

**AN ASSESSMENT OF HEALTH SECTOR
ACTIVITIES IN THE CZECH REPUBLIC**

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TABLE OF CONTENTS

	Page
ACRONYM LIST	iii
EXECUTIVE SUMMARY	v
I. INTRODUCTION	1
II. BACKGROUND	1
III. USAID INVESTMENTS	4
IV. RESULTS	5
A. Program Findings	5
B. Czech Health Care System Change	9
C. USAID's Impact	9
D. Current Conditions	11
E. The Future	15
V. SUMMARY AND COMMENTS	18
ANNEXES	
ANNEX A: SCOPE OF WORK	
ANNEX B: RESPONDENTS	
ANNEX C: IMPROVEMENTS IN CLINICAL CARE	
ANNEX D: HOSPITAL OPERATIONS' IMPROVEMENT PROGRAM	
ANNEX E: NOT-FOR-PROFIT LAW AND CASE STUDY	
ANNEX F: HEALTH MANAGEMENT EDUCATION PARTNERSHIPS	
ANNEX G: QUALITY ASSURANCE/QUALITY IMPROVEMENT ACTIVITIES	
ANNEX H: INSURANCE SECTOR ACTIVITIES	
ANNEX I: HEALTH STRATEGY IN CEE	
ANNEX J: HEALTH SECTOR ACTIVITIES IN THE CZECH REPUBLIC	
ANNEX K: BIBLIOGRAPHY	

ACRONYM LIST

AIHA	American International Health Alliance
APG	ambulatory payment group
CCP	core CVD program
CECHE	Central European Center for Health and Environment
CEE	Central and Eastern Europe
CEVD	cerebrovascular disease
CLA	community living arrangement
CME	continuing medical education
CVD	cardiovascular disease
DGTI	Desider Galsky Training Institute
DRG	diagnosis-related group
DUHA	Foundation for the Integration of the Mentally Disabled (Czech acronym)
GDB	government disability board
GDP	gross domestic product
HDL	high density lipid
HEI	Healthcare Enterprise International
HMO	health maintenance organization
IKEM	Institute for Clinical and Experimental Medicine (Czech acronym)
JAMA	<i>Journal of the American Medical Association</i>
JCAHO	Joint Commission on Accreditation of Health Organizations
JDC	American Jewish Joint Distribution Committee
LOS	length of stay
MIS	management information systems
MIT	School of Management and Information Technology (Czech acronym)
MOF	ministry of finance
MOH	ministry of health
MONICA	monitoring of trends and determinants in cardiovascular disease
NGO	nongovernmental organization
NIPH	National Institute of Public Health
NIS	New Independent States
OECD	Organization for Economic Cooperation and Development
PASA	participating agency service agreement
PIET	Partners for International Education and Training
POV	Prague Wheelchair Users Association (Czech acronym)
QA	quality assurance
SEED	Support for East European Democracy

SMC Second National Clinic of the Third Medical Faculty of Charles
University (Czech acronym)
UCSF University of California, San Francisco
UNLV University of Nevada, Las Vegas
USAID United States Agency for International Development
VZP General Health Insurance Office of the Czech Republic (Czech acronym)
WHO World Health Organization

EXECUTIVE SUMMARY

USAID AND HEALTH IN THE CZECH REPUBLIC

Background

With the fall of communist control in the Czech Republic, all in-patient and ambulatory care facilities were centralized and hierarchically organized under state ownership and control by the Ministry of Health. While the state budget covered the cost of health care, patients did not exercise free choice of physician or treatment facility. Quality was markedly lower than in Western Europe, and the numerous administrative guidelines limited the extent of health care provided to individual patients.

Between the “Velvet Revolution” of November 1989 and 1991, when the United States Agency for International Development (USAID) first became involved, the government of the Czech Republic clearly specified its health care goals and objectives. These goals, which have not changed, include

- universal access to care financed through mandatory health insurance coverage supported by employment wage-based premiums for workers and government contributions for others;
- patient sovereignty and autonomy, with free and unfettered provider choice;
- improved organization, efficiency, and quality in health care services;
- a commitment to maximum privatization of services and facilities;
- payment for care on a fee-for-service basis, thereby incentivizing providers—especially in primary care—to enhance productivity, professionalism, and responsiveness; and
- constraint of service costs through a global budget.

Without exception, these goals have been achieved. In the brief period between the end of 1991 and the present, the Czech Republic has

- conceived, forged political consensus on, and then passed progressive health legislation;
- dismantled old bureaucratic structures;
- rapidly and successfully implemented a sophisticated national health insurance system covering the entire population;
- privatized virtually all ambulatory care; and

- provided consumers with independence and free choice in selecting among care-givers even as the quality of care has improved.

USAID's Role and Activities

Czech health care sector goals reflected the broader philosophical, political, and economic commitment of the new Czech government to enhanced personal choice and freedoms, multiparty elective government, and market forces in place of “command and control” central planning in the allocation of resources. Thus, the “fit” between the Czech Republic's goals and objectives and those guiding the mission of USAID—strengthening democratic institutions specifically and civil society more generally, economic restructuring, and improved quality of life—was remarkably good. Further, in the narrower world of the health care sector, the change strategy developed by the Czech Republic was congruent with the concept of “health markets in democratic societies” that was beginning to find expression in USAID's thinking about Central and Eastern Europe and the New Independent States.

Finally, the relationship between the Czech government and USAID appears to have been unusual if not unique in one important aspect. From the beginning, the Czech government knew what it needed to further implementation of its chosen health care strategy. Consequently, USAID found itself more often responding to requests or targets of opportunity flowing from the Czech strategy rather than “selling” a proposed strategy to the government. It is the Czechs who have provided the necessary critical mass for change while looking to donors—including USAID—for specific facilitating inputs. USAID's success in both supporting the Czech-driven health care sector changes and earning recognition for so doing reflects effective “niche marketing” of U.S. intellectual and technical strengths in health as well as a willingness to adapt to changing Czech needs while remaining faithful to the agency's goals and objectives.

USAID's activities in support of transformation of the Czech health care sector have been wide-ranging and remarkably inexpensive. Over the six-year (1991 through 1997) course of its assistance to the Czech Republic, USAID's total direct health care sector investment has amounted to \$7.5 million. Activities supported by these resources have included the following:

Hospital Management and Quality Assurance Assistance. Management training of hospital leaders by using the U.S. model; introducing internal and external quality improvement programs, which included hospital quality assurance programs and building a quality-enhancing hospital accreditation process that is just about to be fully implemented and is helping to move forward licensing, accreditation, and standards-setting activities across the health care spectrum; partnering American

experts with Czechs in the building of software programs to improve hospital efficiency in diverse areas, including nurse staffing, financial and information management, and preventive maintenance scheduling for highly technical medical equipment (see Annexes D and G).

Privatization in the Health Sector. Development of legislation authorizing establishment of a not-for-profit sector. While the legislation has not yet led to the anticipated conversion of hospital ownership, it has already resulted in building a quickly growing community of nongovernmental voluntary not-for-profit organizations that are strengthening civil society (see Annex F).

Clinical and Preventive Care Assistance. Multi-institutional partnerships developed between Czech and U.S. entities to address two of the leading causes of Czech deaths: cerebro- and cardiovascular diseases. The partnerships have achieved knowledge and skills transfer through successfully implemented treatment-based medical interventions and community-based programs of education interventions to modify lifestyle risk factors—leading to measurable improvements in medical outcomes (see Annex C).

Insurance Sector Assistance. USAID-funded organizations' provision of technical assistance and training in the areas of insurance company regulation as well as insurance management addressing actuarial science and risk management, claims processing, cost control, management information services (MIS), medical review, payment systems, including health maintenance organizations (HMOs) and diagnosis-related groups (DRGs), and other technical training and assistance both in-country and through study trips to the United States. The assistance has been crucial to the chief insurance entity's development and stability as an insurer and to its role as a partner with the Ministry of Health, Parliament, the Chamber of Physicians, and the two Czech hospital associations. In addition, “how to” training has been provided to other insurers through the association of branch insurance companies (see Annex H).

Program Findings and Conclusions

With important but relatively minor exceptions, most of the **USAID-sponsored activities have had positive and substantial impact** and have largely accomplished the objectives for which they were initially undertaken.

A minority of USAID-sponsored activities, even though requested by Czech counterparts, appears to have had little impact. Many activities—including some whose intended direct impact in the health care sector to date has been limited—have had significant “spillover” effects elsewhere, sometimes even beyond the health

arena. **Finally, it is premature to determine the effectiveness of some USAID-sponsored and –supported activities.**

While it cannot be said that the Czech Republic's substantial progress in transforming its health care system would not have occurred without USAID assistance, the assessment team's professional judgment and conclusion is that USAID's consultations have been—and *are perceived to have been*—highly responsive to Czech needs and have been a major source of assistance in the Czech successes. The assessment team is convinced that USAID's program portfolio has made an important contribution to the transformation underway in the Czech health care system and that, without question, the activities, individually and collectively, have furthered both Czech and USAID goals.

In the world of health, USAID has good reason to be proud of both its efforts in the Czech Republic and its staff who helped make so much happen. While USAID's investments in absolute terms have been a pittance, the return on that investment has already been enormous.

First, USAID's direct and contracted consultations helped advance the Czech health care sector's transformation. The training, teaching, and consultations have been diverse, responsive to the country's needs, and never patronizing. Concurrently, USAID has not hesitated in warning and counseling of potential difficulties.

Second, the assessment team observed a level of appreciation among the Czechs for USAID's material and intellectual assistance that seemed disproportionate to USAID's dollar investment. USAID's activities facilitated the forging of personal and professional connections between partners. Those connections will last and expand long after USAID's formal departure.

Finally, it is important to note that the Czech health system continues to face significant problems. Health care costs have grown substantially, in considerable part because of an excess of acute care facilities, a fee-for-service payment system based on misaligned provider incentives, and an absence of patient sensitivity to the true costs of care received. Solving these and other problems will be neither easy nor universally popular. But health system modification and reform is a process in which virtually all developed countries are now engaged—some with leadership, direction, and intent; others through happenstance.

Even as outsiders observe and Czechs complain about the current state of affairs, it is important to remember that communism fell less than eight years ago. Yet, the Czech Republic has already made substantial underlying changes to its health care sector and

is preparing the way for even more dramatic changes.

A Note

In June 1997, following completion of field work and as the last edits were being made to this report, *Zdravotnicke Noviny*, the leading Czech health care periodical, devoted an entire issue to the nation's problems and opportunities in the health care sector. Chief among the topics of focus were

- the necessity for changes in health insurance—the role of risk and competition;
- payment policy—advantages of health maintenance organizations (HMO) and the first HMO-like cooperative effort between Homolka Hospital and the General Health Insurance Office of the Czech Republic;
- efficiency and cost control—looking ahead to DRGs;
- quality assurance—the role of hospital patient satisfaction surveys and the enhanced role of nurses in health care; and
- changes in the hospital sector—the potential for nonprofit facilities and the importance of health management and administration education.

Without exception, as this report details, these are the substance of USAID's activities over the last five years in the health care sector. The serendipity of *Zdravotnicke Noviny's* issue is the most eloquent demonstration that, on the one hand, USAID's activities were directed at the nation's fundamental issues in health care, and that, on the other hand, the intellectual thrust and direction of those USAID approaches have been absorbed and adopted by Czech health leadership.

USAID AND HEALTH IN THE CZECH REPUBLIC

I. INTRODUCTION

In 1989, the U.S. Congress passed the Support for East European Democracy (SEED) Act authorizing the delivery of time-limited assistance by the United States Agency for International Development (USAID) to the formerly communist nations of Central and Eastern Europe (CEE). In 1991, USAID began its activities in the Czech Republic; the USAID mission will close at the end of September 1997. At the request of the in-country USAID mission and USAID/ENI/DGSR in Washington, BHM International, Inc., assembled an evaluation team comprised of two Czech and two U.S. nationals to assess the health care sector activities undertaken by USAID over its six-year period of assistance. The team conducted its work from late March to mid-May 1997, predominantly in the Czech Republic.

This report reflects the assessment team's review of files and related documentation and summarizes interviews with Czech and U.S. participants in and observers of the USAID-supported activities. Ultimately, however, the findings and conclusions reported here, together with the views expressed in this document, represent the assessment team's professional judgment.

II. BACKGROUND

With the late 1989 fall of the communist government in the Czech Republic, all in-patient and ambulatory care facilities were hierarchically organized, owned by the state, and controlled by the Ministry of Health. The state budget financed the centrally managed health care system, with "chapters" allocating resources to each facility and, within each facility, to the individual department and often line item. For all practical purposes, budgetary flexibility within the individual facility was nonexistent. Virtually without exception, skilled health care workers of all types were state-salaried employees whose payment rates and status, always disproportionately low in relation to their educational levels, were closely tied to academic degrees and years of training rather than to productivity, effectiveness, or patient satisfaction. Too often, the system sanctioned instead of rewarded individual initiative.

Even though the state budget completely paid for health care, patients did not exercise free choice of physician or treatment facility while numerous administrative directives restricted the extent of health care provided to individual patients. The quality of health care was inferior to that provided in Western countries not only with respect to the technical equipment and array of available drugs, but also in terms of the

patient-physician relationship. While some population groups—higher party members, members of government, army and other officials and their family members—had access to high-quality health care, most of the citizenry had no freedom of choice in the selection of physicians or facilities.

