1. INTRODUCTION

The general status of the health care (HC) system in the Czech Republic has been determined by a quite radical and rapid reform process that started in the early 90s. It was shaped by the relatively high capacities of the old Czech HC system and a widely shared willingness to increase HC resources in the first year of the reform. The reform itself has introduced a new system of public health insurance and changed completely the situation with respect to HC providers’ autonomy and financial conditions. The reform has introduced a new system of public health insurance and changed completely the situation of HC providers in terms of their autonomy and financial conditions. It also reversed the set of measures and tools available to public authorities reformulating health policy. It brought a new player into the system – an independent payer -- health insurance companies (HICs).

The ability to respond to major system changes has proven to be quite remarkable within the community of health care providers, as well as within HICs. In spite of the constant concerns of many interest groups, including politicians and patients’ associations, there has not been any deep crisis of the system. On the contrary, the quality of care was evaluated as “good” in many public polls in the first years of the reform. Needless to say, there are certainly many shortages and other issues in the Czech health care system. Wasted funds, the growing indebtedness of many health providers (especially hospitals) and the still unclear role of new regional authorities in the system are among them.

The reform has not been completed yet and one can see government attempts to reverse some of fundamental principles, i.e. putting the control over the system back in the government’s hands, bringing back a larger role for government, diminishing “harmful and contradictory” competition that is no longer ideologically desirable in public services, etc.

Education and training programs seem to have had a growing influence on enhancing the capacities and skills necessary for managing such changes. First, programs were mainly run by foreign aid agencies (i.e., Project HOPE), and they addressed top management, such as directors of large health facilities, in order to provide them with managerial skills important for the new “market” economy. Very rapidly, several national institutions (universities and others) developed their own programs. Most of them combined business and management education and training with an introduction to health care economics. Their target groups were current and potential managers and administrators of health care facilities as well as health professionals (e.g., physicians and nurses). This orientation was quite understandable. It was the consequence of the significant increase of autonomy and decentralization in the system.

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1 Public Economics Department, School of Economics and Administration, Masaryk University, Brno, Czech Republic.
2 Examples of courses were human resources management, planning, and financial management.
The other relevant field of competence – public health administration and policy – seems to have fallen behind (not only in terms of number of programs and their graduates, but in comparing their real impact on the system). There is a widespread belief that public authorities’ abilities to create and implement visions, strategies, policies and preferences resulting from thoughtful analysis are limited. Naturally, there are many reasons for this, and a failure of education and training programs in this field is definitely not the main one. However, given the current situation in public health administration, management and policy education and training programs, increasing the quality and availability of “pure” public health administration and policy programs for (mainly) public officials at the regional and the central level should be a priority for the next several years.

2. PUBLIC ADMINISTRATION SYSTEM AND ITS REFORMS

The Czech Republic (CR) and its public administration (PA) followed the same orientation and ideology as the other socialist countries of Central and Eastern Europe after the World War II. There was a centralized, hierarchically organized system of regional, district, and local “National Committees” (NCs). Formally, it was a joint model of public administration (NCs were institutions of self-government as well as state administrations). However, since there was virtually no split between professional administration and communist party structures, the self-government part of this model was marginal.

After November 1989, there was an urgent need to rebuild the whole system. Democracy could not be fully achieved within the old environment. An increased role for local self-governments and the decentralization of government responsibilities and financial resources, etc. were seen as the main means for reaching the following objectives:

- giving greater credit to effective PA within the public sector;
- changing PA from a tool of the state to a modern concept (i.e., view “PA as a service for citizens”); and
- fighting corruption and improving accountability.

LOCAL AND REGIONAL PUBLIC ADMINISTRATION AND ITS REFORM

In 1990, the structure of National Committees was abolished and a new Municipal Act (367/1990 Sb.) was adopted. At that time, the only level of regional self-government was the municipal level, although a potential second level was frequently discussed. It took several years of political battles to reach a political consensus on the major issues, which included:

- whether the primary principle should be to respect territorial aspects or to renew the historical “countries” of Bohemia, Moravia, and Silesia;
- the number and size of regions (including the very controversial issue of a “capital” of each region); and
- whether to use a traditional joint model of governance or to apply a separate model that divided self-government and state administration into two different bodies.

On the other hand, state administration itself was executed at three levels at that time:

- the local level, executed by municipalities (again, the so-called joint model of PA);
the district level, where new District Offices (DOs) were established as executive bodies, with a general jurisdiction; and

- the central level, with a Cabinet.

There also were special (so called “de-concentrated”) executive bodies in the districts and even former regions founded and administered by particular ministries (e.g., Labour Offices, Offices for Social Security, etc.). There was no coordination between ministries, however, and this vertically organized scheme of state administration suffered from a lack of cooperation between the different branches of state administration.

