppliers as employers. For example, they have been at odds with
hospitals and insurers, two of their fellow employer groups, over payment issues. Hospitals are behind on their payments to pharmaceutical companies, which hospitals blame on the insurance funds where are behind on their reimbursements to hospitals (Rath Wants to Repay 2006).

Even the health insurance funds are not fully unified in their policy interests. The General Health Insurance Fund (GHIF) was established by law in 1991 to serve those who are not employed plus others who choose to be insured under the General Fund. The Fund was established in 1992, but instead of its budget coming from insurance contributions, it was financed out of the state budget for the first year. In 1992, members of parliament introduced a bill to create professional and commercial health insurance funds (Háva et al. 1998, 299). The Association of Health Insurance Funds is the organization that represents the interests of these private health insurance funds, which have relatively little autonomy and power in the Czech system and have dwindled in number from about 27 in the mid 1990s to the current 9 firms (Roberts 2003). Different preferences between these two bodies arise from the fact that the Czech Parliament can vote to extend credit to cover the General Health Insurance Fund’s deficits, but can not take such an act for the other, private health insurance funds (Kornai and Eggleston 2001, 151). Also, the General Health Insurance Fund used to complain that the independent health insurance funds had all the young, healthy and rich clients while the GHIF had all the poor, old and ill ones (Association of Health Insurers Interview, 2005). The healthcare employers represented by the Union of Employers’ Associations are diverse and fragmented in their interests and goals, weakening this Union’s ability to advocate a strong, unified position on health policy implementation or reform.

On the other side of the tripartite triangle are the labor unions. One of the seven employee representatives in the full plenary meeting is the head of the Trade Association of Health and Social Care of the Czech Republic, a union for healthcare workers that belongs to the larger Czech and Moravian Confederation of Trade Unions, which also has an additional representative in the full plenary sessions. The Trade Association of Health and Social Care represents about 70,000 people who work in health and social care. This includes instructors at health schools and medical faculty, social workers, and even ambulance drivers. This broad collection of health and social employees means that their interests are fragmented, and this limits the Association’s ability to strongly push for a particular set of interests.
2. State Dominance of Corporatist Structures

The policy influence of both the RHSD plenary and the Healthcare Tripartite are unpredictable, and depend to a great extent on the style and openness of the current Minister of Health. MoH committees, designed to foster idea and information exchange between ministry officials and interests in health policy also serve at the hand of the Minister of Health and have been dissolved when the groups become too problematic for the administration. Despite the proliferation of interests and corporatist structures in which they can participate, the Czech state remains at the center of health policymaking.

The power of the RHSD was weakened in the mid-1990s when the Klaus government ignored agreements made in tripartite negotiations. The Klaus government even made institutional changes to weaken the tripartite organizations and although the social democrats revived the RHSD, it still does not command the power it did before. Today, the RHSD largely serves an advisory and nonbinding role in policy development (Myant, Slocock, and Smith 2000, 727-733). An ILO study also concluded that “even if social dialogue has become official government policy, it is not incorporated into the day-to-day work of the ministries’ activities, perhaps with the exception of the drafting of new legal standards. There is no systematic cooperation, but discussions are initiated by the social partners, if and when they find out what is being planned” (Casale, Kubinkova, and Rychly 2001, 9).

This unpredictable pattern of influence characterizes the healthcare working group, too. Different Ministers of Health have ignored the healthcare tripartite’s recommendations or refused to even meet with the group. For example, only a month into his tenure as the current Minister of Health, David Rath refused a meeting with the healthcare tripartite to discuss his plans for the General Health Insurance Fund and goals for healthcare more generally (Zdravotnická Tripartita 2005). An unwillingness to meet with the healthcare working team is not entirely new to Rath’s MoH, but also existed in past administrations (for example, see healthcare tripartite minutes at Zdravotnická Tripartita Jednala O Léčivech 2002).