Between the “Velvet Revolution” of November 1989 and 1991, when USAID first became involved, the government of the Czech Republic clearly set forth its health care goals and objectives. Major goals and objectives called for abolishing the highly centralized, ineffective, outdated, ill-supplied, and underpaid health care structure of the former communist system and replacing it with a well-equipped, modern system based mainly on private property, private initiative, motivation, and mandatory, employment-based health insurance. Pursuit of these goals and objectives, it was anticipated, would improve the *economic situation* of all categories of health care personnel, especially that of physicians, and increase the *quality* of health care by

- ensuring the availability of effective, previously inaccessible foreign drugs and modern diagnostic and therapeutic equipment;
- privatizing health care facilities, allowing private initiative, and introducing economic incentives and competition; and
- removing barriers to importation of previously unavailable foreign drugs and diagnostic and therapeutic know-how.

By May 1990, the government had not only developed a strategy for transformation of the health care system but had also made its broad outlines fully and publicly available.¹ Indeed, it had even taken some early implementation steps. Fundamental health care sector decisions reflected in the transformation included

- universal access to care;
- free and unfettered patient choice of health care provider;
- improved organization, efficiency, and quality in health care services;

See, for example, “Reform of Health Care in the Czech Republic,” May 1990.

- a commitment to maximum privatization of services and facilities² and, in instances where privatization opportunities were limited, to *deetatification* (decentralizing oversight and management authority, e.g., of hospitals from the republic-level Ministry of Health to municipalities);
- payment for care on a fee-for-service point system basis financed through mandatory health insurance coverage supported by employment wage-based taxes for workers and government contributions for others³;
- establishment of the insurance entity's day-to-day independence of government;
- constraint of costs through a global budget; and
- the reimbursement value of a point linked to the sum of wage taxes and government contributions to the health insurance pool divided by the total number of points claimed by providers for services rendered. The objective of this payment is to incentivize providers—especially in primary care—and therefore enhance productivity, professionalism, and responsiveness; reinforce patient sovereignty and autonomy; and encourage privatized, decentralized ownership and decision making.

These decisions reflected the broader philosophical, political, and economic commitment of the new Czech Republic to enhanced personal choice and freedoms, multiparty elective government, and market forces rather than “command and control”

Note, however, that some price was initially paid for the independence granted to facilities, including the rapid fall-off in data collection. This information problem went unaddressed until individual facility managers, on the one hand, found value in data and the General Health Insurance Office of the Czech Republic, on the other hand, established data reporting requirements for its own analyses.

To ensure the collection of insurance fees and to organize a system of payments to health care providers, the Czech government created the General Health Insurance Office (VZP). The insurance fee was set at 13.5 percent of gross salary, with one-third paid by the employee and two-thirds by the employer. The state pays a contribution to the health insurance fund for persons who are not employed or do not perform any business activity (children, retired persons, army personnel, the unemployed, etc.). The contribution is relatively low and is set as a percentage of the wage tax that would be paid at the official minimum wage. Thus, the role of the state budget in financing health care was substantially decreased.

central planning in the allocation of resources. Thus, the “fit” between the goals and objectives of the Czech Republic and those guiding the mission of USAID—strengthening democratic institutions specifically and civil society more generally, economic restructuring, and improved quality of life—was remarkably good. Further, in the narrower world of the health care sector, the change strategy developed by the Czech Republic was congruent with the concept of “health markets in democratic societies” that was beginning to find expression in USAID's thinking about Central and Eastern Europe (CEE) and the New Independent States (NIS).

Finally, the relationship between the Czech government and USAID appears to have been unusual if not unique in one important aspect. From the beginning, the Czech government knew what was needed⁴ to further implementation of its health care strategy. Consequently, USAID found itself more often responding to requests or identifying timely targets of opportunity flowing from the Czech strategy rather than “selling” a proposed strategy to the government.

III. USAID INVESTMENTS

USAID's diverse Czech portfolio of direct health care sector investments has been organized under two project categories: the Health Markets Projects and the Partnerships in Health Care Project. The Health Markets activities have focused on privatization, demonopolization, decentralization, and the conditions necessary to accomplish these goals, e.g., stable, predictable financing on which providers and potential investors can depend and managers capable of assuming the responsibilities that accompany autonomy. Typically, the Czech participants have been government ministries and payers, e.g., health insurers. Loosely, the Partnerships in Health Care activities have focused on the leading causes of Czech deaths (cardiovascular diseases), their prevention and clinical treatment, and training in health management and administration. The Czech partners generally have been academic, hospital, and other provider entities. The two sets of activities have often overlapped at the health care facility level, where clinical and management practices intersect.

The Czech government also identified potential donors for specific assistance (or not—e.g., it rejected offers from the World Bank). Moreover, it solicited assistance in donors' areas of expertise. For example, it asked USAID for assistance in privatization, hospital management and administration, and health, service delivery, and health insurance-related management systems, all areas of U.S. strength. It initially sought assistance on the point system from the Germans and Dutch but more recently has turned to the United States for assistance with case-based payment systems (DRGs and APGs).

Over the six-year (1991 through 1997) course of its assistance to the Czech Republic, USAID has made a total direct investment of \$7.5 million in the health care sector, including \$2.8 million in Health Markets, \$2.1 million in health education for Partnerships in Health Care, and \$2.6 million in clinical Partnerships in Health Care activities. Among key U.S. entities involved in activities implementing USAID's assistance have been the Health Care Financing Administration and the Office of International Health in the United States Department of Health and Human Services, Healthcare Enterprise International, the American International Health Alliance, the Joint Commission International, and the University of California, San Francisco.

IV. RESULTS

A. Program Findings

1. With important exceptions (see 2, below), most **USAID-sponsored activities have had a positive and substantial impact** and have largely accomplished the objectives for which they were initially undertaken. For example, the Czech health financing system turns on the General Health Insurance Office of the Czech Republic (VZP) (see Annex H). VZP's analytic capacity and ability to maintain political support and independence have been vital. Its future role may be even more important as it seeks to enter into negotiations with providers on diagnosis-related groups (DRGs) and other cost controls that will place some providers at risk, especially in the hospital sector. VZP is the beneficiary of perhaps the longest, most intense—although by no means most costly—of the Czech technical assistance efforts supported by USAID. These have included technical assistance and training in the areas of actuarial science and risk management, claims processing, cost control, information systems, medical review, and payment systems, including health maintenance organizations, ambulatory payment groups, and diagnosis-related groups both in-country and through study trips to the United States. The assistance has been crucial to VZP's development and stability as an insurer and to its role as a partner with the Ministry of Health (MOH), Parliament, the Chamber of Physicians, and the two Czech hospital associations.

The multicomponent cardiovascular-cerebrovascular partnership forged primarily between Czech and U.S. medical faculties and hospitals is among USAID's largest health sector investments in the country. It has focused on early and secondary prevention, dietary/nutrition and related lifestyle changes, and enhanced clinical intervention effectiveness (see Annex C) and has shown remarkable effectiveness in virtually all of its dimensions. While it is too early to tell whether the effort's primary prevention emphasis on school-age children will carry over into the children's adult years, preliminary attitude measurements appear positive; several of the prevention components are ongoing. Provider participants give the program high marks for its impact on clinical treatment and its effectiveness in secondary prevention.

The program has devoted significant resources to quality assurance, enhancement, and improvement efforts (see Annex G) that include traditional QA and, more broadly, continuing medical education and hospital accreditation activities. The *Czech Journal of the Hospital Association* now carries a quality assurance segment that is said to be a direct result of USAID's investment. A voluntary hospital accreditation program sponsored by USAID and supported by the Czech Chamber of Physicians and both hospital associations is currently undergoing pilot testing and is expected to "go live" in late 1997. Enhanced quality improvement programs now exist in virtually all hospitals and many of the larger clinics. As USAID withdraws, interest in these activities continues. Therefore, a partnership has developed among the Joint Commission International and Polish and Czech medical interests to explore potential World Bank or other funding of an expanded accreditation/quality assurance partnership. A USAID-supported analysis of hospital nursing utilization has shown increased staffing efficiency with concurrent improvements in patient satisfaction and quality of care.

Training in health and hospital management and administration has absorbed significant USAID resources (see Annex F) and, over time, has increasingly moved from U.S.- to Czech-based locations, trainers, and cases. Increasing numbers of educational programs in health and hospital management/administration are available at the undergraduate and graduate levels, with foci on career preparation, career development, and mid-career change. The relatively few seeds initially planted by USAID have flowered and are multiplying.

2. A small number of USAID-sponsored activities, although requested by Czech counterparts, appears to have had little or no impact. For example, advice and technical assistance provided to the Ministry of Health regarding health maintenance organizations (HMOs) as a means for organizing the efficient and effective provision of care and controlling costs have generally had no effect to date and seem unlikely to do so in the near future.⁵ Similarly, assistance and advice to the MOH in addressing the potential for revised functions and priorities congruent with changes wrought by *deetatification*, privatization, mandatory health insurance, and other system changes seem to have had no visible impact.

3. Many activities—including some whose intended direct impact in the health care sector to date have been limited—have had significant "spillover" effects elsewhere. For example, at the request of the Ministry of Finance (MOF), USAID supported economic and legal analyses of not-for-profit, tax-advantaged nongovernmental organizations (NGOs) as they exist in the Americas and Western Europe. These analyses were expected to form the basis for Czech law authorizing entities similar to nonprofit private community hospitals in

HMO inaction reflects a philosophical concern. A key objective of postrevolution reforms was to separate payer from provider. Hence, despite clear evidence that the incentives and management systems under HMOs are markedly different from those of the communist period, significant concerns remain that HMOs could represent a regressive step.

the United States. The expectation was that, over time, the MOH would transfer ownership of many government hospitals to such NGOs (see Annex E). The Statutory Companies Act, as finally enacted on September 28, 1995, establishes a third sector—the not-for-profit sector—and provides it with significant tax advantages; but, as currently enacted, the law is inadequate to permit transfers of real property from the government. Nonetheless, since the law's January 1, 1996, effective date, more than 1,800 statutory companies in a wide range of fields have registered and are providing a variety of public benefits and strengthening local communities and the larger civil society.

In support of the Czech interest in health care sector privatization and *deetatification*—and as part of the technical assistance related to the establishment of not-for-profit legal entities—USAID worked with the MOF to examine the use of municipal bond financing as a mechanism for capital accumulation for, among other activities, facility improvements and modernization. For a variety of reasons, not least the instability in the value of the point specifically and in provider financing more generally, this examination failed to bear fruit in the health care sector. It proved directly germane, however, to another USAID-Czech success, the Housing Guarantee program. A long-term municipal infrastructure and housing loan guarantee program, the Housing Guarantee program uniquely allows the issuance of municipal loans with repayment periods of up to 30 years and has brought competition to the municipal loan market with reduced interest rates.

A three-city USAID-funded partnership with the American International Health Alliance (AIHA) has brought together faculties in information, medicine, management, and economics to form a team of medical professionals, not only physicians, to establish new linkages between graduate and undergraduate training institutions (see Annex F). Uniquely, the Czech Military Medical Faculty is a participant in this network, which, among other activities, is developing interdisciplinary training and teaching methodologies. The health management/health administration training initiatives have led to the development of several degree-granting programs, creation of new career paths in management for nurse-administrators and in health for management trainees, and improvements in managerial and administrative skills throughout the health care sector. As Dr. Petrakova, head of the School of Public Health, Post-Graduate Medical School, Prague, noted, “The [USAID] partnership was vital even more for bringing the Czechs into a network than for the U.S.-Czech relationship. But without the latter, [we] could not have gotten the former.” Following the end of USAID support, the partnership has won an MOH grant.

4. Finally, **it is premature to determine the effectiveness of some USAID-sponsored and -supported activities.** For example, the VZP, MOH, and others have received technical assistance and support in the use of DRGs to enhance hospitals' efficiency (see Annex H). VZP is purchasing from a U.S. company the “grouper” software necessary to operationalize DRGs within the payment system; it is unclear, however, whether the government or Parliament will allow effective implementation. It is not yet possible to assay how USAID-provided technical assistance ultimately will play out in actuarial analysis and

premium soundness; maintenance and regulation of a multi-insurer financing structure⁶; the role of enhanced energy efficiency in hospital financial stability; or the role of not-for-profit legislation in changing the ownership and control of hospitals (see Annex E).

For example, USAID provided advice on the need for rules and regulatory oversight to ensure that additional insurers are adequately capitalized, that enrollees are guaranteed coverage and providers payment, and that all are appropriately protected from waste, fraud, and abuse. Legislation that would have accomplished a number of these steps was passed by Parliament but—presumably based in part on the government's commitment to a free market philosophy—was vetoed by the prime minister in October 1994. Subsequently, as several health insurers have failed, the government has taken some preliminary steps toward protective regulations—as it is now also doing in the stock market.

B. Czech Health Care System Change

Overwhelmingly and in a remarkably short period, the Czech government, Parliament, and many others in the health care provider community have realized the major goals and objectives they set forth in 1989. For most participants, the transformation of the health care system has produced many positive changes by

- maintaining universal access and entitlement;
- establishing consumer choice and introducing patient satisfaction surveys;
- emphasizing and enhancing the quality and funding of primary care;
- legalizing the private practice model, which virtually all primary care providers have now adopted;
- realizing substantial improvements in the hospital sector's clinical and management skills, with further improvements anticipated;
- elevating the quality of diagnostic and therapeutic procedures thanks to rapid improvements in the quantity and quality of technical equipment and improved access to progressive know-how;
- substantially improving physicians' interest in, responsiveness to, and treatment of patients;
- significantly expanding physicians' freedom of practice and practice association, access to diagnostic and therapeutic materials, the availability of training and information, and, most notably among primary care providers, professional responsibilities and merit-based opportunities; and
- dramatically increasing physicians' real income even though their income aspirations and expectations have not been fully met and realistically could not have been met.