There was a clear lack of proportionality in this system, as well as a lack of opportunity for comprehensive regional development. This was accepted by the Cabinets that followed. As a result, a second-level of regional self-government was finally established in 2000. Fourteen regions were set up. The government chose the joint model of PA. The logical consequence was the proposed abolition of the District Offices in 2002. This step raised a serious concern and was heavily criticized as too risky, because DOs were probably the most stable and most effective part of state administration. There is still a concern about the ability of municipalities to handle all necessary responsibilities.

Although it is too early to evaluate the outcomes of these changes, the main issues linked to this part of the PA reform can be identified:

- with respect to property matters, the entire process consists of numerous complex transfers (mainly top-down) of ownership, liabilities, and rights among various levels of government;
- regarding financial flows, determining a proper share from centrally imposed taxes to be transferred to regional budgets to support the new responsibilities at this level seems to be a task that will require several years of negotiations, evaluations, and analysis;
- delimiting the responsibilities of former district officers is an example of the naturally colliding interests of different levels of government; the regions and municipalities fought hard against a centrally managed shift,\(^3\) and
- the “state” (the central level) has to learn how to pursue national priorities and policies within a different environment; with the shift of former “state” institutions to regional ones, the central government seems to be slow in preparing legislation to enable it to maintain national standards in various branches of public services.

**REFORM OF STATE ADMINISTRATION AT THE CENTRAL LEVEL**

The central level of the state administration has seemed to be out of focus for a long time - with the European Commission, the OECD, and the Council of Europe repeatedly criticizing government decision making processes as overly centralized, too complicated, and unclear. Human resources at this level were criticized, also. However, until 2001 changes were just marginal. “There was a fundamental failure in a wrong belief [about the government] that there is no need for reform on a central level …” (Vidlakova 2001:41).

\(^3\) More than 14,000 working places had to be shifted.
In 2001, the Cabinet adopted the “Conception of Modernising the Central State Administration” in which short-term and middle-term priorities were presented. Harmonization of the internal organization of ministries and other central offices was to be achieved by 2002. Increased efficiency and coordination of horizontal responsibilities and processes, better management, and the enhancement of strategic and conceptual functions were set as middle-term priorities.4

Since 2002, the new government has declared the “beginning” of the central state administration’s modernization as its priority program. The government’s main objectives are greater efficiency, more rational decision making, the broader use of advanced technologies (including e-government), and the introduction of managerial methods.

EDUCATION AND TRAINING FOR PUBLIC OFFICIALS

In 2001, the European Commission criticized the Czech Republic for a “regrettable” absence of the proper legislation needed to insure sufficient professional status for public officials -- including a system of permanent education and training. Several attempts were made to pass the Public Service Act addressing this issue. Parliament always blocked the government’s proposals, even though major political forces generally agreed on the necessity to increase the professional abilities of officials. Thus, there was no coordinated system of education and training for the PA and human resources management was poor. An essential objective of PA reform was to solve these issues through the compulsory education and training of public administration officials.

The year 2002 represented a breakthrough in this respect. Two major acts were passed: the Civil Service Law (218/2002 Sb.) and the Public Service Law (312/2002 Sb.). As a result, the position of public officials has become more solid; at the same time, compulsory education and specific duties were imposed on them.

A sophisticated permanent education and training system was established by the latter act. Officials must participate in specific programs that are approved and monitored by a special government agency but that may be provided by various accredited institutions. The process of accrediting training institutions and programs began in 2002; the programs themselves began in 2003.

3. HEALTH CARE SYSTEM

Although the transformation of the Czech health care system is not yet complete, it can be described as a relatively well-equipped system, providing high quality health care as well as relatively equal access to health care. The health status of the population is improving, and a significant prolongation of expected life span has occurred (see Graph 1).

4 The European Union PHARE project is essential for this effort.
There is definitely not an alarming crisis of the health care (HC) system in the Czech Republic. There still are, however, several unpleasant failures in the system. The entire system seems to suffer from growing financial instability. The Ministry is said to have inadequate capability to control the system. The same (or perhaps an even worse) situation exists at the level of the newly created regions since their roles and responsibilities also are not clear.

**HEALTH CARE REFORMS**

There was a need for significant changes in the HC system even before 1989. Health professionals spoke openly about a rising crisis in the system. The fall of the former Communist regime opened the door for radical reform. The first reform proposal was published in 1990. The Working Group for Reform (SKUPR), representing a large part of the health professionals’ communities (mainly physicians, academics, and economists, etc.) advocated the following reform principles, which were more or less realized through future reforms (SKUPR 1990):

- transparency;
- economization;
- democratization;
- humanization; and
- a higher standard of quality of care.

The new system brought especially radical changes in organizational and institutional structures, funding, and reimbursement methods.