On the other hand, The Prime Minister fired the previous Minister of Health, Milada Emmerová, in October 2005, in part because of her inability to cultivate support among members of the healthcare tripartite. Emmerová presented to the healthcare tripartite her future plans for healthcare in June 2006, which included some short-term stabilization measures and increasing the independence of regional governments to manage the availability of healthcare (Zdravotnická
The healthcare tripartite rejected her proposal and suggested she return to the recommendations they had given her 6 months prior (Zdravotnická Tripartita: Koncepce Je Špatná 2005). This was probably more a symptom than a cause of her difficulties in forging strong ties with the fragmented health policy interests. In October 2005, she had to step down from her post when again the healthcare tripartite expressed dissatisfaction with her proposals (Zdravotnická Tripartita Je Proti 2005). It’s important to add, however, that although the healthcare tripartite disfavor was important, the Prime Minister’s decision to replace Emmerová came about one day after doctors protested outside the Health Ministry and demanded Emmerová’s resignation (Interfax Czech Republic 2005).

Another controversial element of Emmerová’s MoH was her dissolution of the drug Categorization Commission. This Commission is an external advisory body established in 1997 to set the reimbursement levels that health insurance funds will pay for every drug available by law in the Czech Republic. Members include MoH officials, representatives from the pharmaceutical industry, doctors, health insurance companies and even patients’ rights groups (Petrenko Interview, 2005; Rokosová et al. 2005, 68). Initially, the Commission met every 3 months to update the reimbursement rates but since January 2000 it has met only every 6 months. The Commission’s decisions were always fully adopted by the MoH until Emmerová’s administration ignored several of them, and without explanation changed some of the reimbursement rates, which “cast considerable doubt on the transparency of the entire process” (Rokosová et al. 2005, 68) These doubts were further heightened when Emmerová completely dissolved the committee and for at least one cycle of decision-making, the drug reimbursement rates were determined exclusively by MoH officials without input from outside advisors (Žídek Interview, 2005). These ad hoc advisory bodies operate as consensus-building corporatist structures only when the Ministry of Health allows them to. Since the MoH can dismiss the decisions and even existence of these groups, their policy implementation and regulation influence can change at any time, making it unpredictable and ultimately leaving power in the hands of the state.

3. Conclusion

This discussion of state-dominance has focused on the power of the MoH and the Government. Of course, other state actors exist, notably Parliament, the Ministry of Finance and subnational governments. Both chambers of the Czech parliament have committees dedicated to
health policy issues. Draft legislation is developed and revised in the MoH and approved by the Cabinet before making it to parliament. The Parliamentary health committees can certainly make amendments, but they are not where the bulk of the legislative work is done. Members of the committees acknowledge, for example, that the committees do not receive a lot of interest group visitors who try to influence the discussion (Senate Interview, 2005). Parliament plays a role when fundamental reform requiring a new legal framework is under discussion. Implementation and regulation of the existing system, the focus of my discussion here, operates largely outside the sphere of Parliamentary influence.

The Ministry of Finance and subnational governments have more potential for implementation and regulation power, although these are currently underdeveloped. For the Ministry of Finance, the extent to which budget constraints shape health policy decisions has varied by government, with ODS giving more weight to the Minister of Finance and the current Social Democratic regime granting relatively less important to Finance. Subnational regional-level governments are a relatively new addition to the political institutions involved in Czech healthcare governance. These were recreated in 2000 and on January 1, 2003, assumed management of all publicly-run hospitals, which had previously been run either directly by the national government in Prague or district offices of the national government (Rokosová et al. 2005, 25-27). Regional governments operate outside the tripartite structures. Their independence from the central state, weakens of the power of the MoH to determine the future of hospitals and in that way decentralizes the policymaking process. The ODS-dominated regional governments have challenged central state policies and have worked to represent their regional interests against those of the central state. As these regional governments gain greater capabilities and exert their influence in health care policy, they may become more important actors in the management of current health policy; to date they have been relatively weak due to their recent addition to the system.

3 Since the Social Democratic government came to power, the Ministry of Finance has still made efforts to curb the rising costs of Czech healthcare. For example, in 2004, the Ministry of Finance coordinated a visit of World Bank consultants with important Czech healthcare stakeholders. Although these meetings generated ideas for reform, a change in government leadership and a new Minister of Health meant that the plans were dropped (Ministry of Finance Interview, 2005).