C. USAID's Impact

While it cannot be said that the above achievements would not have been realized without USAID's assistance and that of its consultants, the team concluded that USAID's consultations have been—and **are perceived to have been**—highly responsive to real Czech needs and to have assisted and facilitated Czech successes. The assessment team is convinced that USAID's program portfolio has made an important contribution to the transformation underway in the Czech health care system and that program activities—individually and collectively—have furthered both Czech and USAID goals. Moreover, time after time throughout the assessment team's interviews, Czechs in the MOH, MOF, VZP, several of the

partnerships, and elsewhere singled out USAID in-country and Washington, DC, staff members for special acknowledgment. Especially in the education partnership grants, U.S. and Czech partners considered the contributions of the mission's long-term Czech national employees as vital.

In examining conditions seemingly associated with the more rather than less successful USAID activities, the team identified certain important factors. The most successful activities seemed to result when USAID and its contractors

- were able to deal with entities not affected by frequent changes in organizational purpose, direction, structure, or leadership. Such stability has typified VZP, the partnership hospitals, universities, and professional associations; in contrast, the Ministry of Health has undergone a multitude of changes, especially in its leadership.
- could cooperate on primarily “technical” problems that neither depended greatly on specific local conditions for their definition nor presupposed substantial knowledge of the local economic and social situation for their resolution and that were not given high priority by one or another political party.
- were able to engage the same foreign experts for an extended period or secure their repeated return. Ongoing or repeated exposure moved consultants up the learning curve regarding Czech needs, conditions, and opportunities. In several interviews, respondents commented that, on occasion, an expert would be in-country so short a period that he or she did not gain sufficient knowledge to understand how to apply his or her expertise effectively.⁷

The assessment team often heard praise for the expertise contributed by USAID's consultants, for the “can do” approach they brought to their various missions, and for the timeliness and general high quality of their products. Unprompted, those interviewed by the assessment team often singled out individual consultants and entire missions for praise. HEI staff and participants in the clinical program for cardiovascular disease reduction (Annex C), in the health management partnerships (Annex F), and in the quality assurance activities (Annex G), who often were able either to spend substantial time in-country or to make multiple returns, received special mention, as did several individuals from HCFA and elsewhere in the U.S. Department of Health and Human Services who brought special skills to bear.

The assessment team found it especially noteworthy that several interviewees volunteered that USAID staff and missions had on more than one occasion paired delivery of the requested assistance with caveats. For example, USAID staff and consultants warned of the following problems: fee-for-service payment arrangements embody incentives likely to result in escalating system costs; under the terms and conditions to be imposed on them, multiple

This complaint was generic, applying across all donors.

insurers would likely lead to inefficiencies, not competition; and, absent an effective regulatory system, unexpected insolvency was highly probable for some insurers. Respondents acknowledged that certain problems currently affecting the Czech health care system might have been ameliorated had some of USAID's warnings received more attention and been accorded more credence. National political and/or policy decisions at the time had made this impossible.

USAID staff have voiced concern that the broad array of program activities undertaken with severely limited resources may have diluted program impacts. In the team's judgment, such concerns are unwarranted. Again, the Czech counterparts have been remarkably clear about many of their wants and needs; they have been willing to reject assistance that fell outside those bounds. Thus, it is the Czechs who have provided the necessary critical mass for change while looking to donors—including USAID—for specific inputs. USAID's success both in supporting the Czech-driven health sector changes and gaining recognition for so doing reflects effective “niche marketing” of U.S. expertise in health care and a willingness to adapt to changing Czech needs while remaining faithful to USAID goals and objectives.

D. Current Conditions

The changes that have taken place in the Czech Republic's health care sector have been profound. Especially in the cost and health care financing areas, the changes have also been connected with and on occasion have resulted in new problems and difficulties. As USAID prepares to withdraw, the Czech Republic finds itself among that select set of nations whose real health care costs now approach and could soon exceed 10 percent of gross domestic product (GDP).⁸ Nonetheless, stable and incentivized provider payments do not exist at levels

Private communication. There is no “official” figure for health care as a percent of current GDP, and available Czech figures are not necessarily comparable over time or with those of OECD and other organizations. Time-line comparisons are especially difficult because of the add-on formerly represented by “envelope payments” during the communist period and the current “direct personal health expenditures” (i.e., copayments, payments for noncovered services, and other out-of-pocket costs); at best, such comparisons can only be estimated. Officially, health care in the Czech Republic in 1988 consumed 5.8 percent of GDP, but as much as an estimated 2 percent of GDP may also have been devoted to health through direct, under-the-counter, or so-called envelope payments in the unofficial private sector (cf. “Health Care in the Czech Republic: A System in Transition,” *JAMA*, May 13, 1992, p. 2462). In 1995, “public expenditures” (the sum of health insurance corporations' expenditures and those of the Czech budget [Chapters 335, Ministry of Health, and 715, Health Establishments under Local Control]) amounted to 7.63 percent of GDP. Direct personal health expenditures represent an estimated additional 0.7 percent of GDP (*Czech Health Statistics Yearbook 1995*, Prague, 1996, pp.159-161). *If* these figures are accurate, they suggest that

sufficient to justify nongovernmental capital investment in and profit-oriented private ownership of hospitals. Instead, the country remains dramatically oversupplied with undercapitalized hospital beds officially devoted to acute care. The incentives for fee-for-service payment have dramatically overcome the prerevolution problem of low physician productivity—now, ironically, those same incentives may be leading providers to oversupply services. Yet, in comparison with other developed nations' health care systems, labor costs are a substantially small component of health care costs. Drugs, however, consume a substantial and disproportionate share of resources due to increased use of imported drugs at prices pegged to Western markets. Although the growth rate in drug consumption and costs appears to have eased recently, it is not clear whether this stability can be maintained. Even though an excessive but declining number⁹ of insurers split the market and offered the same benefit package to all comers at the same politically defined price, VZP dominates with more than a 70 percent share.

Beyond the depth and magnitude of the changes, the transformation of the health care system unfolded **very** rapidly. Particularly in its initial stages, the transformation may have even been inappropriately hasty from an operational perspective. The Czech government abolished the organizational structure of the existing health care system before it fully considered and made decisions about maintenance of some necessary functions. The government appears to have made other decisions as a result of special interest pleading rather than in response to appropriate analysis, especially with regard to downside risks—sometimes, no doubt, because appropriate data for analysis have been lacking. The new health care system integrates

health care growth as a proportion of GDP has been fairly restrained over the period, from perhaps 7.8 percent in 1988 to 8.3 percent in 1995. In his March 1997 presentation to the USAID-sponsored regional health reform conference in Bratislava, the head of VZP indicated his informed judgment that 1996 health sector costs had been at least 9 percent of Czech GDP and were growing.

The assessment team would note only that those respondents willing to hazard a guess regarding current health care costs universally thought the postcommunist costs to be significantly higher than before the revolution and cost growth to have been substantial.

USAID and several of its consultants had cautioned early on that the multi-insurer structure under consideration was problematic, especially in the absence of capital, financing, and other regulatory requirements and oversight. As recently as December 1995, there was a total of 27 insurers; at the end of April 1997, only 16 remained. Overwhelmingly, providers have borne the brunt of losses associated with the 11 firms that have failed to date.

inadequate control and feedback mechanisms.¹⁰ The government has corrected some problems, but often solutions have unfolded slowly, have not been fully responsive, and have sometimes been inconsistent. Tensions in the system have surfaced, especially between the costs of services and the financial resources available for payments.

While many consider the fee-for-service provider payment system as the cause of steadily growing health care expenses, the problem is more complicated. The costs of health care are a serious economic problem in every developed country. For the Czechs, the situation has been complicated by the fact that, simultaneous with the general transformation of the economy, the nation has had to address the health care sector heritage of the communist era: outmoded technical equipment, salary deformations, a shortage of good management staff, the apathy of a state bureaucracy that lacked initiative, and the public's unrealistic belief that good health requires no personal responsibility and does not reflect lifestyle, that care “costs nothing,” and that there is no limit in the provision of expensive, intensive, high-quality health care for all.

As if the above reasons were not sufficient, several Czech-specific influences are also at work, including

- surplus capacity in outpatient and inpatient facilities together with the uneven distribution of hospital beds across facilities providing different levels of care;
- loosening of volume controls under conditions of supply-induced demand and the fee-for-service system;
- insufficiently explicit and poorly defined rules and requirements for and expectations about facility privatization;
- significant and often desirable growth of certain inputs into the health care system, e.g., diagnostic and therapeutic technologies; and
- the improving but still too-low quality of management at all levels of the health care system.

To compound matters, the Czech Republic's health insurance sector is not competitive. By political decision, all health insurance carries identical benefits and all insurers must accept all applicants and receive the payroll tax for employed enrollees. A percentage of the payroll tax is pooled with government contributions to equalize partially the payments to insurance

For example, in decisions on services to be offered, individual facilities sometimes appear to have given inadequate consideration to the needs of those affected, alternative resources already available, or the qualifications of staff who will be responsible for delivery of services.

companies for nonworking enrollees. As a method for shifting costs from the national budget, achieving solidarity, and depoliticizing benefit and payment decisions, such a time-honored approach is reasonable. However, in the name of choice, competitive efficiency, and misunderstood economic theory, Parliament terminated VZP's administratively efficient monopoly position by providing for establishment of multiple “insurers”¹¹ with a single product at a single, nonactuarial price—but without the regulatory safeguards necessary to ensure the insurers' solvency or to protect against waste, fraud, and abuse.

In sum, current difficulties in the Czech health care sector reflect a variety of influences. While agreement is by no means universal, several respondents indicated that cost problems, including high fixed costs and the substantial use of imported drugs, which inflates variable costs, stem from significant growth in the quality and range of health care provided—which, by its nature, is expensive and which in the Czech Republic is currently limited only by the capacity of health care facilities. In comparison to other developed countries, capacity—especially acute care capacity—is excessive.

E. The Future

Government Action?

Against the background of current conditions, various additional efforts already or soon to be put in place hold the potential to enhance efficiency, modify incentives, and control costs. On the government side, formal government consideration of a draft plan for bed closings is scheduled for late May. Similar announcements made in the past, however, have not produced change. Worse, closing “beds,” should such an approach survive, could well border on the meaningless.

Great numbers of “acute care beds” are currently either empty or used as “social beds.” Virtually no system savings accrue from closing an empty bed or a bed used simply to provide hotel services. Consequently, although “closing beds” has a ring of action to it, that ring is largely hollow. Real system savings and efficiencies can flow from closing entire acute care hospitals and converting them to other uses. Such benefits are unlikely to flow from the politically less arduous step of shutting down a few beds in every hospital.

The problem, of course, is political. Employees, patients, suppliers, and communities never want “their” hospital closed. And, in the face of such resistance, locally elected officials (mayors and members of Parliament) are subject to great pressure to protect constituents' facilities against closure. But, in fact, the present location of acute care hospitals, especially

The Czech government originally anticipated that each health insurance “branch” or company would operate only in a specific economic sector or geographic territory, but all started comprehensive membership recruitment activities, each trying to cover the whole country and to attract clients from all sectors of the economy.

in rural areas, at best reflects the transportation system of days long gone. With current Czech transportation capacity and availability, hospitals no longer need be only ten to 15 kilometers apart for patient or patient family access. Indeed, there is every reason to believe that fewer acute care hospitals, each serving a larger population and geographic catchment area, would lead not only to more efficient but also to **better** patient care.

Insurer Action?

VZP is in a unique position regarding system costs and related data. With assistance from USAID, VZP from its inception has adopted and maintained a comprehensive uniform data set, which over time has come to include provider-level encounter, productivity, and case mix information. Not only has the information been critical to the analytic process in advancing reform, it has also allowed VZP to explore and negotiate various cost containment measures. These include reducing per diem payment as individual case length of stay (LOS) increases; cutting outlier payments on an age-adjusted, specialty basis in outpatient care and by DRG in inpatient settings; and reducing payments to physicians who prescribe excessively. But the ability of insurers and providers to exercise negotiated self-governance is unclear due to varied political pressures and the continued desire of government to gain and hold decision-making power.

These steps—taken in the context of an appropriate regulatory/oversight system¹²—together with the logical consequences of installing a DRG-based, bundled hospital payment system would create substantial financial incentives for enhanced efficiency at the level of the individual hospital. If permitted to play out, the consequence is that the payment system would drive the closing of facilities that fail to respond adequately to the payment system's incentive-based imperatives. Over time, inefficient, excess acute care facilities would wither while the payment system financially rewards more efficient facilities.

VZP, which dominates the market, shows every sign of willingness to move down this path. In fact, a 16-hospital DRG pilot demonstration is just concluding. With USAID's assistance, the insurer is purchasing and plans soon to put in place the algorithms (the “grouper” software) necessary to implement a DRG payment base on a widespread basis. VZP has begun informally to explore using the software with several key hospitals. Moreover, VZP leadership indicates that it fully understands and is prepared to accept the multiple pressures it will face.

