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Health Care Systems in Transition

Czech Republic

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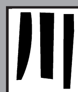

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Foreword

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of a health care system and of reform initiatives in progress or under development. The HiTs are a key element of the work of the European Observatory on Health Systems and Policies.

HiTs seek to provide relevant comparative information to support policy-makers and analysts in the development of health care systems in Europe. The HiT profiles are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services;
- to describe the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health care systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries.

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides the detailed guidelines and specific questions, definitions and examples needed to compile a HiT. This guidance is intended to be flexible to allow authors to take account of their national context.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health

care system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and data from the World Bank. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

The HiT profiles provide a source of descriptive information on health care systems. They can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health care systems. This series is an ongoing initiative: material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT profiles are most welcome and can be sent to info@obs.euro.who.int. HiTs, HiT summaries and a glossary of terms used in the HiTs are available on the Observatory's website at www.euro.who.int/observatory.

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The 2005 HiT profile is based on the 2000 HiT profile, which was written and edited by Reinhard Busse with editorial support provided by Wendy Wisbaum (European Observatory on Health Care Systems) on the basis of a previous version by Peter Struk (then Ministry of Health of the Czech Republic) and Tom Marshall (WHO) as well as invaluable input from Roman Prymula (Medical Military Academy of J.E. Purkyne) and Alena Petrakova (WHO Liaison Office in the Czech Republic).

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The current series of Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies. The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat, and research directors Martin McKee, Elias Mossialos and Richard Saltman.

Technical coordination was provided by Susanne Grosse-Tebbe, and production and copy-editing was led by Francine Raveney, with the support of Shirley and Johannes Frederiksen (layout) and Janet Barber (copy-editor). Administrative support for preparing the HiT on the Czech Republic was undertaken by Caroline White and Pieter Herroelen.

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This document and the data included reflects the situation at February 2005.

Introduction and historical background

Introductory overview

Political and economic background

The Czech Republic is located in the middle of Europe (Fig. 1). Covering an area of 78 867 km^2, it borders Germany to the west, Poland to the north, Slovakia to the east and Austria to the south. The western part of the Czech Republic is called Bohemia and the eastern part consists of Moravia and part of former Silesia. Until 1918, these territories were part of the Austro-Hungarian Empire. Following the break-up of the Empire after the First World War, these territories joined together with Slovakia to form the State of Czechoslovakia. Czechoslovakia continued to exist until 1938, when it was divided as a result of the Munich Treaty. Bohemia and Moravia were occupied by Germany between 1939 and 1945. Following the end of the Second World War, the Czechoslovak State was restored and the country came under a communist administration in 1948. A short period of liberalization was started in the late 1960s but was ended by Warsaw Pact forces in 1968. The process of democratization began in 1989, leading to democratic elections in 1990. A legal separation of the Czech and Slovak Republics took place in 1992, and the Czech Republic was established on 1 January 1993.

The Czech Republic has been a member of the OECD since December 1995, a member of the North Atlantic Treaty Organization since February 1999 and a member of the European Union (EU) since May 2004.

Fig. 1. Map of the Czech Republic

Source: UN Carthographic Section.

The Czech Republic is a multiparty parliamentary democracy headed by a president (elected for a 5-year term). Currently, Vaclav Klaus is in that position. The constitution provides for a bicameral parliament that is responsible for final decision-making to approve any new legislation (constitution, laws, acts, etc.) proposed by the Czech Government. The 200 members of the House of Representatives are elected for a 4-year term, while the 81 members of the Senate are elected for 6-year terms. The present government is a coalition lead by the Czech Social Democratic Party. Stanislav Gross has been the Prime Minister since August 2004. There are four vice-prime ministers who are responsible for inter-ministerial coordination. The government proposes new legislation for the health sector, as in other sectors, to the parliament (usually by the Minister of Health). The Minister of Health has changed 11 times since 1989.

A regional structure dividing the country into 14 regions was introduced legally on 1 January 2000 (Fig. 2). Parliament approved the following administrative structure in order to bring Czech legislation into line with that of the EU:

- the Czech Republic as a whole
- territorial units (eight) as designated by the EU
- regions (14)
- municipalities/communities.