**Changes in Organizational and Institutional Structures**

An important part of the reform was the separation of payers and providers of care. A new participant in the system was established – Health Insurance Companies (HICs). A contractual model replaced an integrated one. Existing institutions (so-called National Institutes of Health, or UNZs) were transformed into a network of independent, relatively autonomous health care facilities that became regular legal entities making decisions in their own name. While there were only about 430 health care facilities in 1991, by 1995 more than 22,000 existed (a physician’s private practice was considered to be an independent health care facility). New non-state and
private facilities were founded. State institutions were transferred to municipalities, some hospitals were privatized, and most outpatient care was privatized, also.

*Changes in Health Care Funding*

The transformation from a NHS model funded through the government budget to a system of compulsory, universal public health insurance was possibly the most important element of the reform. There were several reasons for this strategic change:

- It was important to keep the current level of broad access to care for all citizens as a central pillar in the new system.
- Health insurance has had a long tradition in Czechoslovak history and also is quite common for the Czech Republic’s neighbouring countries in Central Europe.
- There was a widespread belief in the need to introduce new methods of reimbursement for medical care which reflected the quantity and quality of care.
- Insurance (a contractual model) created an environment that was much more friendly for the privatization of medical services.
- The need to make financial flows more transparent in order to make the public more aware of the real costs of (i.e., the expenditures on) medical care; the belief was that this approach would create an incentive for the general public to be more responsible and take better care of their own health.

The system was designed as a multiple payer one. HICs are not-for-profit, public-law, self-administered entities, although special legislation (adopted in 1991-1992) strictly regulates their functioning. HICs are open; citizens may choose their insurers.

Health care is funded from several sources (see Table 1). The main source is public insurance premiums collected by HICs. Employees, employers, and the government pay insurance premiums, with the amounts based on income. Out-of-pocket payments represent less than 10% of total expenditures (mainly for drugs); and public budgets have played a more important role here.
Table 1. Health Care Expenditures (million CZK)*

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TOTAL</th>
<th>PUBLIC</th>
<th>PRIVATE</th>
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<tbody>
<tr>
<td></td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td></td>
<td>Total, including</td>
<td>Central and Local Budgets</td>
<td>Health Insurance Comp.</td>
</tr>
<tr>
<td></td>
<td>(3) + (8)</td>
<td>(3)</td>
<td>(8)</td>
</tr>
<tr>
<td>1993</td>
<td>45,652</td>
<td>43,552</td>
<td>36,971</td>
</tr>
<tr>
<td>1994</td>
<td>73,062</td>
<td>69,262</td>
<td>6,114</td>
</tr>
<tr>
<td>1995</td>
<td>86,418</td>
<td>81,136</td>
<td>7,052</td>
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<td>1996</td>
<td>100,675</td>
<td>93,309</td>
<td>7,674</td>
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<tr>
<td>1997</td>
<td>110,662</td>
<td>102,400</td>
<td>7,212</td>
</tr>
<tr>
<td>1998</td>
<td>118,914</td>
<td>109,033</td>
<td>7,015</td>
</tr>
<tr>
<td>1999</td>
<td>129,871</td>
<td>119,267</td>
<td>6,408</td>
</tr>
<tr>
<td>2000</td>
<td>141,871</td>
<td>123,453</td>
<td>7,164</td>
</tr>
<tr>
<td>2001</td>
<td>158,799</td>
<td>145,096</td>
<td>8,052</td>
</tr>
</tbody>
</table>

* Excludes expenditures of other government departments (approximately another 1,000 million CZK).
1) Reported in the central government’s budget (the year 1992 had a special financial regime).
2) Calculations by ÚZIS ČR, based on regular statistics of “households’ budgets” (ČSÚ).
3) Estimated by ÚZIS ČR.


The impact of the reform on the system’s overall financial situation is clear from Graph 2. The introduction of the new insurance scheme was associated with a sharp increase in expenditures. The system has had to search for a financial balance, and this is still a major issue.

Graph 2. Health Care Expenditures as Share of GDP (%)

Source: ÚZIS (2002).

Changes of Reimbursement Methods

Formerly, national health system institutions were paid from annual general budgets based on historic cost patterns. Even in the late 1980s, this method was criticized as providing strong economic disincentives. There was no linkage between either quantity or quality of provided care and reimbursements for physicians and the health facilities.

The new system applied a fee-for-service scale, with a cap on total health care expenses. It applied to all services, including in-patient and general practitioner (GP) care. This appeared to
be a mistake after a short time, and important changes were adopted in 1997. A combined capitation-performance payment was introduced for GPs, and hospitals began receiving mostly lump sum payments - based on their output in the previous year.

**IMPACT OF REFORM CHANGES ON HEALTH CARE MANAGERS’ PROFESSIONAL PROFILE**

In the past, the typical hospital director was a physician with some postgraduate training and special attestation. Health care services were considered to be a field of “social consumption”; the system was highly centralized, with each facility having limited autonomy. This naturally had certain direct implications on the prevailing professional skills of managers. Since the only economic task was to stay within the budget, there was absolutely no data on cost of services, and managers had limited knowledge about actual output. Economic criteria played only a marginal role in decision making, especially with respect to investment, new equipment purchases, and the like.