Despite these steps and VZP's apparent intent to continue pursuing its present course, members of the assessment team are skeptical that an elected Parliament and government will

It is necessary to ensure that hospital cost savings reflect real increased efficiencies, not the sacrifice of patient care and service quality; that interhospital comparisons are fair, e.g., adjusted for different patient loads and severity levels, etc.; and, most important, that necessary patient protections are honored.

be politically able to permit the parastatal insurer to use a revised payment system to close hospitals. It is questionable whether action-oriented leadership from VZP provides enough “cover” for the Parliament and government to stand aside. If not, can VZP leadership maintain its self-proclaimed independence from the government?

A Third Way?

The current economic problem in the Czech health care system is most directly linked to hospitals' near-universal financial difficulties and the excess capacity that feeds them. The most pressing inhibition against radical yet rational restructuring of the hospital system is political: neighborhoods, communities, medical faculties, mayors, council members, and patient-voters do not want their local facility to close no matter how much it drains *others'* (i.e., VZP and the national government's) resources.

The USAID-supported activities reviewed by the assessment team may be the basis for a third approach to rationalizing that part of the health care budget linked to excess supply of acute care hospitals. Specifically, modest revision to the current not-for-profit, nongovernmental organization legislation—as initially proposed by USAID's consultants and embraced by the MOF—would vest most Czech hospitals with a status akin to that of most voluntary “community” hospitals in the United States. In the United States, such facilities that, for whatever reason, fail to secure service revenues sufficient to maintain viability and invest in facility improvement look to municipal debt financing and/or voluntary community and individual fund-raising efforts for financing. If potential donors and/or lenders do not see a level of benefit sufficient to justify their investment, the facility will fail.

A hospital system in which large numbers of voluntary community not-for-profit NGO facilities face DRG payments provides hospitals with significant incentives to improve their efficiency and competitive position. But their claim to additional government tax revenues to fill any shortfall becomes attenuated, and the “cover” provided to political figures at the national level is comparatively strong—the ability to note that most hospitals are local facilities and an individual hospital's problem is subject to local remediation through local voluntary giving or municipal bond financing if the local citizenry cares enough.

Finally, as noted elsewhere in this report, the assessment team learned that various municipal government leaders were expressing interest in rationalizing health care facilities. A large part of the reason might be that they, too, need cover in their effort to reduce the municipal fiscal vulnerability represented by their current control over most hospitals.

V. SUMMARY AND COMMENTS

Without doubt, the Czech Republic faces considerable difficulties in its next round of health care system changes. The excess acute care capacity and its close cousin—cost problems—are especially severe and may seem intractable in the near term. But these, like many of the other problems confronting the Czechs, are the difficulties that flow from vast successes over a remarkably brief period. Indeed, the underlying changes are so dramatic that it is hard to remember that communism was unseated less than eight years ago.

In the world of health care reform, the United States Agency for International Development has good reason to be proud of its efforts in the Czech Republic and its staff who helped make so much happen. In absolute terms, USAID's investments have been a pittance. Yet, the return on that investment—in the two components that count—has already been enormous.

First, USAID's direct and contracted consultations have truly facilitated the Czech health care sector transformation. The training, teaching, and consultations have been diverse, responsive to the country's needs, and never patronizing.

Second, the assessment team observed that the Czechs' genuine appreciation for USAID's material and intellectual assistance was disproportionate to USAID's dollar investment. USAID's activities facilitated the forging of personal and professional connections between partners. Those connections will endure and expand long after USAID's formal departure.

In conclusion, the assessment team—even as it recognizes the difficulties facing the Czech health care system—would end on the most optimistic of notes. A vigorous people who have accomplished so much so fast are likely to find the appropriate approach and political will to overcome the next set of obstacles.

ANNEX A

February 26, 1997

SCOPE OF WORK

ASSESSMENT OF HEALTH SECTOR ACTIVITIES IN THE CZECH REPUBLIC

I. BACKGROUND

Under the communist system of government, the ideological, political and economic beliefs held that the social sectors were nonproductive compared to industrial sectors, and thus the health sector was often neglected. Nonetheless, the population believed that the social contract with the state, which guaranteed basic health, housing and income for all, was one of the differentiating qualities of the socialist state over the democratic state. Thus, despite the poor condition of the health care system and the declining health status of the population at the beginning of the post-communist era, many reformist leaders began to realize that the people viewed changes in the health sector as a litmus test for the legitimacy of market economics. Because 100% of the population are health care consumers, the impact of changes in the system could be felt rapidly.

In 1990, the democratic government of the Czech Republic issued a document which described its concept of the new health care system. It embraced new public and private roles in the health care system, patient choice of provider, improvements in the organization, efficiency and quality of health care services, decentralization of management authority, and privatization across the health care sector. Recognizing the need for capital to modernize industrial production of health care commodities as well as antiquated health care facilities, foreign investors were invited to participate in the privatization initiatives.

In 1991, the United States Agency for International Development (USAID), Asia/Near East Bureau began its assistance efforts in Central and Eastern Europe. Three strategic objectives were adopted for the CEE region: strengthening democratic institutions, economic restructuring and improving quality of life. (In 1991 the Asia/Near East Bureau was reorganized and renamed the Bureau for Europe, and in 1994 the Bureau for Europe was reorganized and renamed the Bureau for Europe and the NIS.) The ANE/Office of Health was assigned responsibility for designing and implementing two centrally managed, regional health projects. These projects included dimensions which cut across all three strategic objectives, but were considered

primary activities of the third, improving quality of life. Annex I includes a graphic description of the two projects and Annex J provides a list of the activities that were undertaken in the health sector in the Czech Republic.

The first project was the Hospital Partnerships Project, which provided grants to U.S. health care organizations to form partnerships with host country institutions. The purpose of the partnership was to address the leading causes of death in the region and to improve clinical care in the treatment of these conditions.

The second project was the Promotion of Private Health Markets Project, which provided technical assistance and training to support health reform with a strong emphasis on the privatization of health sector activities. Project activities addressed policy and institutional reform, improved management of scarce resources, and increased private investment in the health sector. The Promotion of Private Health Markets project was implemented through four mechanisms: A consortium contract with Healthcare Enterprise International, Inc. (HEI) (a joint venture between American International Group and Health Corporation International), a Participating Agency Service Agreement (PASA) with the Department of Health and Human Services, Office of International Health (DHHS/OIH), a cooperative agreement with American International Health Alliance (AIHA) and a contract with the Joint Commission International (JCI). The word "private" was later dropped from the name of the project because increased competition, improved management structures and introduction of other market-oriented mechanisms were equally important to reform as privatization.

Several projects which were designed and implemented by other offices within the ENI Bureau also touched on the health sector. These were the Energy Efficiency Project, American Schools and Hospitals Abroad, Privatization and Economic Restructuring project, the Democracy Network, the Partners for International Training and Education (PIET)Project and others.

As USAID completes its period of assistance to the Czech Republic, it finds a health care sector that has been dramatically transformed in a very short time. Today, health care represents 9% of Czech GDP, an increase of four percentage points since 1989, and is now at a level on a par with countries in the West. Thus, the importance of the health sector is now more sharply in focus than ever before with routine media coverage of current issues and wide debate of proposals for improvement. Universal entitlement has been preserved and citizen satisfaction has increased. There is now private financing of health care and over 95% of physicians practicing in out-patient settings are privatized. There is active competition among private physicians for patients. Physician and nurses salaries have increased, although this remains one of

the most onerous issues. Professional associations and patient advocacy groups are now active in voicing the interests of their constituents. However, many challenges remain because like Western democracies, the Czech Republic also faces spiraling costs due to increasing demand for services and costly pharmaceuticals.

From the outset, the goals of the Czech health sector reforms were clear and leadership at the highest level of government (i.e., the Prime Minister) was fully committed to the strategy. While turnover in the leadership at the Ministry of Health occurred about every 2 years, the continuous leadership of the Prime Minister and the Director of the General Health Insurance Office provided the unwavering vision and support needed to proceed with reform. USAID's programs complemented this situation by providing both a stable core of activities in some areas and an ability to respond to specific needs as the opportunities arose in other areas.

II. PURPOSE OF THE ASSESSMENT

The purpose of the assessment is to document the range and benefits of the health sector activities in the democratization and economic transformation of the Czech Republic over the 6 year period of assistance under the Support for East European Democracy (SEED) Act of 1989. Reflecting the important role that the health sector has played in the rapid transition of the Czech Republic from a centrally controlled, command economy to a market-based economy, health sector activities were undertaken by several different program groups, including -- health, democracy, energy, environment, privatization and training. The assessment will address the role USAID has had in supporting the reforms designed by the Czech government. The team should also identify the priority issues to be addressed by the Czechs as they move ahead in their reform efforts.

III. STATEMENT OF WORK

The role of the team will be to assess the overall benefits of the assistance to the Czech Republic in the area of health sector reform.

Questions which should be addressed by the assessment team are as follows:

- A. A short description of the changes that have occurred in the transformation.
- B. An assessment of USAID efforts, including issues such as the following:
 - 1) Did project activities support the Bureau's strategic goals?

- 2) Were project targets directed at priority needs as determined by the Czech partners?
- 3) Were activities targeted appropriately to support the reform effort?
- 4) Did diversity of program activities enhance USAID's effectiveness in this sector?
- 5) Were counterparts sufficiently engaged as partners in the selection of activities and demonstration sites to assure their commitment to and participation in these activities would attain the results sought?
- 6) Do local counterparts view this assistance effort as constructive, progressive and necessary? Determine the quality of the assistance.
- 7) Were workplans of contractors, grantees and cooperating agencies conceptually sound?
- 8) Will the relationships be sustained at a level appropriate to the participating institution?
- 9) Based on anecdotal information, how did the changes in the health care sector which occurred over the 6 year period of the project impact the citizens of the Czech Republic? What were the positives and negatives of the reform program from the standpoint of the people of the Czech Republic?

IV. METHODOLOGY

The assessment will be managed by Basic Health Management (BHM) through their support services contract with ENI/DGSR. They will assemble a team of health sector experts from both the U.S. and the Czech Republic. BHM will notify all the contractors, grantees, cooperating agencies regarding the purpose and timeline for the assessment. The team will compile a full description and assessment of the health sector activities undertaken over the 6 year assistance period.

A. Team Composition

The team will consist of up to 4 professionals of the type and with the expertise described below. All team members should have knowledge and experience in health care reform in Central and Eastern Europe.

1) Team Leader: Individual with experience as a senior level policy maker, preferably in the U.S.

2) Physician Hospital Manager: A Medical Doctor with experience managing health care institutions in a health insurance financed context.

3) Health Policy Educator: Individual with broad knowledge of the purpose and direction of health sector reform in the Czech Republic.

B. Document Review

Review workplans and/or reports of each of the following: HEI, DHHS/OIH and HCFA, AIHA, Joint Commission International (JCI), 3M.HIS, Democracy Network grantees ((e.g., Jewish Joint Distribution Committee, breast cancer screening program), PIET, CEELI, ElectroTek (energy contractor contact Rob Russo (703) 351-4492), Project Hope, and others as appropriate.

C. Interviews

The Czech and American team will conduct orientation and background interviews with USAID/Prague, USAID/Washington, DHHS/OIH and HCFA, 3M.HIS, JCI, AIHA, and Czech counterpart organizations to be identified through consultation with the USAID/Prague.

D. Site Visits

Prague Third Medical Faculty, Vinohrady Hospital
AIHA HME Partners
VZP
MoH: Accreditation Office
Jewish Joint Distribution Committee
Breast Cancer Screening Programs

MoF/Volf, MoJustice/Pelant
CEELI
Project HOPE

V. PROPOSED ILLUSTRATIVE SCHEDULE

Weeks 1 and 2:

Team meets with USAID/ENI/W, including health, energy and democracy offices

Team meets with USAID/Prague, including Jim Bednar, Bob Posner and Helena Vagnerova for brief orientation and review of expectations.

Team compiles and reviews all available written reports.

Week 3:

Prepare interview and site visit schedule. Begin Prague-based interviews and site visits.

Week 4:

Complete Prague-based interviews and site visits. Conduct visits to other sites in Czech Republic as necessary.

Week 5:

Complete report and submit draft to USAID/Prague and USAID/Washington.

Week 6:

Incorporate comments from USAID and finalize report.

VI. LEVEL OF EFFORT/PERIOD OF PERFORMANCE

The period of performance is March 17 to May 15, 1997. The level of effort is 120 days based on a maximum of 4 consultants for an average of five six-day work weeks. We estimate one round trip Prague-Washington, D. C. for each consultant.

VII. REPORTS

One week following the completion of the field assignment, the contractor will submit a report which addresses the following: (1) a summary of interviews with names of attendees and institutions represented, (2) Summary of key reforms in the Czech health care system since 1991, and the use of USAID technical assistance and training to support the direction of reforms, (3) Special examples of impact, anecdotes and "quotable quotes" regarding the assistance provided under the auspices of USAID. The report should be issued in Czech and English.

ANNEX B
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Miroslav Votapeck, SEVEN
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Frantisek Weber, MUDr, Head, Hospital and Polyclinic
Teplice, Czech Republic

Carlos Zarabosa, Health Care Financing Administration
Washington, DC

ANNEX C

IMPROVEMENTS IN CLINICAL CARE

Program for Reduction of Cardiovascular and Cerebrovascular Disease in the Czech Republic

PARTNERSHIP IN HEALTH CARE

Background

Mortality from both cardiovascular (CVD) and cerebrovascular disease (CEVD) in the Czech Republic is among the highest in the world and, relative to most other developed nations, has been worsening. Major risk factors for both diseases are extraordinarily prevalent. The World Health Organization's 1985 MONICA (Monitoring of Trends and Determinants in Cardiovascular Diseases) Surveys, conducted in six Czech districts, found that the prevalence of hypercholesterolemia among those 25 to 64 years of age ranged from 36 percent for males to 38 percent for females and that hypertension averaged 22 to 27 percent. The surveys also revealed that 48 percent of men and 27 percent of women were smokers and that from 18 to 30 percent of the population was obese.