4 For example, in January of 2006, the Association of Regional Governments developed their own version of a law on nonprofit hospitals to counter parliament’s bill which would have created a network of 140 public nonprofit hospitals. The regional government’s charged that the parliamentary version would threaten the closing of current hospitals under regional control. In the end, neither bill ended up passing parliament (Kraj Přídou 2006; Zákon O Neziskových Nemocnicích 2006).
The fragmented interests of Czech health policy pose serious challenges to a smooth-functioning corporatist structure. Groups that are joined together by the corporatist institutions often having cross-cutting interests, which makes it difficult to forge agreements and compromises. Added to this, the dominance of the state through the Government and the Ministry of Health has further limited the power of corporatist structures. The MoH has routinely ignored demands of the healthcare tripartite and other external advisory bodies. There are consequences to those actions; the MoH needs some support from health policy interests or it can not achieve even basic maintenance of the system. Although the MoH’s independent power is not unlimited, it does remain at the center of the corporatist institutions and is able to choose when and whether to put their decisions into practice.

B. The Privileged Power of Doctors

The most powerful nonstate actors in Czech health policymaking are doctors’ associations. Physicians benefit from their central role in crafting initial reform legislation in the early 1990s and the privileged position they enjoy through the Czech Medical Chamber. Although Czech doctors still remain a powerful force, the mechanisms through which they exert their influence have changed. Since the mid-1990s, doctors have used confrontational, pluralist strategies, especially strikes and demonstrations to push their policy agenda. This is most evident in the issue of doctor’s salaries, which will be the particular focus of this section. The change in doctors’ strategy could be the their response to a more crowded corporatist network of health policy interests and the strength of the state in these bodies; they can no longer exert their will through corporatist structures alone, so they use their associations and trade unions to press their agenda by other means. Given their unusually high level of organization, doctors’ associations had the resources to organize large-scale strikes and demonstrations. Other groups, most recently pharmacists, have started employing these strategies as well.

1. Doctors’ Policymaking Privileges

Czech doctors led the initial 1990 health policy reform plans. They drafted most of the legislation while the Ministry of Health officials were mere implementers of policy crafted by others (Lawson and Nemec 2003; Potůček and Radičová 1997; Roberts 2003, Chapter 6). Although physicians had worked from the outside to develop this initial legislation, since 1990, all but one of the 13 Ministers of Health since 1990 has been a practicing physician before taking
up the post (Lawson and Nemec 2003). In addition, leaders of the Czech Medical Chamber (CMC), the professional association of Czech doctors, have had simultaneous positions in the Ministry of Health (Kubek 2000) or, as in the case of the current Minister of Health, David Rath, took up MoH positions after working at the CMC. Doctors privileged position was also manifested in early policy decisions, especially the form of reimbursement for private-practice doctors and in the creation of the Czech medical Chamber.

The quick introduction of private practices for general practitioners, competition among health insurance firms and a fee-for-service payment scheme all reflect doctors’ interests. Doctor’s expected that the introduction of market mechanisms such as multiple payers and private providers would lead to an increase in their salaries (Jaroš and Kalina 1999, 31) as would the ability to run their own private practices. The fee-for-service structure of the new health system encouraged doctors to provide more services to patients, whether they needed them or not. This system was incorporated into healthcare reform despite World Bank warnings that it would lead to skyrocketing health costs (Roberts 2003). In response, healthcare spending exploded from 6.5 percent of GDP in 1990 to 9.5 percent in 1995 and the General Health Insurance Fund’s per capita spending increased 31% the between 1993 and 1997. To address these increasing costs, the government eventually responded by lowering the reimbursement rate for services. This had the effect, however, of encourage doctors to offer more services, in order to compensate for the reduced profit from each individual service. In 1997, an interim government passed legislation, against the wishes of the doctors, to introduce capitation payments and a fixed budget system for financing hospitals (Roberts 2003; Rokosová et al. 2005, 75).

Early legislation also created institutions that secured doctors a place in the policymaking process. The Czech Medical Chamber (CMC) was created through a legislative act of parliament in June 1991 as part of the implementation of the healthcare reform plan passed in December 1990. Two other groups, the Czech Dentist’s Chamber and the Czech Chamber of Pharmacists were also established at this time and serve a similar function for their respective members. Parliament tasked these bodies with overseeing professional standards of physicians, both ethically and medically, and gave them the exclusive power to license doctors, dentists and

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5 There are a total of 14 professional chambers established through Czech legislation, so this structure is not uncommon in the country. Other chambers range from the Agrarian Chamber to the Czech Chamber of Architects (Mansfeldová and Kroupa 1997, 168-1169).
pharmacists. The CMC describes itself as “an independent, non-political autonomous professional organization responsible for the interests, the professionalism, the ethics and the honour of the medical profession” (Czech Medical Chamber). The legislation requires all doctors to be members of the CMC, with a current membership of about 40,000 physicians (Czech Medical Chamber). Each doctor pays modest annual dues which finance the activities of the CMC.