Fig. 2. Regions from 1 January 2000

1. Karlovarský	8. Královéhradecký
2. Plzeňský	9. Pardubický
3. Ústecký	10. Vysočina
4. Středočeský	11. Olomoucký
5. Praha	12. Jihomoravský
6. Jihočeský	13. Moravskoslezský
7. Liberecký	14. Zlínský

This information was compiled by the editors.

In the sphere of public administration, the period between 1999 and 2002 was a very important stage, as it brought the commencement of the implementation of a long-planned reform aiming to shift some responsibilities to regional self-governing units as delegated powers. This means that public administration is being modernized and decentralized. In 2000, an election of the regional governments took place. Some of the powers of the central public administration

bodies were shifted to the newly established regional offices and those bodies began working. At the beginning of 2003 the regional offices acquired further powers, including those concerning health care. Some of the functions of the former district offices were transferred to the regional administration bodies (see *Organizational structure of the health care system*).

The preparation for EU entry primarily required the harmonization of the Czech legal system with EU norms. That process was successfully completed before all chapters of the pre-accession negotiations were closed, and before the Czech Republic was invited to enter the EU (upon the completion of the appropriate ratification processes) in May of 2004. The modifications made in this context also represent significant progress with respect to the legal framework of the transformation of the economy and an improvement in its functioning.

A significant political moment was also the acceptance of the country into the North Atlantic Treaty Organization and the participation of the Czech Army in some of its actions.

Table 1. Development of basic economic indicators

Indicator		1990	1993	1995	1999	2000	2001	2002
Gross domestic product	Index 1990=100	100.0	88.0	95.3	98.0	101.2	104.3	106.4
Household consumption	Index 1990=100	100.0	86.0	96.7	106.9	109.4	113.6	118.0
Consumer price index	Annual change (%)	–	–	+9.2	+2.1	+4.0	+4.7	+1.8
Unemployment (unplaced job applicants)	Unemployment rate (%)	0.7	3.5	2.9	9.4	8.8	8.9	9.8
Real wages	Index 1990=100	100.0	84.2	98.7	114.5	117.3	122.1	–

Source: Ukazatelé sociálního a hospodářského vývoje České republiky, ČSÚ (Český statistický úřad) 2002 and the authors' own calculations based on the ČSÚ data.

It may be said that the economy has been led out of the recession which came about during the first large privatization wave at the beginning of the 1990s. After a sharp decline until 1993, the gross domestic product (GDP) finally increased. In 2002, the GDP per capita reached US $15 600 (recalculated in terms of "purchasing power parity"), which corresponds to 42% of the level in the United States and 59% of that in Germany. An important factor in GDP growth was household consumption. Changes regarding old-age pensions were less favourable. The average pension, in real terms, has not yet reached the level

in 1989. In 2001, pensions reached only 92.4% of their value in 1989. Another critical issue is increasing unemployment. In 2001, the unemployment rate was 9.81% of the workforce.

An adverse phenomenon is the growing deficit of public budgets and the growth of government debt, which is primarily the consequence of transformation costs, expenditures related to the restructuring and modernization of the economy and an increase in mandatory expenditures of the national budget.

Demographic and health status development

As of 1 July 2002, the number of inhabitants of the Czech Republic was 10.2 million, of whom approximately 65% lived in urban areas. There were 4.96 million men and 5.24 million women; the density of the population was 129 people per km^2. The population consists of 94% ethnic Czechs, 1.9% Slovaks, 0.5% Polish and 0.4% German. Roman Catholics account for 26.8% of the population; atheists account for about 59% of the population *(1)*.

The figures in Table 2 show that the number of people dropped by 86 000 between 2001 and 2002. The natural population growth rate was negative, and amounted to –1.5 per thousand inhabitants, as a consequence of the mortality rate being higher (10.6 per thousand) than the birth rate (9.1 per thousand), all in spite of the fact that the birth rate increased in that year, probably because of the “baby boom” in the 1970s. On the whole, the decline in the number of inhabitants that started in 1994 has been continuing. Particularly important is the fact that the total fertility rate was only 1.18 in 2002 and was therefore under the fertility replacement level (i.e. 2.1 per thousand). The changes in infant mortality are very favourable. Its long-term decline has been continuing and reached 4.1 per 1000 live-born children in 2000, ranking as one of the lowest levels in Europe.