This mortality experience and the risk factors underlying it reflect the Czech lifestyle developed during the communist regime: high consumption of meat, eggs, and dairy products as social indicators of prosperity; a shortage of fruit and vegetables resulting from production disincentives; and historically conditioned habits involving diet and smoking. Under totalitarian rule, some argue, the Czechs also developed a sense of fatalism about their health and exhibited little interest in active prevention of diseases.

Given the magnitude of the problem, it was clear that no single strategy or project would be sufficient to reduce CVD risk in the Czech Republic. Instead, conditions called for a combined approach that focused on, first, public health/community-based prevention programs to address pervasive perceptions and cultural traditions that increase the risk of CVD and, second, strategies to treat high-risk individuals. A community-based health education program would inform people about CVD risk factors and motivate them to make changes in behavior to lower CVD risk while a set of strategies would identify high-risk individuals and provide access to effective medical treatments.

Against this background, Czech experts asked for and USAID agreed to provide—through the latter's partnership program—assistance in reducing of the risks

of cardiovascular and cerebrovascular diseases—the leading Czech killers—through medical and educational intervention targeted to high-risk people and the community. The proposal ultimately funded by USAID reflected longstanding professional contacts between Czech and U.S. experts.¹³ Consequently, those contacts facilitated startup and working relations between the partners following USAID's eventual grant award.

Partners

U.S. Institutions

University of California, San Francisco (UCSF)

Stanford University, Palo Alto

Central European Center for Health and the Environment, Berlin and Washington, DC (CECHE)

Czech Institutions in Prague

Institute for Clinical and Experimental Medicine (IKEM)

National Institute of Public Health (NIPH)

Second Medical Clinic of the Third Medical Faculty of Charles University (SMC)

Project Description

A major aim of the project was the transfer of U.S. knowledge and technology to the Czech Republic; therefore, the project began with an intensive four-week training program for Czech health professionals in the United States. The training provided by faculty and staff of the Stanford Center for Research in Disease Prevention focused on community-based intervention. The design and implementation of proposed epidemiological surveys, including measurement protocols, were reviewed by training participants. Trainers provided guidelines regarding design and conduct of community-based CVD risk reduction programs that would include community involvement, school-based projects, health fairs, and health communications incorporating such mass media approaches as health education print materials. The program's community-based primary prevention component took place in Dubec, a small village of less than 2,000, and focused on three lifestyle-related behavioral risk factors: smoking, diet, and exercise.

¹³For example, even during the communist period, Rudolf Poledne, PhD, from IKEM's Laboratory for Atherosclerosis, Prague, and Richard Havel, MD, from UCSF had been in contact regarding Czech health conditions.

Introductory steps included baseline medical screening and attitudinal/knowledge surveys of the Dubec population followed by provider education activities and, finally, education-based community intervention efforts. Education activities involved broad, multimedia campaigns to provide information about risk factors and risk factor reduction through lifestyle modification.

As in many other primary prevention education efforts, the project focused on achieving lifestyle modification among the young. It placed special emphasis on the Dubec Primary School, which was also participating in a WHO project entitled Healthy Schools and, in turn, was linked to USAID efforts through a variety of components. Among the most important program component at the primary school were curriculum activities, including student

- analysis of harmful nitrates in vegetables in the local market;
- surveys of vegetable and fruit consumption in the town;
- cooperation with the Hygiene Station regarding water purity; and
- surveys of food handling and quality maintenance in local stores.

In addition to the lifestyle primary prevention effort, the partnership Program for Reduction of Cardiovascular and Cerebrovascular Disease conducted a screening, treatment, and secondary prevention/patient monitoring component. Core responsibilities for this component lay with IKEM's Preventive Cardiology Clinic and its Lipid Laboratory, which provided laboratory services, and with the Town Hospital of Litomerice and the Second Medical Clinic of Charles University, where treatment and monitoring of myocardial infarct and high-risk patients took place.

In addition to the primary and secondary prevention and treatment activities, the partnership included support for a three-year bachelor's degree program in nutrition. The new baccalaureate program was intended to fill one of the major gaps in cardiovascular disease prevention in the Czech Republic: the overwhelming absence of trained nutritionists.

The partnership program was intended to transfer primary and secondary prevention skills in cardiovascular disease, together with enhanced treatment protocols and skills, to the Czech Republic. The skill sets included nutritional, epidemiological, medical screening and intervention, public information, and lifestyle-behavioral risk identification and reduction modification capabilities. Given this wide set of goals, it

is not surprising that the original partnership grant period, set to run for three years from 1992 to 1995, was given a no-cost 18-month extension.

Results

Preliminary results are highly favorable. The primary prevention program is showing some benefits in terms of improved “consumer” information and modest dietary modifications. Based on survey results, the community intervention program initiated in Dubec appears to have introduced healthy attitudinal and behavioral changes at the grass-roots level. A nursery school program directed at dietary change is said to have succeeded. Information courses on the relation between diet and lifestyle and CVD/CEVD risk are claimed to have drawn good attendance. As shown by the U.S. experience, however, it is premature to be secure that, absent extended follow-up, the newly acquired knowledge will result in substantial long-term changes in lifestyle and habit. Additional caveats suggest that the emphasis on body weight reduction through exercise is at odds with an entrenched lifestyle. Further, the struggle to reduce smoking has been especially difficult in the face of substantial advertising by tobacco companies.

Despite these caveats—which apply to public health-based behavioral change efforts in any society—USAID has chronicled and distilled the “Healthy Dubec” activities of the partnership. As of early 1995, the program content had been disseminated to four additional districts: Prague 10, Kutna Hora, Litomerice, and Liberec.

In the secondary prevention/intervention component, partnership participants claim dramatic results: virtual cessation of smoking among postmyocardial and postcoronary patients a year after therapy and a dramatic reduction in non-HDL cholesterol levels.

Conclusions

The Program for Reduction of Cardiovascular and Cerebrovascular Disease started a vital process designed to make people aware of and responsible for their own disease prevention and health promotion. The project began the process of providing the knowledge necessary to understand the importance of personal responsibility for one's own health.

The successful transfer of information and the adaptation of that information to the Czech culture and lifestyle were extremely positive outcomes. This collaborative program trained both new and established Czech health professionals in the design and implementation of a wide range of clinical and epidemiological methods for reducing CVD/CEVD risk. The Czech Republic realized the following substantial benefits:

- efforts targeted to the most challenging health problem;
- the rapid and effective deployment of a program based on already existing personal relationships between U.S. and Czech scientists;
- USAID-supported transfer of knowledge to the Czech health system; and
- the introduction of potentially sweeping changes in individuals' understanding of the link between personal lifestyle decisions and one's own long-term health outlook.

Finally, the successful implementation of this large project has facilitated replication and acceptance of similar approaches elsewhere in the country.

ANNEX D

HOSPITAL OPERATIONS' IMPROVEMENT PROGRAM

Background

Postrevolution changes in the Czech health care sector demonstrated the need for, importance of, and gap in the availability of hospital managers,¹⁴ management tools, and techniques. In the belief that common threads run throughout the management problems facing many hospitals and that redressing them could lead to overall improvement of hospital management activities, USAID in late 1994 initiated the Hospital Operations' Improvement Activity—a demonstration—through Healthcare Enterprise International (HEI), its contractor.

In March 1995, an HEI assessment team visited the Czech Republic and recommended selection of three hospitals and their related projects for inclusion in the demonstration. Between May 20 and June 9, 1995, three teams of two consultants each were introduced to their respective hospitals. The mission was highly successful; projects at all three hospitals were launched as planned. Between July 26 and August 15, 1995, two of the three teams returned for follow-up project development. The third team (University Hospital Vinohrady team) was delayed until September 1995 because of holdups in delivery of both software and hardware. Progress at all three sites continued, and the teams worked as originally planned toward late fall seminars, the culminating events of the projects.

Project Description

USAID and the Czech Association of Hospitals agreed to the overall design of the Hospital Operations' Improvement Activity and developed a short list of candidates from self-nominated hospitals. Preliminary selection was based on clearly defined, management-oriented problems that appeared, first, to be common to a number of hospitals; second, amenable to technical solution through the joint efforts of U.S. advisory experts and the Czech hospital managers; and, third, likely to be completed in six months.

Based on these criteria, USAID and the Czech Association of Hospitals chose three hospitals—Boskovice Hospital, Town Hospital of Litomerice, and University Hospital

For discussion of USAID's extensive administrative and management training activities, see Annex F.

Vinohrady. The institutions' "presenting" conditions, as noted below, were generic hospital management issues of concern to all facilities that exercise some control over costs and productivity:

- development of efficient, cost-effective nurse staffing patterns that are responsive to the medical needs of the changing patient census (Boskovice);
- creation of a management-oriented information system (Litomerice); and
- preparation of a preventive maintenance schedule for costly, high-technology medical equipment (Vinohrady).

Each of the three hospitals' issues lent themselves to computer-based software solutions that take advantage of software programs in wide use in U.S. hospitals. But gaining the agreement of the relevant parties to participate in the negotiations necessary to define their problems adequately, "customize" programs to local needs, and accept the implementation of the several technical solutions was not always easy.

After introductory discussions, U.S. experts worked with the three hospitals to address their management problems. Through managerial and technical assistance to define the problem operationally and select, develop, and, as necessary, customize the appropriate tools to the local environment, the project provided techniques and software to solve the hospitals' respective problems. At the end of the project, each of the three hospitals organized seminars as a means of broadly disseminating knowledge of new management tools to key managers from all Czech hospitals.

Results

The project progressed so well that the three hospitals, initially supported by HEI, joined together to present to representatives of other Czech hospitals a description of their achievements and to provide them with all appropriate information on the projects and their results, thereby permitting those hospitals to evaluate the newly developed capabilities and to adapt them as appropriate to their specific needs. The results were presented at three seminars attended by almost 340 participants representing 125 hospitals.

- Boskovice Hospital

The program permits nurse staffing to be linked to the medical requirements of the in-patient census in “real time.” Consequently, the program has led to a marked enhancement in managerial flexibility in scheduling and assigning scarce nursing resources while maintaining effective patient-driven coverage.

The program demonstrated that almost every Czech hospital was understaffed. For nurses, the program presented a unique opportunity to enter into professional partnerships with physicians. Implementation of the program in additional facilities would provide head nurses with objective numbers on needs in differential nursing and support categories.

- Town Hospital of Litomerice

The information system developed at Town Hospital of Litomerice embodies both financial and statistical reporting capabilities. Based on new capacities developed under the project, hospital management is now able to prepare annual department-level budgets and monitor supply use, patient length of stay, and other cost and utilization data. An important side effect was building a rational departmental reporting structure that allows management to monitor operations and provides the basis for timely corrective actions.

- University Hospital Vinohrady

The hospital thought that the system initially developed by the project was unnecessarily sophisticated but, with modifications agreed to both by maintenance/repair technicians and user-doctors, it eventually formed the basis for a somewhat simplified system used to manage both preventive and repair procedures as well their scheduling and budgeting. The project initiated a uniform approach in the maintenance process. Implementation has extended the useful life of equipment. Respondents understand that the software system has the capacity to be used in purchasing but did not know whether technically feasible extensions of use had been implemented.

Conclusions

The Czech Republic Hospital Operations' Improvement Activity has demonstrated the great value of cooperative efforts between Czech hospital personnel and U.S. consultants under the sponsorship of USAID. The project culminated in three seminars in which participant hospitals presented results and offered useful information to other

Czech hospitals about procedures, tools, and techniques acquired during the projects and their demonstrated benefits to hospital efficiency. Preliminary indications suggest that a number of other Czech hospitals have found the managerial activities to be significant and are exploring their replication.

ANNEX E

NOT-FOR-PROFIT LAW AND CASE STUDY

Background

In the health care sector as elsewhere, an important objective of the postrevolutionary Czech government has been the privatization of state-owned facilities. Both the for-profit and not-for-profit approaches, however, require an appropriate legal structure as a prerequisite to privatization. After the revolution, the Czech government quickly established the necessary statutory basis for for-profit entities. While for-profit privatization of ambulatory care occurred rapidly, the hospital sector did not achieve the same success. One of the several explanations for for-profit privatization's failure holds that the expected income stream was inadequate to pay back not only the purchase price but also the substantial additional costs required to modernize and update many of the hospitals. Put bluntly, the private sector viewed the use of resources to privatize and convert government-owned facilities into for-profit hospitals as a poor investment.

The generally problematic investment status of hospitals has led to a variety of hybrid ownership forms in other countries. While these ownership structures are often variations on not-for-profit ownership by nongovernmental organizations (NGOs), the Czech Republic had no legal structure for authorizing such entities. Thus, the Ministry of Finance (MOF), observing the failure of for-profit hospital privatization, became interested in the early 1990s in the opportunity potentially offered by similar ownership forms for *deetatification* (removal from direct state control and operation) of hospitals in the Czech Republic and, by a letter dated December 1992, asked USAID for assistance. In addition to supporting this goal, USAID saw the development of not-for-profits as a potentially important mechanism for privatization as well as for strengthening the Czech civil society and supporting continued democratization.