Compulsory CMC membership makes it a potentially more powerful organization. The organization is guaranteed financial resources from all doctors’ annual fees, a periodically controversial issue. In 2002, a Civic Democratic member of the Chamber of Deputies proposed removing the CMC membership requirement because it limited doctor’s freedom and seemed like an outdated requirement in the current market system. Not surprisingly, then CMC president David Rath, supported compulsory membership (Skodova 2002). If doctors had the choice to exit, he would lose funds and legitimacy in the eyes of other health policy actors. In the end, the lower house of parliament voted to keep compulsory membership.

An organization like the CMC can unify physicians interests and can speak with legitimacy and on behalf of all licensed and practicing doctors. In addition, since the state created this institution, it carries additional weight in the governance system. Nothing in the legislation requires that the CMC participate in the development of policy, but its status as an official Chamber makes it more difficult for the government to dismiss its positions. However, a compulsory doctor’s organization carries the potential but not the guarantee of unifying physicians’ interests. In fact, CMC membership includes doctors with completely different interests. There are doctors who work at a hospital as state employees and make very little money versus doctors who own their own practice and have the ability to earn much more. In fact, the Czech Republic has one of the highest rates of private practice among primary care physicians; 95 percent of primary care physicians are self-employed (Kornai and Eggleston 2001, 163). There are also doctors who are managers in hospitals and those doctors who work for them. When David Rath was president of the CLK, he acknowledge that this posed a challenge and that “really it isn’t easy to find agreement among these different interests” among doctors (Rath Interview, 2005).

Slovakia has a slightly higher rate of 98 percent of primary care physicians working as self-employed. Among East Central European countries, only Hungary comes even close at 76% of PCPs in private practice (Kornai and Eggleston 2001, 163).
Since Rath took over the reigns of the CMC in 1998, the organization has had a more conflictual relationship with the Ministry of Health and the Czech governments. Some critics argue that Rath has refashioned a professional organization concerned with ethical and medical standards into a labor union focused on wages. Increasing salaries of physicians has certainly been a key goal of the Czech Medical Chamber since the late 1990s. In response to the criticism, however, Rath argues that “of course we must put pressure to hold these ethical norms, but if we make standards for these people, so that with extreme pressure on these ethical norms you drive them to an impossible situation because they don’t have the conditions for good practice, for work…The economic foundation goes hand in hand with putting pressure on professional [standards] and ethics” (Rath Interview 2005). He says it is for this platform that he was elected as president of the Chamber and for which he’s been working for 7 years. He emphasizes that the democracy within the Chamber continues to elect him and that should satisfy his critics (Rath Interview 2005).

Doctors initially directed health policy reform. They created reimbursement policies and professional institutions that could serve and protect their general interests. Doctors are not a uniform group, so not all doctors feel empowered by the practices of the CMC. However, the Czech Medical Chamber does consolidate resources, legitimacy and access into one venue for doctors. This situation led Martin Potůček and Iveta Radičová to argue that “[t]he Czech health care policymaking process has developed a corporatist structure” but “professionals have been quite successful in ‘capturing’ government, especially the Ministry of Health, in order to protect their interests. For this purpose, they used the corporatist institutions—the Czech Chambers of Physicians, Dentists, and Pharmacists, and the trade unions” (Potůček and Radičová 1997, 1578-1579).

2. Doctors’ Pay and Doctors’ Power

Physicians may have captured the MoH and used their institutional leverage in the early 1990s, but if they had truly captured the state and the corporatist structures, then why have doctors resorted to national strikes and demonstrations? The story of the debate over doctor’s pay illustrates the limits of doctor’s privilege. Some doctors were frustrated by the lack of state action on the issues of physician salaries and formed an independent labor union, separate from the CMC. In addition from working outside the originally created corporatist structures, this new trade union employed confrontational strategies that were effective in meeting the physicians
immediate goal of higher salaries, although have not resulted in a fundamental reform of healthcare financing or consideration of financial sustainability.