The reform created an entirely new environment for health care providers. Skills essential for the successful management of independent health facilities (e.g., financial analysis and management, strategic management, managerial/business accounting, marketing, information systems management), were lacking. Essential skills in the field of public health policy and administration were missing, too, but this absence was less evident and, except for a few academics, nobody was overly concerned.

Starting from the first years of the reform, filling this gap was an objective of many education programs. Some foreign aid agencies (e.g., USAID, Project HOPE, World Bank) initialled pioneering programs in this field. The supply of managers with the necessary new skills increased, driven mainly by local universities and professional education agencies.

Nevertheless, as the Czech Republic faces probably its biggest health care challenge in the past five years, namely, the introduction of the regional level of self-government and the determination of its proper role within national health policy (under growing pressure due to resource scarcity), the persistent lack of public policy and administration skills is more apparent.

**4. PUBLIC ADMINISTRATION EDUCATION AND TRAINING PROGRAMS**

Skills and knowledge are essential for the successful implementation of reforms. The education and training system in public administration/public management (PA/PM) has three main target groups:

- regular students – young people looking for future careers; universities and other schools within the education system primarily provide programs for them;
- current state administration officials at the central level – they seek mainly short-term training and education programs that are offered by various institutions. Part-time university degree programs are available to them; and
- current regional and local public administration officials – a system for their training and education is an important element of the reform. Special legislation (Public Service Law, 312/2002 Sb.) was adopted to build up a comprehensive system of education and training for this group.
**ACADEMIC PROGRAMS IN PA/PM**

Programs in public administration/public management are offered by high schools, upper vocational schools, and universities. These institutions primarily offer basic education for future public administration officials, but they also provide more advanced education for officials and offer some training courses.

Universities represent the main part of this system. In 2003, there were eight faculties/schools (in Prague, Brno, Pardubice, and Ostrava) with comprehensive bachelor’s, master’s, or doctoral programs in public administration or regional development. Courses in public administration or in related subjects like public finance, local finance, public economics, and administrative law also are regularly incorporated in many other programs (Wokoun and Nemec 2000).

There is growing interest in PA/PM study in the Czech Republic. In addition to the traditional schools (University of Economics in Prague (3 faculties), Charles University in Prague, Masaryk University in Brno, University Ostrava, University Pardubice), new private universities are seeking to provide bachelor’s programs in PA/PM. One of these institutions, for example, “Vysoká Škola Finanční a Správní” (The School of Finance and Administration), focuses exclusively on public administration officials.

Given the relationships between public administration and the formerly underestimated regional problems, on the one hand, and the provision of graduates in territorial administration, on the other hand, schools have begun to provide a common major field of study in public administration and regional science.

The universities’ main role is to prepare future employees for public administration. They also offer part-time programs (mostly at the bachelor’s degree level) for current public administration employees and play an important role in the new system of education for regional self-government officials by offering short courses and special training programs under the supervision of the Ministry of Interior. In addition, universities serve as important centers for research and development.

**TRAINING FOR STATE ADMINISTRATION OFFICIALS AT THE CENTRAL LEVEL**

The Civil Service Law created a basic framework for this system; however, the law will not be fully implemented until 2004. It addresses the obligation to provide education and training activities for officials and to organize them for state authorities. The State Official Examination is defined in great detail.

There are three different categories of education and training:
- that provided by the special educational institutions; in particular, government departments;
- programs conducted directly by the institution employing an official; and
- education and training purchased by authorities from other institutions, domestic as well as foreign ones.
Central authorities establish departmental training institutions whose task is to provide special training for officials working within the departments. The Diplomatic Academy, Police Academy, and Institute of Postgraduate Education for Health Care Professionals are examples of such institutions. The Institute of State Administration (IMS) has a special position. It was founded as a result of the Civil Service Law and is supposed to fulfill special tasks, e.g., organize cross-sectional programs, provide information services for all central authorities, and guarantee the quality of the entire national training system. The IMS also is participating in the definition of requirements concerning the educational profiles of state officials. [This role of the Institute is significantly underdeveloped, according to some of its employees.]

Various ministries frequently use foreign aid resources (e.g., the European Union PHARE program; individual donor nations) to provide advanced education for their officials.

**TRAINING FOR REGIONAL AND LOCAL AUTHORITIES’ OFFICIALS**

A completely new, comprehensive training system for regional and local officials was initiated in the Public Service Law (312/2002 Sb.). The law provides that officials have an obligation to take part regularly in proper training under an individual qualification plan. Authorities are either supposed to provide an accredited program for regional and local officials, or to purchase them. There are four kinds of programs:

- “entrance training” for new employees;
- required “Special Professional Abilities” (ZOZ) courses, which include special final examinations, for certain officials;
- “general training programs,” which include a variety of programs enhancing officials’ special knowledge of administration; and
- education for executive officials -- to be completed within four years by any official who leads subordinates.