Project Description

The goal of the project was to examine not-for-profit and NGO statutes in place in Western Europe and the Americas; summarize their language, operation, problems, and opportunities; and develop draft language for consideration by the government and Czech Parliament. USAID's funding supported tax, legal, and policy consultants who undertook these reviews; provided information and education on these matters to the government, to Parliament, and to the public; and served as a drafting resource as, over time, the government considered its options and alternatives.

Results

In mid-July 1994, the Czech government invited the Resident Advisor to USAID's core consultant, Healthcare Enterprise International (HEI), to the Ministry of Finance to meet with the deputy minister and others. These officials informed the Resident Advisor that, the previous day, the Czech government had approved the proposed principles of an act authorizing establishment of nonprofit legal entities. Further, the government expressed its appreciation for the significant contribution made by USAID and its consultant. The deputy minister and others noted that just a year earlier the prime minister and the government had been strongly opposed to the creation of a not-for-profit sector in the Czech economy. Much of the credit for this remarkable turnaround goes to USAID-supported efforts in educating various constituencies about not-for-profits. Subsequently, the principles were elaborated into the final draft of a bill, which, with minor modifications, Parliament approved in October 1995; the law took effect in January 1996.

At the request of the MOF, USAID became involved in the development of the not-for-profit law, with the expectation on both sides that the legislation would primarily facilitate the break-up of the hospital system then controlled and funded by the state and lead to the creation of nonprofit, nongovernmental, privately operated institutions. As the law evolved, however, it became clear that the hospital sector would not soon be *deetatified* as originally envisioned. As finally passed by Parliament in 1995, the law did not contain provisions for the transfer of state property to nongovernmental institutions.¹ Instead, as an interim step, the hospital sector was largely decentralized by transfer of governance responsibilities and control to the municipalities.

Communist rule strictly banned entities organized by citizens at the grass-roots level, independent education and cultural activities, and certainly any nonparty political activity. Thus, the act did not have the anticipated *deetatification* effect on hospitals, but it unquestionably opened the gates for the establishment of not-for-profit, nongovernmental organizations (NGOs), which are commonly referred to as the "third sector." Subsequent development of this sector in the Czech Republic has been rapid and powerful. Since the act became law in 1995, more than 1,800 new NGOs have been registered. The swift embrace of this form of organization, which favors decentralization and grass-roots origins and involvement, is encouraging. In the view of Dr. Michael Andel of IKEM, a major partner in the USAID-supported CVD

Nor did it allow donors to take a tax deduction for the value of their contribution, an important feature of the charitable nonprofit environment in many other countries.

reduction partnership program with Stanford and UCSF, NGOs play a crucial role in reducing CVD in the Czech Republic. In his words, the future “must include NGOs, a democracy complex.”¹

It is important to note, however, that during the assessment team's discussions with a senior MOF policy maker, the team learned of renewed interest—especially on the part of municipalities—in a legal change that would permit not-for-profit NGOs to “own” and operate community-level hospital facilities. In addition, at the time of the team's field work, the health reform plan under development for the minister of health assumed that the large hospitals, including university hospitals now owned by the MOH, would be similarly transferred. Thus, the original work supported by USAID continues to play a significant role in these discussions and may yet be more fully realized in the hospital sector.

Czech NGOs are now spread across a variety of sectors, including health, culture, education, trade and professional associations, political groups, and service organizations. Many have a political voice while also playing an economic or social role in Czech society. Several new NGOs are focused on health issues either through advocacy or direct service. While the act did not provide for the transfer of property from the state to NGOs, it does not prohibit the acquisition or construction of new sites. One example of an institution organized as an NGO, similar in structure to a U.S. nonprofit hospital, is the new 55-bed “home” built by Nadace Sue Ryder for dignified care of the frail elderly. In addition to live-in care, the facility provides daycare, rehabilitation, physiotherapy, occupational therapy, bereavement counseling, a meals-on-wheels component, and a host of other services. The home has engaged in education and outreach to build a constituency for itself, successfully networked to build a powerful local and international board of directors, and conducted a successful fundraising campaign to support facility construction. The new facility is scheduled to open in 1997.

Even as the growing management competence of Czech NGOs continues to allay fears about the organizations' sustainability, the need for long-term funding sources grows more crucial. With the withdrawal of USAID and other large institutional funding sources, many Czech NGOs are scrambling to avoid massive program cuts and/or closure. USAID programs such as the Donor Forum and Democracy Network,

To this end, he spent the final week of his USAID-supported training in the United States at the headquarters of the American Heart Association and is currently developing the infrastructure for a Czech Heart Association.

together with technical assistance and funding for the nonprofit resource center, are providing training in fund development and community building to help NGOs ensure sustainability.

Conclusion

The support provided by USAID through the health care sector activities and the democracy program contributed significantly to the development of a “third” sector—from assistance with drafting the legislation to training NGO managers and board members to funding individual NGO programs. This work will undoubtedly have a lasting and profound effect not only on Czech democracy but also on the economy as a whole. NGOs are beginning to provide social services that have been the responsibility of the state (or neglected by the state) at little or no public cost. As these “toddler” NGOs gain their balance and begin to develop a power base, recognition of their importance and acceptance of this form of organization will grow. In time, the government should come to appreciate and rely on a community-based level of operations, eventually easing the implementation of the hoped-for transfer of property and funding from local governments to community-based boards of directors of the nonprofit sector. A period of trust building is a natural consequence of the recent history of the country. USAID's support for the fledgling NGOs during this period is already yielding and will continue to pay dividends throughout the next decade.

An example case study is provided below.

Disabled Children Community Action and Services

Although the USAID-funded disabled children program had a direct emphasis on health issues, its funding came through USAID's 032 (social services) program account. It is discussed here not only because it affected health care sector efforts in the Czech Republic but also because it highlights the impact of some of the many nonprofit organizations now operating under the provisions of the not-for-profit law, which USAID assistance helped to make a reality.

The goal of the program was to begin the work of “facilitating the inclusion of persons with disabilities into all aspects of Czech and Slovak society.” With oversight and funding from the American Jewish Joint Distribution Committee (JDC) and technical and financial assistance from USAID, the project (spanning April 1991 through December 1995) undertook a broad range of objectives. Activities included establishing the Desider Galsky Training Institute (DGTI), an NGO for the training of professionals, parents, and families of people with disabilities in modern theory and practice of care; encouraging the integration of modern care practices into Czech

academic, government, NGO, and other institutions; and establishing model Community Living Arrangements (CLAs) to provide housing facilities with comprehensive treatment and support services for severely disabled individuals to foster independence and community integration.

Specific activities that fell within the wide scope of this project included

- establishing the DGTI in cooperation with the Charles University Faculty of Education, Department of Special Education (1991);
- one-year core training programs delivered by international experts to Czech and Slovak professionals in the field of disability (90 graduates);
- short-term seminars and courses provided at the request of government ministries, universities, and other nonprofit organizations and intensive workshops for family members (1,000 participants);
- training 350 personal assistants in maximizing the autonomy of persons with disabilities;
- an international symposium concentrating on decentralization of social services for teams from five countries in the region (Prague, April 1995). Symposium experts made follow-up visits during the summer to assist in implementing the plans developed during the symposium;
- organizational development workshops for Czech NGOs engaged in work for the disabled led by American and Czech trainers. The workshops helped ensure the sustainability of NGOs by enhancing skills in board of director recruitment and training, program planning, public relations, and fundraising, financial, budget, and human resources management.
- establishing CLAs, or model apartments, for mentally retarded adults in cooperation with the Foundation for the Integration of the Mentally Disabled (DUHA), incorporating employment and independent living training. A myriad of other services, such as counseling, speech and physical therapy, and appropriate supervision and frequent outings to activities outside the CLA, were integrated; and
- a partnership with the Prague Wheelchair Users Association (POV) to facilitate the expansion of its information system and to establish a Center for Independent Living as a community resource center.

Results

While the list of accomplishments is impressive in itself, the efforts directed to sustainability have amplified the initial reach of JDC-USAID actions. The program has influenced thousands of people and organizations through new, independent training conducted by DGTI graduates; contact with POV and DUHA; and the multitude of activities conducted by NGOs now better able to fulfill their own missions as a result of the assistance provided by the project. The institutionalization of the education process has been rapid.

Over and over, participants cited the dedication and expertise of the expatriate instructors employed by DGTI. Participants felt strongly that the long-term commitment of the instructors, rather than the brief involvement of consultants or “tourists” who come and go, was pivotal in building lasting relationships and ensuring impact.

A few examples of the program's many long-range effects follow:

- DGTI has a five-year plan for expansion and development into a regional center serving not only the Czech Republic but also other CEE countries.
- Six more CLAs have now opened with fully independent financial support—often from state and local sources cultivated through initial JDC educational outreach to influential government officials.
- POV now operates independent of JDC support, handling 200 to 300 requests for information each month and offering job placement, recreational, and social programs as well as ombudsman services.
- The Rehabilitation Center of the Third Medical Faculty of Charles University has modified its curriculum and has adopted a new, multidisciplinary approach to treating disabled patients (although the hoped-for incorporation of DGTI into the faculty did not materialize).
- DGTI graduates have founded several new NGOs and programs, including:
 - a network for students, parents, and professionals;
 - summer camps for families with disabled and nondisabled children;
 - a program of support for parents of newborns with disabilities, with MOH support; and
 - a comprehensive employment training and placement program.

- Fund development activities, often based on USAID models, are successfully facilitating the continuation and growth of many NGOs involved in this programming area—a result of the grant application skills training.
- The Czech Republic is using the Internet and “www” capabilities to communicate with the West, other CEE countries, and the project experts who have returned to their home countries.

Perhaps most important, thoughtful contact and consultation with influential policy makers has led to government support for institutional change. For example, DGTI created a direct line of communication between government decision makers and the grass-roots by including representation from the new Government Disability Board (GDB) on its board of directors. The chair of the Government Disability Board is the Czech prime minister. An independent evaluation conducted in June 1995 claimed that “the evaluators were particularly impressed with the access and involvement of key individuals from government agencies through the GDB.” One important result of government interest and involvement was the GDB's introduction of legislation entitled a “**National Plan to Reduce the Negative Impact of Disabilities,**” which traces many of its ideas back to DGTI.

The DGTI board also includes representation from an umbrella organization of 97 “disability” NGOs, the Charles University Rehabilitation Department faculty, and networked parents and professionals. This inclusive policy should serve DGTI well not only in terms of program objectives but also as a base for continuing fund development activities.

Conclusion

An earlier project evaluation observed that “when the history of people with disabilities in the Czech Republic is written, the JDC-USAID Project will be viewed as a watershed event.” As that same evaluation noted, “Indeed, one could argue that the human rights interests inherent in the project goals come with a price tag. What is the cost in terms of human potential and dignity that would have been lost if this project were not funded?”

The impact of the program during its three years is obvious and wide-ranging. It is clear from the program's documented and ongoing developments that the outcomes USAID contracted for have been realized. Moreover, the thoughtful decisions to include a broad base of important organizations (including GDB, Charles University, and others) in DGTI's governing council and to provide comprehensive NGO training for major NGOs and DGTI graduates will be felt in ever-expanding ripples long after USAID's departure. Programs of this type will play a strong role in educating the

Czech government and citizenry about disability issues and the power and importance of the fast-growing “third sector” nonprofit organizations.

ANNEX F

HEALTH MANAGEMENT EDUCATION PARTNERSHIPS

Background

In the years of central planning preceding the revolution, the communist government considered health management and administration neither professions unto themselves nor an appropriate component in the early training of new health professionals. Instead, practicing physicians received short courses in aspects of management as deemed necessary, largely through the Post-Graduate Medical School in Prague. However, changes in the Czech health care system brought about by the postcommunist transformation provided powerful evidence that the absence of strong administrative and managerial skills imposed a serious constraint on development and that enhancement of such skills required national attention. Both the Ministry of Health and, perhaps especially, the Czech hospital sector recognized this need as critical. In response, USAID undertook support of a variety of related training activities.

The first substantial USAID-sponsored management and administration training effort was initiated with Project HOPE, with participation limited to key senior policy personnel in the Ministry of Health, major care facilities, and elsewhere in the health care sector. The Project HOPE program was very well received by the Czech government, which considered it extraordinarily useful within and beyond the ministry. For example, in recruiting heads of several of the largest hospitals, the program was held up as an example of the type of managerial training required of applicants. Accordingly, it served in significant measure as a model for various subsequent, broader-based activities (detailed below).

Project Description

As articulated by the Czechs themselves, including participants in the 1994 USAID-sponsored regional conference on health care reform held in Prague, the country's need for modern, comprehensive education in health management and administration extended substantially beyond policy makers at the highest levels to mid-level practitioners and bureaucrats involved in day-to-day facility management and policy implementation activities. USAID's response to Czech requests for broadened assistance was to begin developing the Health Management Education Partnerships program as a means of hastening the introduction of high-quality health care management education to the Czech medical, management, and administrative training systems.

The program focused immediately on fostering partnerships with U.S. universities specializing in health management and in increasing the information access capacity of Czech undergraduate, graduate, and postgraduate institutions through the development of Internet resource centers. The ultimate goal was to develop and implement health management curricula and degree programs in Czech institutions. The program placed priority on efforts that reached current as well as future health practitioners, managers, and administrators of the Czech system. USAID/Prague and USAID/Washington identified several possible partners, with final selections made with the help of the American International Health Alliance (AIHA).