Under the soviet system of health care established in 1951 in Czechoslovakia, all health care workers were employed by the state and paid a fixed salary regardless of the quantity or quality of their work. This health care model significantly limited doctor’s power over their own income. Doctors’ salaries could vary only the extent that they accepted “gifts” from patients in exchange for faster or better service (Jaroš and Kalina 1999, 3). With the introduction of multiple health insurance funds and a fee-for-service (rather than fixed salary) payment system after 1990, doctors would have the opportunity to increase their remuneration by providing more services (Háva et al. 1998, 296; Jaroš and Kalina 1999, 31). These changes gave doctors greater leverage over their pay in two ways: they could establish a private practice and control their own costs and payments and they could earn money from insurance companies on a fee-for-service basis, so that if they chose to provide more services, they could earn more money.

Doctors’ monthly average wages in 1993, before the new system had been operating more than a year, were 10,347 Kč (Háva et al. 1998, 313). Even by 1999, when average monthly physicians’ pay had more than doubled to 22,606 Kč (Institute of Health Information and Statistics of the ČR 2005, 32), this still represented only 1.7 times the average Czech salary. Although this is still higher than the pay of Polish, Slovak or Hungarian doctors, it compares poorly with the Czech Republic’s neighbor, Germany, where doctors earn over 4 times the average salary of their fellow Germans (Kornai and Eggleston 2001, 167). Social Democratic governments have passed several incremental increases in the salaries of doctors at public hospitals, since coming to power in 1998 (Kubek 2001). This mean that by 2002, physicians salaries had increased yet further and were at 2.05 times the average Czech salary (Kubek 2003). The impetus for these increases is due largely to the confrontational and public tactics employed by doctors organized outside the state-created corporatist bodies.

Some doctors were upset about the slow growth of doctor’s wages and charged that the Czech Medical Chamber was too focused on its licensing and ethical role and not concerned enough with unsatisfied doctors’ concerns, especially on issues of pay (Kubek 2000). In fact,

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7 Studies suggest that in the Czech Republic, these gratuity payments are smaller and less common than in many countries in the region, especially in Poland, where 60-70% of those receiving treatment in a hospital had made an extra gratuity payment and where these payments were, in 1994, roughly equivalent to Polish doctor’s official gross salary (Kornai and Eggleston 2001, 170)
although in 2002 David Rath supported mandatory CMC membership, earlier in the 1990s he had argued for voluntary membership and had even refused to pay his membership fees as a sign of protest (Skodova 2002). He was one of those doctors who envisioned a CMC more aggressive on increasing doctor’s salaries. Disappointed with the state-created professional association, these physicians created the Doctor’s Union Club (LOK) in 1995. David Rath was a founder and chair of LOK. Milan Kubek served as LOK president until 2005. In 2000, the LOK fused with the Association of Czech Doctors, to form the Doctor’s Union Club-Association of Czech Doctors (LOK-SCL).

The LOK-SCL is an independent trade union and does not belong to one of the large confederations of unions represented in the tripartite bodies. Although most independent trade unions are formed along local or company lines, LOK-SCL is unique in that it is a national organization open to all physicians (Hála et al. 2002, 26). Unlike the Czech Medical Chamber, membership in LOK-SCL is voluntary; it has a membership base of about 5,500 members (Kubek Interview, 2005), or about 14 percent of all licensed doctors. Increasing doctors’ salaries is one of the main objectives of LOK. Its goal is to achieve an average wage for doctor’s that is 3 times the average wage in the country and a salary for nurses that is 1.3 times the average (Kubek 2000). This goal has not yet been reached, but doctor’s salaries have increased several times in the late 1990s, at least in part to LOK-SCL activities.

Since LOK-SCL is an independent trade union, it does not have a formal role in health policy development. For example, the Czech Medical Chamber is a formal commenting body in the legislative process. The government is required to send the CMC copies of draft legislation and to respond to (but not necessarily appease) any concerns raised by the Chamber. LOK-SCL is not guaranteed such participation, although Milan Kubek, then president of the LOK-SCL, noted that the union is an “unofficial” commenting body, because knowledgeable ministers know that the Club’s support is important to getting health policy passed and implemented (Kubek Interview 2005). The LOK-SCL gained this stature with the MoH by focusing its activities on directly influencing decisions at the Ministry of Health or in the Office of the Government rather than emphasizing social dialogue in the tripartite organizations. One of the ways that LOK-SCL earned this prominence, is through an active campaign of strikes in the 1990s.