In the last 10 years, the number of people in the youngest age group (0–14 years) dropped significantly in the Czech Republic (by almost one quarter). In 1991, the share of that group in the Czech Republic (20.8%) was higher than that in the EU Member States before 1 May 2004 (18.3% in 1990). In 2001, it was lower, at 16.1%, than the 2000 EU level (17.0%). A comparison with the EU Member States before 1 May 2004 (16.0% in 2000) also shows the share of the oldest age group (65 and over) to be lower, being 13.8% in 2001. In general, there are clear signals of the ageing of the Czech population, although the demographic situation is still more favourable in the Czech Republic than in the EU Member States before 1 May 2004 *(2)*.

Table 2. Basic demographic indicators

Indicator	1970	1980	1985	1990	1995	2000	2001	2002
Population (million)	9.80	10.33	10.34	10.33	10.33	10.27	10.29	10.20
Birth rate (per 1000)	15.08	14.89	13.14	12.6	9.3	8.85	8.87	9.1
Mortality rate (per 1000)	12.6	13.1	12.7	12.46	11.41	10.61	10.54	10.61
Infant mortality (per 1000)	20.2	16.9	12.5	10.8	7.7	4.10	3.97	4.15
Total fertility rate (per 1000)	1.93	2.1	1.97	1.89	1.28	1.16	1.15	1.18
Life-expectancy – males (years)	66.18[a]	66.84	67.46	67.63	69.76	71.75	72.12	72.15
Life-expectancy – females (years)	73.33[a]	73.97	74.7	75.54	76.81	78.60	78.66	78.79

Source: WHO Regional Office for Europe health for all database, October 2004; Institute of Health Information and Statistics of the Czech Republic (UZIS: Ústav zdravotnických informací a statistiky České republiky).
Note: [a] 1971 data.

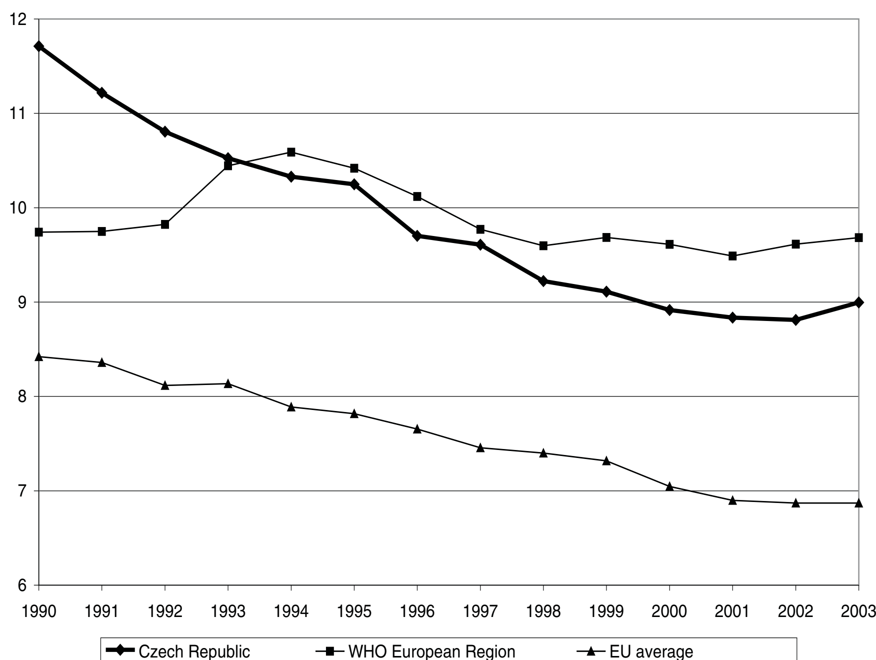
The increase in life expectancy continues, as it reached 72.15 years, at birth, for men in 2002 and 78.79 for women (compared to an average of 67.7 years for men for the period 1986–1990 and 74.8 years for women over the same period). This increase is the largest of all EU countries. In spite of this increase, life expectancy in the Czech Republic is still lower than the average of the EU Member States before 1 May 2004 (in 2000: 75.57 years in men and 81.74 years in women).