Two U.S. university systems and four Czech systems formed two umbrella partnership agreements covering a wide range of disciplines and levels of study (see table below). While one agreement linked a single U.S. medical school with a single Czech medical school, the second partnership became more of a network, linking one U.S. university system, two Czech universities (incorporating six different faculties representing four different disciplines), and the Czech Post-Graduate Medical School in Prague. Partnership agreements were signed in February 1996.

The agreements included provisions to broaden the reach of the program and to increase future capabilities by identifying possible teachers from current students and practitioners. The agreements also called for networking actively within the community of practicing health managers in the Czech Republic and the entire region through conferences, materials, and other appropriate means. The partnership agreements placed priority on replicability and sustainability of the new programs.

Health Management Education Partnerships

Institution

Curriculum Goal

(1)

Virginia Commonwealth University
Department of Health Administration
and
Palacky University
Nursing Faculty, Olomouc

MA, theory and practice of nursing

(2)

University of Nevada
*University of Nevada Medical School,
Reno and Las Vegas*
*UNLV Department of Health Care
Administration*
and
East Bohemia University, Hradec
Kralove
*School of Management and Information
Technology (MIT)*
Purkyne Military Medical Academy
School of Pharmacy, Charles University
School of Medicine, Charles University

BS, health services management
Cooperative with MIT program
Cooperative with MIT program
Cooperative with MIT program

South Bohemia University, Ceske
Budejovice
and Jindrichuv Hradec
*Faculty of Management, Jindrichuv
Hradec*
*Faculty of Social Medicine, Ceske
Budejovice*

BS, economics, with emphasis on health
Additional semester of health
management in BS program

Post-Graduate Medical School, Charles
University
School of Public Health, Prague

Postgraduate education for working
health management professionals

The program was administered through a contract with AIHA. Within the 18-month time line developed for implementation, the partners (with the assistance of AIHA) were to establish resource centers at the Czech institutions, identify and develop faculty (including training in the United States and in-country when necessary), develop and test educational materials, increase faculty capabilities with regard to teaching methods and techniques in management education (including travel between partner countries as necessary), begin offering courses using the new curriculum, and develop a plan to offer new degree programs in health management at the appropriate level.

Results

The success of this program lies not only in its meeting its stated goal—the introduction of quality health management education in the selected institutions—but in participants' enthusiasm for the networking process begun by the partnerships. For the first time, a cooperative information network is operating not only between the formally linked institutions themselves, which cover a multitude of disciplines and levels of study, but also between the two partnerships and outside the partnerships.

The Czech institutions have developed degree programs. At this time, most have admitted their first group of students. The Post-Graduate Program admitted 35 to 40 students in its first term and is adding a second parallel term to accommodate demand. Approximately half of the participants are directors or deputy directors of hospitals. Other participants include staff from the Ministry of Health, insurance managers, university teachers, hygienic station managers, and district health personnel.

The Jindrichuv Hradec management program began its term with approximately 45 part-time students. Student selections were based on applicants' commitment to the health field, with preference given to slightly older, working students, especially those with experience in health. The program is directed to the economic side of hospital management and works in close cooperation with the Jindrichuv Hradec Hospital, one of the few hospitals in the Czech Republic currently showing a profit. The hospital's director is an economist. The coursework for the program covers a professional medical orientation: the economic aspects of management, including financing, taxation, accounting, etc.; a law component; and practical application at the hospital.

The Hradec Kralove program, which will offer a BS in information management emphasizing health, is similarly oriented. The institutions in Hradec Kralove expect to launch the first term there in fall 1997. Despite a certain natural competition between the undergraduate management programs, the sharing of information, human resources, etc., is taking place. In fact, the Czech universities are currently codeveloping a Czech health management textbook.

According to faculty and administrators in Jindrichuv Hradec, the preferred approach to preparing future health managers in this period of flux is to emphasize analytic skills rather than “specific system knowledge.” Students study and analyze cases from throughout Europe and the United States as well as systems in place today in the Czech Republic; the goal is to equip students to adapt to a potentially changing scene.

Based on participants' comments, it is clear that individual and group training in-country, in the United States, and in third countries played a crucial part in the program's success. Particularly helpful were sessions dealing with teaching methods new to the Czech Republic—the more interactive Western methods offer a dramatic change from the traditional lecture method generally employed by Czech institutions. When the assessment team asked the vice dean of the management school in Jindrichuv Hradec how his faculty had developed the necessary knowledge to offer the program, he replied that they were learning from the U.S. institutions and “leaning on the experiences of our partners.”

The USAID partnerships have fostered relationships that will continue to grow long after the agreement ends in September. The Czech partners have shown initiative in developing more capacity than initially envisioned. The long-term effects of this short, formal agreement include

- independent development of resource centers modeled on the program's linking more institutions to each other and to new information;
- an already approved grant application to the Ministry of Health to continue and enlarge the institutional networking. Dr. Petrakova, director of the public health component of the Post-Graduate Medical School, sees the programs as “leveraging off the USAID funding”;
- a distance learning program implemented in Jindrichuv Hradec offering short, intensive courses for working professionals;
- demand for the Post-Graduate Public Health program, serving mostly hospital directors and other top-level working health managers. Demand has been so great that a second, parallel term has been added, thereby doubling the number of enrollees and rapidly taking theory to practice at the top level; and
- formation of a support network for these programs within the new NGO community in the Czech Republic.

Conclusion

Designed around U.S. objectives of increasing health management capacity and the self-defined needs of its Czech participants, the program was well conceived and successfully implemented within its time line. It fostered relationships and methods of communicating that will far outlast its formal expiration date. Within a short period of time, the program began delivering high-quality health management education to a wide range of students, from the undergraduate to the postgraduate level and, perhaps most important, included nurses and both mid- and top-level health managers. The changes facilitated by USAID in this program have quickly been institutionalized.

ANNEX G

QUALITY ASSURANCE/QUALITY IMPROVEMENT ACTIVITIES

Background

Whatever their delivery or payment structure, all health care systems face the problem of ensuring that care meets requisite quality standards. In the Czech Republic, a general quality assurance (QA) mechanism was in place before the revolution. But, for the increasingly decentralized environment of the Czech health care system that evolved after November 1989, the prerevolutionary quality system lacked sufficient focus and adequate differentiation among facilities. Consequently, provider privatization, patient choice and fee-for-service payment, and issues of quality and the related matters of medical appropriateness, hospital licensure, and the credentialing of physicians providing services grew increasingly important as the Czech system moved rapidly from a centralized, state-run system to hospital autonomy. Thus, when the Czech government initiated a new process of medical quality measurement and assurance with USAID's assistance in June 1993, the Ministry of Health, the General Health Insurance Company, and the Czech Hospital Association supported the process enthusiastically.

As defined by the MOH, the Czech medical quality program initiated in 1993 is "customer-tailored" and was driven by

- the desire for improved quality of hospital care and competitiveness in quality of care among hospitals;
- cost control objectives. The surplus of acute care facilities is a major factor in the current Czech cost difficulties. An effective, professionally accepted accreditation system could help identify both high-quality facilities that should be preserved and substandard units whose closure would improve overall system quality and efficiency; and
- the need for definition of quality in primary care, including standards of both education and service.

While the primary objective is to improve quality of care delivered by health professionals to their patients, improved efficiency and cost control may ultimately be significant byproducts.

An effective quality assurance/quality improvement effort requires data collection, standards against which to measure, and a feedback/education process. All of these elements are part of the evolving quality assurance process emerging in the Czech Republic. While USAID's support has in part been financial in terms of supporting tours and study seminars, the agency's efforts in arranging consultancies have perhaps been even more important. USAID-supported U.S. experts have worked as colleagues with Czech participants and have helped guide the overall process.

Program Description

When QA uses broadly applicable and objective data-gathering and evaluation procedures and involves health care workers in these efforts, the result is an enhanced commitment to building a health care system that provides high-quality, cost-effective care. The establishment of both internal QA standards in hospitals and polyclinics as well as external QA in the form of standards, licensure of physicians and other professionals, and accreditation of facilities are all components of the quality-enhancing structure and process. USAID has assisted in all QA activities in the Czech Republic by

- assisting the Czech Society of Nephrology and Dialysis in setting standards for kidney dialysis services and initiating the Medical Chamber's oncology standard-setting procedures;
- helping hospitals undertake patient satisfaction surveys;
- guiding the Medical Chamber in its exploration of the potential role of licensure and continuing medical education in quality assurance;
- using seminars, intensive consultations, journal articles, hospital and medical association publications, and other information feedback tools to share information and findings across the medical spectrum generally and with specific provider hospitals, physician groups, and nursing organizations as appropriate;
- sponsoring a mobile seminar (March 1994) organized by USAID's consultant. Five Czech physicians made site visits to Georgetown University Hospital, Penn State Medical Center, the Cleveland Clinic Foundation, and the Joint Commission on Accreditation of Health Organizations (JCAHO); and
- assisting the MOH and the hospital association in working with the JCAHO to explore use of U.S. hospital accreditation standards, modified as necessary to the

Czech environment and, based on that work, pilot testing revised accreditation standards.

Results

A process and broad program of quality-of-care-enhancing activities have been initiated with strong support from the Czech Medical Chamber, MOH, hospital associations, and nursing and specialty societies. But quality assurance/quality enhancement activities are continuous and never finished. In many ways, the most important result may be that Czech participants in the health care system have come to understand and now fully accept this principle.

In addition to the acceptance of the underlying principle that quality assurance/quality enhancement is a process, the project has realized a variety of substantive accomplishments. For example,

- respondents indicate that the significant reductions in patient length of stay and nosocomial infection rates are largely outcomes of the quality assurance process and its activities.
- in January 1996, the Institute of Postgraduate Education held a seminar for 60 health insurance company representatives on the economic aspects of quality assurance/improvement. It was the first time that these health insurance company representatives had been exposed to the principles of QA, with much interest expressed in the economic implications. As a first step, with the encouragement of insurers, the Ministry of Health, the Medical Chamber, and others, a generic quality “checklist” was developed and is now used by most Czech hospitals to collect data on the care of their patients. In general, it is possible to undertake cross-hospital comparisons of checklist items. Again, USAID consultants played a substantial role in checklist development.
- in May 1995, the Ministry of Health established an office to develop a process for accreditation. A committee was established and USAID's chief QA consultant was invited to serve as its adviser.
- the capstone to the hospital-related quality assurance efforts will be implementation of a formal Czech hospital accreditation process. Surveyor training is nearly complete, and full implementation of the accreditation program is planned for late 1997.

Conclusions

The quality assurance/improvement process is dynamic, continuous, and evolving. The goals of the current program have been to describe and explain QA, promote implementation of quality improvement programs at the facility level, establish pilot studies that can be used for national standard setting, and set the background for the development of a national hospital accreditation program. Future activities should build on the current base of programs and logically expand QA activities.

Future activities are likely to include

- consultation with individual health care facilities as to the best means for determining national standards of care in medicine and nursing, how to document standards, and how to make improvements in quality of care based on the results;
- accreditation of ambulatory care facilities with emphasis on primary, continuing, and preventive care—assuming that the MOH assisted by the JCAHO moves ahead with hospital accreditation as scheduled;
- accreditation of continuing medical education (CME) programs; and
- licensing, certification, and credentialing of physicians. The Physicians Chamber is involved in exploring these activities, but beyond licensure no process or standards are yet in place.

ANNEX H

INSURANCE SECTOR ACTIVITIES

Background

The Czech General Insurance Company (VZP) and its fellow health insurance companies are somewhat anomalous entities in purpose, form, and function. Following more than 40 years of communist rule and reliance on the government budget for health care's single-source legitimate funding, the postrevolution government decided to move health care off the general tax-based state budget to a wage tax-based general insurance system. That system, for which VZP was the sole “administrator” for a period, was designed to accomplish several goals, including

- facilitate privatization of the provision of health care and provide at least partial independence from the political process;
- increase resources for the health care sector even while moving a sizable claimant to off-budget government monies by substituting for tax revenues a dedicated special, mandatory, wage-based and income-related health “premium” for all workers, with government subsidies for nonworkers, including children, students, and pensioners; and
- separating funding from the provision of health care by moving, to the extent possible, both provider and payer out from under direct government control. This, together with a fee-for-service payment system, has given providers substantial benefits. Physicians, on the one hand, have generally realized enhanced prestige and income. Hospitals have generally secured considerable flexibility in both resource management and organizational independence. Both physicians and hospitals have gained treatment flexibility.

While all participants speak about those entities responsible for making provider payments as insurers, VZP originally and its fellow companies subsequently have no acknowledged control over benefits, lives to be covered, or wage tax levels to be charged. By law, all insurers must provide to any citizen who seeks coverage the same benefit package at the wage tax rate that is invariant among insurers, over employer companies, and with regard to age, sex, or geographic location of employment or residence. In addition, the law permits no variation from the government-defined benefit package, with the mandatory “price” set by the government at 14.5 percent of wages, with two-thirds paid by the employer and one-third by the employee.

The result is mandatory universal coverage, no substantive interinsurer competition, and fee-for-service payment rates through a modified German/Dutch “point” system, all in the context of a global national budget derived from a wage-tax formula.

Project Description

Perhaps no single component of the Czech health care system has received as varied and continuous a package of USAID-sponsored assistance as VZP specifically and the insurance sector generally. Beginning in August 1991, USAID conducted seminars for MOH staff on insurance principles and management issues. In March 1992, a U.S. study tour was conducted for the newly appointed VZP director. During that tour, the director met with actuarial, policy, and political staff of the U.S. Medicare program—which, for the American elderly, generally parallels the insurance program the Czechs were then putting in place—and with staff of HMOs and indemnity insurance companies.