Programs include modules that can be combined in different ways. Institutions offering any program to public administration authorities, as well as programs themselves, are subject to the approval (accreditation) by the Ministry of Interior and its Special Accreditation Commission.

The Commission started its work in October 2002, and thus far it has approved several hundred programs offered by very different educational and training institutions. Almost all regions have created their own educational capacities in order to provide at least entry-level training for their employees and for the municipalities in their jurisdictions. Many private companies compete for this stable and interesting education and training business; not-for-profit organizations, including universities, also are involved (the number of entitled officials is in the tens of thousands).

**Problems of Accreditation Process**

The system of accreditation (relating to the right to deliver training programs for civil servants within the framework of the Civil Service Law) illustrates issues of rhetoric and reality regarding public policy and its implementation (issues that are symptomatic of the entire Central and Eastern European region). The accreditation process has been implemented in a way that can easily serve as an example of typical government failures, primarily due to limited control over the bureaucracy and the limitations imposed by political processes (Stiglitz 1988). The
government is hardly able to implement its policy in a consistent way; it especially has failed to transform generally relevant and desirable principles into proper legislation.

The new civil servants’ education and training system is supposed to be built upon the progressive principle of managed competition. A new market of education and training programs provided by public and private entities was envisioned. Regional and local authorities were supposed to have the opportunity to choose the most appropriate programs for their civil servant employees relative to the prices and orientations of the programs.

Quality assurance is clearly a key goal of this system. Many education and training programs and providers in the past have been evaluated by their participants, or by public authorities, as incompetent, of poor quality, obsolete, and worthless. Lecturers often know little about public administration, and their pedagogical skills were low. Local and regional public administration representatives sought a clarification of the education and training market, and the setting of rules to avoid the problems of the past.

Consequently, the new system of education and training introduced a process of accreditation (analogous to the accreditation system that works well in the field of university education). A special Accreditation Commission of the Ministry of Interior was created to approve training programs as well as the institutions offering them.

During the process of approving the relevant legislation in the House of Representatives, the text prepared by experienced officials from the Ministry of Interior was substantially changed. Due to the influence of public administration employees’ trade unions, almost all provisions requiring officials to pass any examinations “disappeared” from the proposed bill.

In addition, the process of the gradual “specification” and “clarification” of the formal requirements for accreditation proposals, as well as conditions for approval, have greatly limited the opportunities for any real assessments, evaluations, and decisions by the Accreditation Commission. Its role has come to be quite formal. Even some members of the Commission (who are nominated from respectable academic and/or professional quarters) admit that they deal more frequently with the purely formal requirements of applications rather than assessing a program’s real value in terms of the quality of the content, lecturers, and the like. Accreditation is sometimes granted even though none of the Commission members truly believes the applicant is able to deliver a quality program. The entire process seems to have a typical Czech, “Kafkaesque” feature: the new law is obeyed, but the old reality stays the same.

5. CURRENT EDUCATION AND TRAINING ACTIVITIES IN THE AREA OF HEALTH CARE ADMINISTRATION, MANAGEMENT, AND POLICY

The need for a higher level of managerial skills, including knowledge of public health management and policy, has been evident from the beginning of the reform. Until the early 1990s, only one institution offered postgraduate education in the management of health care facilities and public health, the Postgraduate Education Institute for Medical Professionals – School of Public Health (IPVZ). Its curricula reflected both the different ideologies and the different positions of the entire health care industry.
Some health policy or public health courses were taught at medical schools. Programs addressing health care administration, management and policy, as currently understood, generally did not exist.

This gap was filled for several years in the following ways:

- IPVZ modernized its study programs, underwent substantial changes, and became a more flexible, demand-oriented institution.
- International aid was essential for strengthening early initiatives, especially the program provided by Project HOPE, through which many hospital directors were trained; programs supported by the World Bank (Flagship programs) and USAID/AIHA also significantly improved the professional skills of health care workers and academics.
- Later, universities, and some private firms, entered the market, offering MBA and other programs for health services managers as well as short-term courses such as business accounting and financial management.

The current scope and scale of education and training activities for health managers and policy makers is much broader (see Appendix A and Appendix B). However, the dominant segment of current programs focuses mainly on managerial skills (and these programs are primarily offered to health care administrators and hospital managers), rather than on necessary public administration and public policy knowledge. An ability to design a public health policy and to implement it in a given region or community is simply not covered sufficiently.