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8 In 2005 he took over as President of the CMC, when David Rath left that post to be Minister of Health.
The LOK-SCL played an instrumental role in gradual changes in physician salaries, although their efforts were not always nor immediately successful. In 1995, the LOK sponsored the first national strike to occur in the Czech Republic since the end of communism. There was a demonstration held in front of the Ministry of Health and doctors boycotted their administrative duties by sending all patient paper work to be “processed” at the Ministry of Health (Czech Doctors 1995). This did not illicit a positive response from the ODS government; the Minister of Health threatened to sue the LOK for violating patient privacy because the paperwork for 20 abortions had been sent to the Ministry. Even the President Havel requested that the LOK call off the strike with a promise that he would help the doctors’ cause (Kubek 2003). The LOK acquiesced. However, a year later in 1996, there was another demonstration of 16,000 medical workers on Wenceslas Square in the center of Prague. Both of these demonstrations were visible and put public pressure on the Ministry of Health and the Government, but did not immediately result in pay increases.

In 1999, the LOK organized a Protest Day of Health Workers. Dr. Milan Kubek, then the president of the LOK, said that “We were told the government would bring the economy to a normal Western model and that once the country becomes richer, we, the intelligentsia, will profit…It is 10 years after the revolution and that hasn’t’ happened. Doctors must realize they have been deceived” (as quoted in Elash 1999). Kubek also claimed that the Protest Day resulted in the removal of the then Minister of Health Ivan David. Kubek criticized this Social Democratic Minister of Health as completely failing to communicate with doctors (Kubek 2000). In fact, Jan Culik reported that David described the 1999 doctor’s strike as “‘an extreme example of social imbecility.’ He added that there was no point in him entering into a debate with the doctors about the state of the health service because all decision-making in the Czech health service has been de-centralized and he has no power to do anything. The Prime Minister, Milos Zeman, accused the doctors’ trade union organization Lekarsky odborovy klub of blackmailing the government and refused to deal with them” (Culik 1999). Although the LOK did not reach its goal of a salary increase, it did exert enough pressure to bring about a change in Health Ministers.

Vladimír Špidla ran the MoH for three months and then Bohumil Fišer, a doctor, took over in February of 2000 as the third Minister of Health in less than two years. Fišer was open to cooperating with the doctors on the issue of salaries (Schlanger Interview 2005) and even invited
the Czech Medical Chamber, then directed by David Rath, and the LOK to work with the MoH to prepare several health-related bills, most of which were not passed due to the politics surrounding the upcoming 2002 election (Kubek 2000). Fišer argued for an increase in health care spending in order to maintain the quality of care, but others in the government did not support him. At the end of 2000, however, the government finally approved a 10 percent wage increase for doctors and then in January of 2001 they received another 16 percent increase (Kubek 2001).

Physicians who were unsatisfied with their existing channels of influence were able to form a rival professional organization, the LOK-SCL. As this group gained prominence, the CMC elected Rath as its leader and he took many of the same priorities to this state-established institution. The LOK-SCL worked outside corporatist channels, especially employing strikes and demonstrations to pressure the government to pass increases in doctor’s salaries. This was effective in bringing down Minister of Health, although even the LOK-SCL was not able to realize increased salaries until the MoH took the initiative to invite the CMC and LOK-SCL into the policy development process. Fišer’s willingness to work with the doctor’s may have been shaped by the failures of his predecessor and an effort to avoid the public confrontations of strikes. This review of the issues of physician salaries shows the ability of doctors to organize and press an issue using pluralist strategies rather than the existing corporatist structures. It also, however, reemphasizes the first main point of the paper, that the state is still the gatekeeper of the health policy process and will ignore even the powerful lobbies of doctors, at least for awhile.