Throughout 1992 and 1993, several U.S. expert missions and consultancies to the Czech Republic took place that

- provided assistance to VZP on payment methodologies, hospital-insurer relations, administrative and organization structure, the point system of payment, management and payment information systems, medical review principles, and the potential for adverse selection;
- trained staff in policy and actuarial analysis, copayment approaches, HMO care delivery principles, and DRGs as an information-collecting mechanism and payment approach; and
- provided similar “how to do it” training to representatives of the new companies as the parliamentary act establishing multiple insurers moved toward implementation and trained government personnel in the regulatory needs of a multi-insurer system, especially with regard to assurance of financial stability—including potential adverse selection, reinsurance, and cross-subsidy issues—and protection against waste, fraud, and abuse.

This pattern of frequent, multiple expert assistance consultancies has continued even to the present day. As USAID prepares to terminate its assistance role in the Czech Republic, a closing action is assistance to VZP to bring “in house” the software (the “grouper” algorithm) needed to run a DRG system in the Czech Republic.

Results

Certainly, the advice and caveats about competitive insurance models and mechanisms provided incidentally by USAID consultants have not led to price or benefit competition or to product differentiation among insurers. For better or worse, USAID has not engendered an American health insurance market in the Czech Republic. To the extent that the assessment team could discover, however, the development of such a market has never been USAID's goal, purpose, or intent. Rather, USAID's intent has been to support Czech goals to establish a stable financing system capable of underpinning private provision of health care. The agency did this through the provision of expert advice from its own and consultant personnel.

VZP's director demonstrated his appreciation for USAID assistance by commenting that

- his initial USAID-sponsored meeting with Medicare's actuary and policy staff had been among the most important since VZP's founding in laying out the borders of the world into which he was venturing;
- personnel from USAID's Washington office and consultants from the Department of Health and Human Services had been especially helpful and intellectually challenging;
- USAID's mission in Prague often had gone to extraordinary lengths to facilitate the provision of requested assistance;
- VZP had implemented several of the suggestions and recommendations made by USAID's staff and consultants. The suggestions had proved useful to the effective accomplishment of VZP's work; and
- he saw in the forthcoming implementation of DRGs the hope for major breakthroughs in improving hospital efficiency and controlling health care costs.

Conclusions

As discussed in the body of this report, VZP is an independent parastatal entity that reports to the Parliament. Since the director is not a political appointee, VZP in particular bears major responsibility for trying to “fix” significant problems in the Czech health care system. The most notable problems include escalating costs and excess acute care hospital capacity. Whether the insurers prove themselves up to these challenges and/or successfully gain political support in addressing them remains

unclear. But of the major participants, VZP stands out not only among insurers but among virtually all other players with regard to vision, direction, stability, and leadership. In the judgment of the analysis team, USAID has been critical in providing many of the tools used by VZP in accomplishing its organizational goals.

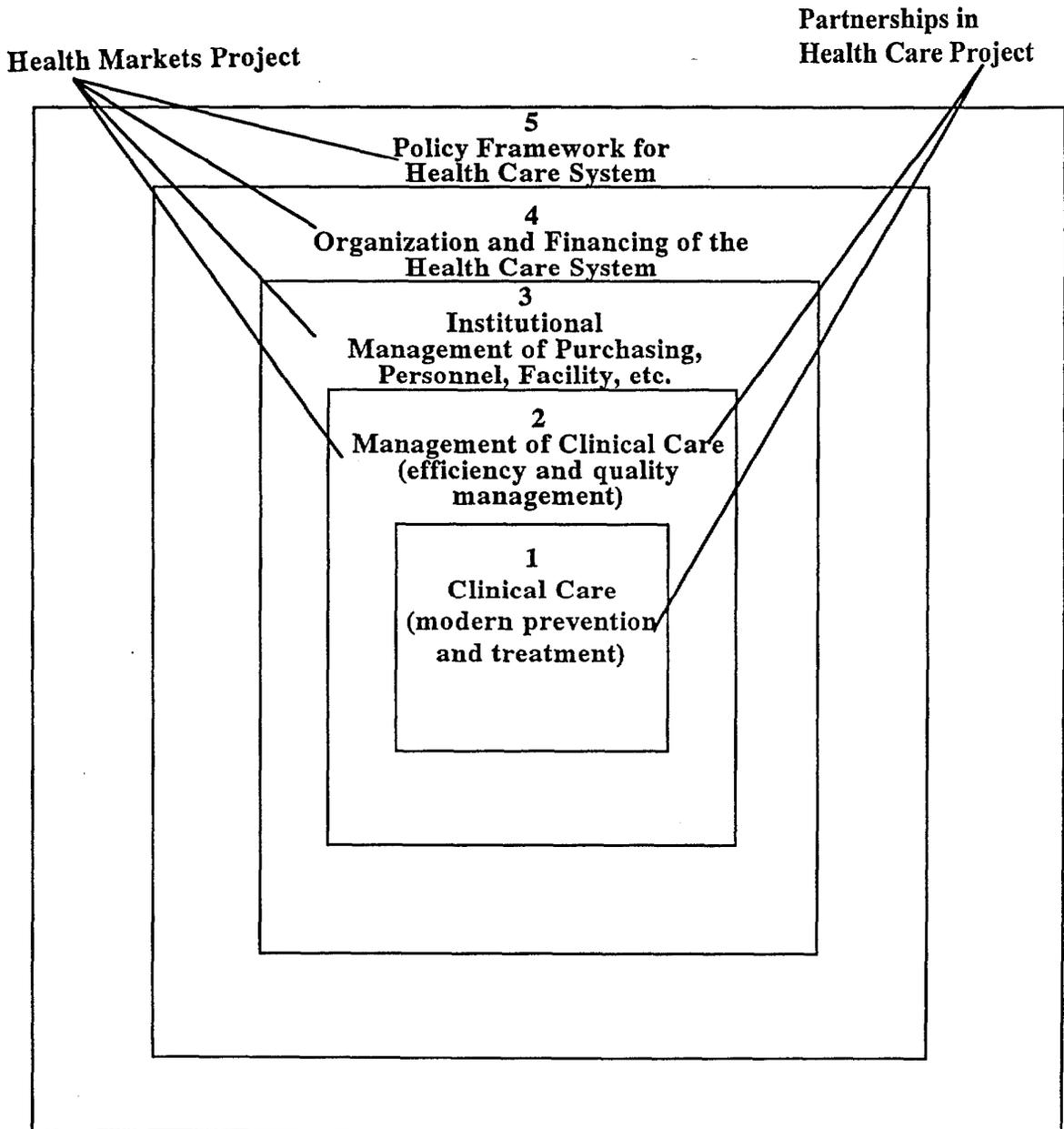
ANNEX I

HEALTH STRATEGY IN CEE

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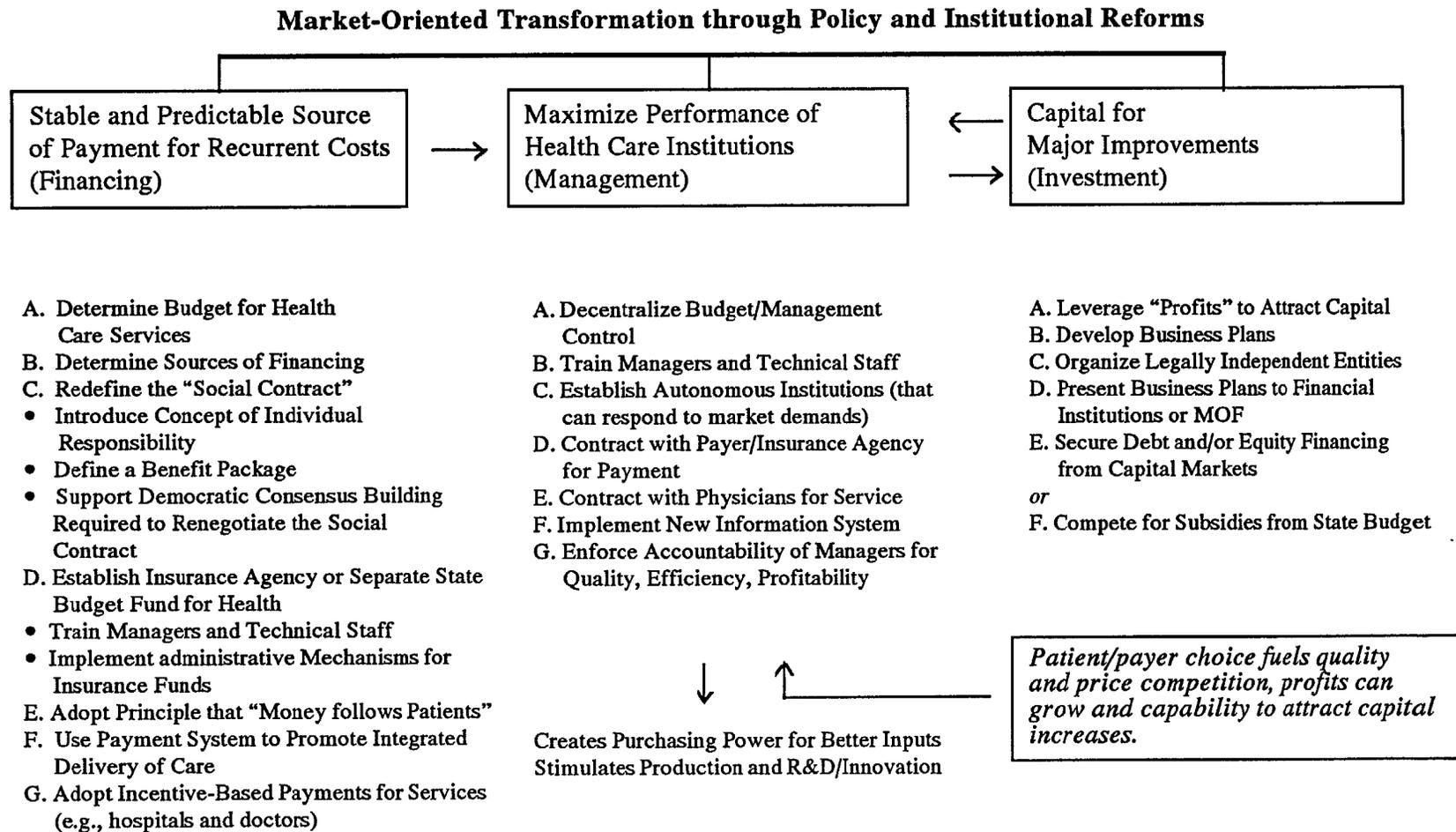
**ANNEX I
Health Strategy in CEE**

**Transforming the Health Care Sector
Improving Health Status**



Intersection of two initiatives is in improving management at the level of health care facilities

FIGURE 1: Improve Health Status and Increase Productivity of the Health Care System



ANNEX J

HEALTH SECTOR ACTIVITIES IN THE CZECH REPUBLIC

1. Emergency medical assistance (Project Hope through the Schools and Hospitals Abroad Program)
2. Policy dialogue on general direction of health reform (HEI, DHHS/HCFA, Squire, Sanders & Dempsey [SSD], CEELI, and USAID)
 - Market-oriented reform and the social contract
 - Decentralization, competition, and privatization of the health sector
 - Asset transfer strategies for improved health sector performance
 - Redefinition of functions of the Ministry of Health
 - Creation of a not-for-profit sector
 - Capital formation and the introduction of municipal bond financing
 - Training programs in financing, incentive payment, system restructuring, information systems, etc.
3. Capacity building in launching National Health Insurance with multiple purchasers (DHHS/HCFA, USAID, and HEI)
 - Concepts of health insurance
 - Role and functions of insurance companies
 - Actuarial-based insurance analysis
 - Health insurance operations management
 - Role of health care financing in achieving service delivery reform
 - Incentive-based provider payments systems—diagnosis-related groups (DRGs), Ambulatory Patient Groups (APGs), capitation, copayment structures, etc.
 - DRGs as clinical management tool
 - Medical appropriateness review and utilization monitoring
 - Analysis of regulatory framework for private “branch” insurance companies
 - Training in principles of managed care and health maintenance organizations (HMOs)
4. Hospital operations improvement programs (HEI, ElectroTEK, and PIET)
 - Hospital operations improvement in context of new payment systems
 - Financial management systems
 - Equipment maintenance scheduling system

- Nursing acuity-based staffing
 - Energy audits of hospitals
5. Quality improvement methodologies (DHHS/HCFA, HEI, JCI, and USAID)
- Patient satisfaction surveys
 - Internal hospital and polyclinic quality improvement systems
 - Introduction of licensing and accreditation function for health care facilities
6. Health management education partnerships (AIHA)
7. Improvements in clinical care and social services (UCSF, CECHE, PIET, and the American Jewish Joint Distribution Committee)
- Secondary prevention of heart disease
 - Health promotion
 - Breast cancer screening
 - Family planning management
 - Community-based services for the mentally disabled
 - Community-based advocacy and services for disabled children
8. Analysis of investment opportunities (HEI)
- Privatization of SEVAC, a vaccine production enterprise
 - Investment promotion mission
 - For-profit PPO and HMO
9. Capital Development (HEI)
- Community-based fundraising for social service organizations (alternative sources of capital)
 - Corporate citizenship and foundation development

ANNEX K

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