There are several reasons for this lack of coverage, both on the demand side and on the supply side. The demand for managerial skills was much stronger and was driven by several key “players,” including medical facilities (mainly hospitals), physicians interested in setting up their own practices or private clinics, health insurance companies, nurses, etc. The demand for health policy skills was driven only by the central government for many years, and this demand was not intensive. But there is now a growing demand for such skills. Today, the situation has changed – regional offices need to find specialists knowledgeable in designing and implementing regional health policies and able to deal with the many acute problems (e.g., a reduction in the number of beds, emergency services organization and funding, medical transportation). At the same time, however, a shortage on the supply side can easily occur. Teaching management seems to be much easier than teaching policy, especially within the changing, turbulent environment that now exists.

“STANDARD” ACADEMIC PROGRAM IN HEALTH MANAGEMENT

Since there was no required curricula to educate health managers, international know-how was used to start such programs (for example, universities in Jindrichuv Hradec, Hradec Kralove, and Olomouc and also IZVP Prague were involved in a USAID/AIHA project to establish sustainable academic programs in health services management and economy). There were two U.S. partner universities: the University of Nevada and the University of Virginia. As a result, most schools now use similar curricula and program structures, usually realized at the bachelor’s level program, and delivered by the school of economics or the medical school.
The “standard” program has typically been designed as a specialization of some broader program in economics or management. The following subjects (or fields of study) can usually be found in the curricula:

- health care economics (introduction to HC economics; medical markets analysis; demand for and supply of medical care and health insurance; rationing supply and demand; adverse selection; methods of economic evaluation, etc.);
- finance and health finance (funding, reimbursement methods, economic incentives, financial management, pricing);
- health care systems (organization, comparison, capacity assessment, reforms);
- managerial epidemiology;
- medical quality;
- statistics for health care information systems;
- management (planning, organization, leadership, motivation, control), clinical management, human resources management;
- health policy, including objective and preference setting and evaluation of health care systems;
- medical law; and
- public administration and health care.

**TRAINING PROGRAMS IN HEALTH MANAGEMENT**

The first activities conducted or supported by foreign aid institutions (e.g., Project HOPE in 1992-94) were oriented to current hospital managers and high-level public officials. [It should be noted that, both at that time and now, there have been no explicit compulsory requirements to keep or hold managerial positions in the Czech Republic in terms of special health management education.]

The second wave of training programs was aimed at the middle management level – nurses, physician’s practice administrators, and the like. The basic hypothesis was that the role of this management group would increase significantly. The formation of group practices of private physicians was expected, and the emergence of a new profession of health services administrator was anticipated. This prediction has not yet been fulfilled, though. Czech private physicians still prefer an individual practice, and most of them deal with necessary administration on their own or with the help of their families. They see few benefits from having a professional do that job, given their own low level of remuneration for their work. In addition, hospitals have not created additional administrative jobs since mid-level management is conducted effectively by current personnel, mainly by registered nurses. Due to limited demand, then, the supply of training programs, as well as academic programs, decreased at the beginning of the 21st century.

A boom in training activities might occur since the system of public administration has changed. The role of regions as well as municipalities is greater; correspondingly, there is a greater need to teach officials how to deal with their new regular agendas effectively as well as to offer courses for health departments’ managers. Officials are likely to seek evaluation, assessment, and planning skills, as well as logistics, crisis management, and public relations skills.
At the moment, though, this does not seem to be a priority for the new regional authorities. They struggle with a lack of money as they seek to solve their most urgent problems (e.g., the indebtedness of former state hospitals). While dealing with emergencies, they do not have sufficient power to establish their own regional health policies and the related system of education and training.

6. CONCLUSIONS

The Czech Republic is one of the most developed of the transitional countries and is expected to join the European Union in 2004. Its health system was heavily reformed after 1989, with privatization and the introduction of a health insurance-based system of financing as main features. An important outcome of the health care reforms is a more or less privatized health care system (from the point of view of producers of services), but one that is still based on the principle of universal access (i.e., health services are more or less accessible for everybody through social health insurance). Most recent problems of the system are connected with finance; other elements, including access, quality, and the health status of the population, reflect positive trends.

With the privatization of the delivery of health services and the use of market-based instruments to finance health care, the need for health managers is evident. Decentralization also increases the need for greater numbers of well-educated and trained health policy makers; policy making and implementation currently are the weakest parts of health care reform in the Czech Republic.

In the current Czech health care system, there are many positions that should be occupied by health managers and policy makers. For this reason, it is difficult to develop any single “optimal” health manager’s profile that fits all of the potential requirements of the current system – and thus it also is difficult to describe what kind of education and training is most required.

Despite the fact that there are many excellent, well-skilled and successful health managers and hospital directors who are trained as physicians, it is likely to be more effective and less expensive to educate economists, managers, or administrators to understand health services specificities than to educate medical doctors to be managers. However, since effective management often is due to factors other than knowledge, especially during the turbulent and changing times of health care reform, teaching health care management and policy to current hospital directors (mostly physicians) has had good results in terms of the management of health care facilities. Managerial skills are not generally considered to be a major issue in the Czech health care system.