IV. The Consequences of Czech Healthcare Governance

Czech doctors and pharmacists articulate their grievances in public squares because they have the resources and the ability to organize and do so because their other avenues of influence are now crowded with other interests or because the corporatist bodies that they previously captured are now largely dominated by the state. On the surface, the Czech health policy process appears to be a corporatist system with a separate healthcare tripartite body and a legislatively-established Czech Medical Chamber tasked with licensing doctors and representing their concerns to the state. However, the healthcare tripartite, like the larger tripartite body, serves only an advisory capacity and numerous governments have been willing to ignore and oppose it.
The tripartite group represents government, employers and employees, but it leaves out or obscures some important health interests. First, patients’ rights groups are forced to operate in a pluralist system, where they compete for the attention of policymakers and do not have any established, guaranteed access to them. Second, and more importantly for health policy governance, some Czech doctors have felt that their interests were disregarded in the large corporatist bodies, which necessarily have to compromise among many different perspectives. In the early 1990s, the Czech Medical Chamber operated as a professional licensing and ethical body, but did not view its role as one of a labor union to advocate the wage interests of physicians. The Trade Association of Health and Social Care includes so many different types of health professionals, that the doctor’s own particular concerns about their salary were not a priority, especially when many other medical workers receive even less pay. In response to the inability of these broad organizations to respond to the particular salary demands of some doctors, they formed the Doctor’s Trade Union Club-Association of Czech Doctors. This organization has led the way in the use of pluralist strategies. It organized demonstrations to demand higher wages and drew national attention to the problem. When the Minister of Health has been open to these strategies, the doctors have exerted tremendous influence over the policymaking process. It took several years of persistence, however, to find a minister open to working with the doctors. Of course, now that David Rath, the former president of the Czech Medical Chamber, is the Minister of Health, it is likely that the ministry is once again open to the perspectives of physicians.

This two-track, corporatist-pluralist policy governance model has not been good for policy development. One of the biggest problems is that the process is unpredictable. With every change in Minister of Health, access to the ministry changes. For example, a lot of groups, even those officially represented in tripartite structures, gain a lot of their influence through ad hoc committees called or canceled by different Ministers of Health. This encourages the high-stakes public demonstrations, because this is one of the best ways to ensure your group will be among those in conversation with Ministry officials. It is also the best way to try to oust a Minister of Health who is unwilling to cooperate with your interest groups.

In fact, other groups have also started to employ pluralist strategies, this time against David Rath. Pharmacists demonstrated outside the Ministry of Health in January 2006 and other groups have been organizing to protest what they characterize as Rath’s anti-democratic style of
Ministry leadership (Proti Rathovi 2006; Většina Českých Lékáren 2006). This may suggest that the pluralist mode of seeking policy influence is on the rise in the health policy sector and that the consensus-building role of corporatist institutions continues to decline.

These types of pluralist approaches further politicize the policymaking process and further raise the stakes. As is always the weakness of the pluralist approach, certain voices are left out. So far, only well-organized physicians and now pharmacists have been able to coordinate mass demonstrations. In fact, the Czech Pharmacists Chamber, the pharmacists version of the CMC, has led the recent protests against the current MoH administration. Other medical professionals, private healthcare facilities, or patients’ rights groups, for example, may find it more difficult to organize and demonstrate. Since the whole process is unpredictable, it is difficult for smaller, less-resourced organizations to know how or when to try to shape the policymaking process.

In policy terms, the dominance of the state, the weaknesses of corporatist institutions and the irregular power of pluralist lobbying leads to piece reforms that usually address a single issue of concern to the most powerful interest groups of the moment. In this environment, a sustained development of coherent policy reform is impossible. The MoH might benefit from ceding some of its power to corporatist bodies to discourage further strikes and demonstrations. That said, it is already difficult for the MoH to exert a strong guiding hand in the future fundamental reform of healthcare policy and to address basic issues such as the financial sustainability of the system. If the MoH grants interest groups greater power in policy-implementing decisions, it may also increase the power of these groups over policy-reforming legislation, which would surely slow efforts at legislative change.

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9 There is an Association of Patients (Svaz Pacientů), which was established in 1995. It has a very small staff that seeks to help patients who feel they’re not getting adequate care or are facing problems with the health system. Although this organization was invited by the Minister of Health Emmerová to join Ministry discussions on topics such as drug reimbursement schemes, in the course of my interviews, all the other stakeholders in the healthcare process viewed this organization with skepticism, one claiming that it was just a vehicle for furthering the political careers of the men leading the Association (Schlanger Interview, 2005). A newer Coalition for Health was established in 2004. This group serves as an umbrella organization for the many patients groups that operate around a particular disease or health condition. The Coalition facilitates cooperation among these already existing groups and represents a simplified and unified set of comments and concerns to the Ministry of Health and other healthcare providers (Petrenko Interview, 2005). At least through the 1990s, patients have not contributed in significant ways to the development of health policy (Háva et al. 1998, 316; Potůček and Radičová 1997, 1579).
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