More and more frequently, politicians are said to be incapable of designing a better health care system, with financial instability by far the most intense issue. However, the main finance-related reform failures can be found on both sides of the “battlefield” – caused by the failures of executive managers in the system, as well as by the negative external influences of poor government policy. When both policymaking and system management do not perform properly, it is not surprising that certain expected outcomes of health reform (privatization, and the introduction of a social health insurance financing system) do not adequately occur, and, consequently, the reform has failed in some of its dimensions.
A future vision of the health care system is not yet clear in terms of the roles of the state, the regions, health insurance companies, and autonomous health care facilities. Yet this situation should have only limited influence on the training that health managers and policy makers should have, since the key skills are quite universal. Nevertheless, this uncertainty causes some difficulties for health policy education programs. Future target groups are not clear; moreover, the demand for these programs seems to be too low.

The increased roles of the regions and municipalities are expected to introduce a new stimulus. Municipal and regional self-governments must seek proper programs in order to learn how to deal effectively with their new agendas. Evaluation, assessment, and planning skills, as well as logistics, crisis management, and public relations skills, are likely to be in increasing demand.

The current system for delivering health management education and training in the Czech Republic is relatively comprehensive and diversified. Yet the limited demand for academic and training programs (due to a lack of newly created managerial posts in the medical establishment and doctors remaining in their current management positions) and the limited demand for training delivered by non-health care institutions in the training market have negative impacts on its structure (e.g., some universities have recently ceased their programs). The link between health management education and training delivered by medical institutions and that delivered by public administration schools, created in the earlier phase, is threatened in such conditions, although new impulses (like decentralization and de-monopolization of the training market) may help revive it.

The main gap in the Czech Republic is in the field of health policy education and training. Although there are key institutions (e.g., Charles University in Prague, Masaryk University in Brno, Health Policy and Economics Institute in Kostelec), this subsystem does not, in reality, function. The Czech Republic has already paid a significant price for this situation through reform failures, and it is hoped that further decentralization will increase the status of policy making and implementation theory and practice generally – and in health care, particularly.
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- Zákon č. 101/2000 Sb., o ochraně osobních údajů a o změně některých zákonů
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# APPENDIX A. LIST OF CURRENT ACADEMIC PROGRAMS IN PUBLIC HEALTH MANAGEMENT AND POLICY

<table>
<thead>
<tr>
<th>Institution</th>
<th>Program</th>
<th>Specialization</th>
<th>Kind of degree</th>
<th>Form</th>
<th>Standard length (years)</th>
<th>Started</th>
<th>Cancelled</th>
<th>Graduates, students (avg./year)</th>
<th>Graduates’ profile</th>
<th>Target group</th>
<th>3 main skills, fields of study</th>
<th>Economics:mgmt.: HC policy: other (approx. ratio)</th>
<th>Greatest advantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masaryk University BRNO School of Econ. and Admin.</td>
<td>Public economy and administration</td>
<td>Health care economics and management</td>
<td>BC</td>
<td>part-time</td>
<td>3</td>
<td>1995</td>
<td>30</td>
<td>administrators, PA officials</td>
<td>secondary school graduates, registered nurses</td>
<td>administration, economics, health policy</td>
<td>10:6:6:12</td>
<td>theoretical background in HC economics, finance</td>
<td></td>
</tr>
<tr>
<td>Charles University PRAHGE School of Humanitarian Studies</td>
<td>Social policy and social work</td>
<td>Management and supervision of health services facilities</td>
<td>MA</td>
<td>full-time</td>
<td>3</td>
<td>2002</td>
<td>59 (enrolled in 02/03)</td>
<td>top managers administrators</td>
<td>secondary school graduates</td>
<td>analysis, economics, field work</td>
<td>7:12:11:9</td>
<td>innovations, research activities, international relations</td>
<td></td>
</tr>
<tr>
<td>University of HRADEC KRALOVÉ School of Informatics and Management</td>
<td>Health services management</td>
<td></td>
<td>BC</td>
<td>full-time</td>
<td>3</td>
<td>1998</td>
<td>16</td>
<td>administrators</td>
<td>registered nurses</td>
<td>human resources management, sales management, marketing</td>
<td>11:5:12:9</td>
<td>co-operation with Univ. of Nevada (AIHA project)</td>
<td></td>
</tr>
<tr>
<td>Military Medical Academy HRADEC KRALOVÉ</td>
<td>Military health management</td>
<td></td>
<td>BC</td>
<td>full-time</td>
<td>3</td>
<td>NA</td>
<td>5</td>
<td>administrators, PA officials</td>
<td>secondary school graduates</td>
<td>health policy, law, economics</td>
<td>n/a</td>
<td>complex and balanced preparation to solve real problems</td>
<td></td>
</tr>
<tr>
<td>University of ECONOMICS JINDRICHUV HRADEC School of Mgmt.</td>
<td>Health services management</td>
<td></td>
<td>MA, BC others</td>
<td>full-time</td>
<td>2; 3</td>
<td>1997</td>
<td>24; 5</td>
<td>all levels managers and PA officials</td>
<td>secondary school graduates</td>
<td>medicine, law</td>
<td>13:9:6:8</td>
<td>interdisciplinary program</td>
<td></td>
</tr>
<tr>
<td>Palacky University OLOMOUC Medical School</td>
<td>Economics and management of health care</td>
<td></td>
<td>BC</td>
<td>full-time</td>
<td>3</td>
<td>1999</td>
<td>5</td>
<td>PA officials, state health administration supervisors</td>
<td>secondary school graduates, registered nurses, managers</td>
<td>economics, public health, management, (nursing)</td>
<td>1:10:3:40</td>
<td>comprehensiveness</td>
<td></td>
</tr>
<tr>
<td>University of OSTRAVA School of Health and Social Matters</td>
<td>Public health</td>
<td></td>
<td>BC</td>
<td>part-time</td>
<td>3</td>
<td>2002</td>
<td>26</td>
<td>PA officials</td>
<td>secondary school graduates</td>
<td>medicine, hygiene, management</td>
<td>6:7:17:5</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>University of OSTRAVA School of Health and Social Matters</td>
<td>Economics and management of health care</td>
<td></td>
<td>BC</td>
<td>full-time</td>
<td>3</td>
<td>1993</td>
<td>40</td>
<td>PA officials</td>
<td>secondary school graduates</td>
<td>medicine, hygiene, management</td>
<td>2:2:25:5</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Charles University PRAHGE 3rd Medical School</td>
<td>Public health</td>
<td></td>
<td>BC</td>
<td>full-time</td>
<td>3</td>
<td>1993</td>
<td>15</td>
<td>PA officials</td>
<td>secondary school graduates</td>
<td>medicine, hygiene, management</td>
<td>2:2:25:5</td>
<td>n/a</td>
<td></td>
</tr>
</tbody>
</table>
**APPENDIX B. LIST OF MAIN TRAINING PROGRAMS IN PUBLIC HEALTH MANAGEMENT AND POLICY**

<table>
<thead>
<tr>
<th>Institution</th>
<th>Title of the Course</th>
<th>Length</th>
<th>Admission</th>
<th>Specification</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Military Medical Academy Hradec Králové</td>
<td>Organisation and management of military medical services</td>
<td>26 weeks</td>
<td>15</td>
<td>Ministry of Defense</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Organisation and management of military pharmacy</td>
<td>6 weeks</td>
<td>3</td>
<td>Ministry of Defense</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hygiene, occupational sickness</td>
<td>6 weeks</td>
<td>5</td>
<td>Ministry of Defense</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical services</td>
<td>6 weeks</td>
<td>6</td>
<td>Medical services management in the Army</td>
<td></td>
</tr>
<tr>
<td>Postgraduate Education Institute for Medical Professionals – School of Public Health Praha</td>
<td>State administration reform: 2003 special course</td>
<td>1 day</td>
<td></td>
<td>Disability-assessing physicians</td>
<td><a href="http://www.ipvz.cz">www.ipvz.cz</a></td>
</tr>
<tr>
<td></td>
<td>Special seminar: Public health care and medical law for 1st grade attestation</td>
<td>1 day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Administration Institute Benešov u Prahy</td>
<td>Preparation for a special professional ability examination of public officials</td>
<td></td>
<td></td>
<td>Rule MVČR č. 345/2000 Sb.</td>
<td><a href="http://www.mvcr.cz">www.mvcr.cz</a></td>
</tr>
<tr>
<td>CMC Graduate School of Business Čelákovice</td>
<td>Health care management</td>
<td>9 days</td>
<td>80</td>
<td>Medical facilities’ directors and top management</td>
<td><a href="http://www.cmc.cz">www.cmc.cz</a></td>
</tr>
<tr>
<td></td>
<td>Dynamic manager in medical services</td>
<td>13 times 3-day modules in 2 years</td>
<td></td>
<td>Middle and upper levels of management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1- day seminars on management of medical services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project HOPE</td>
<td>Management of changes: Increasing the role of middle management</td>
<td>16 days</td>
<td>3-member-teams from 20 facilities</td>
<td>Medical facilities’ management</td>
<td><a href="http://www.projecthope.cz">www.projecthope.cz</a></td>
</tr>
<tr>
<td>Prague International Business School (PIBS)</td>
<td>MBA in Health Services Management</td>
<td>n/a</td>
<td>n/a</td>
<td>Managerial teams from large hospitals</td>
<td></td>
</tr>
</tbody>
</table>