The overall death rate has fallen in recent years, but there is still a large difference between the level for the Czech Republic and those for the EU Member States before 1 May 2004 and Scandinavian countries (Fig. 3).

As in other developed countries, diseases of the circulatory system are also the most frequent cause of death in the Czech Republic (Table 3). The change here is similar to that for overall mortality, i.e. there has been a slight continuous improvement since the mid-1980s. The overall mortality rate was slightly better than the Europe-wide average last year, or rather, it was better than the average for central European countries, but the lag behind EU countries and Scandinavia is still significant. Cardiovascular mortality as a proportion of overall mortality continues to drop.

A reduction in mortality in this category of diseases has been apparent primarily since the beginning of the 1990s, when a drop for both genders was very marked, and its rate in the 0–64 age group is more significant than

Fig. 3. Overall standardized death rate per 1000 inhabitants



Source: WHO Regional Office for Europe health for all database, January 2005.

in EU countries. The causes of that positive development have yet to be fully elucidated. Overall, it is attributed to the expansion in the introduction and use of modern diagnostic and therapeutic methods after 1989; this led to a more effective cure and the "postponing" of death of a proportion of the sick to higher age groups. This opinion could be supported, for example, by the fact that the hospital mortality with this diagnosis dropped between 1986 and 2000 from 25.2 per 100 000 to 12.9 per 100 000. While in 1986 one in four hospitalized patients died of this disease, in 2000 it was only one patient in eight. The total number of people dying of cerebrovascular incidents dropped, during those years, from 25 377 in 1986 to 17 343 in 2000. This decline means that if, in 1986, approximately three people died of cerebrovascular incidents every hour in the Czech Republic, in 2000 it was one death every half hour. Mortality from cerebrovascular incidents, therefore, has dropped by more than 30% in the last 15 years (3).

A similar development can be seen for mortality from acute myocardial infarction. Hospital mortality dropped, over the same period, from 17.3 per 100 000 to 12.5 per 100 000 in 2000. Overall, in 1986, 17 407 people died of an acute myocardial infarction, which represented 48 people per day and meant

Table 3. Changes in mortality rate, by cause of death per 100 000 inhabitants (standardized data – European standard)

	1970	1975	1980	1985	1990	1995	2000	2001	2002
All causes of death	1 299.0	1 230.1	1 269.7	1 217.1	1 171.2	1 024.8	891.5	883.5	881.1
Diseases of the circulatory system	659.6	638.5	660.0	676.9	645.0	559.6	462.5	459.8	456.0
Malignant neoplasms	240.8	242.3	244.1	248.4	258.6	252.2	237.8	234.1	233.8
External causes, injuries and poison	92.2	88.2	85.7	85.8	84.8	76.9	62.4	60.9	60.5
Diseases of the respiratory system	122.2	97.8	106.7	70.2	49.2	43.5	40.2	38.0	38.2
Diseases of the digestive system	48.8	49.7	52.3	45.2	46.7	38.7	36.2	37.4	37.3
Diabetes mellitus	–	–	–	–	19.6	7.6	11.2	9.6	9.9
Diseases of the blood and of blood-forming organs	–	–	–	19.7[a]	1.5	1.0	0.7	0.6	0.6
Tuberculosis	–	–	–	2.3[a]	1.9	0.8	1.1	0.8	0.7
Infectious and parasitic diseases	10.9	8.3	6.1	3.9	4.0	2.2	2.3	2.6	2.7

Source: WHO Regional Office for Europe health for all database, October 2004; Institute of Health Information and Statistics of the Czech Republic 2001, 2002 (UZIS: Ústav zdravotnických informací a statistiky České republiky).
Note: [a] 1986 data.

that one person died of that cause every half hour in the Czech Republic. In 2000, "only" 11 347 people died of that cause, which equates to 31 people a day and a decline by one third *(4).*

The situation in the Czech Republic is less favourable for neoplasm-related mortality. Since the 1970s, the mortality rate in the Czech Republic has been higher not only compared with EU or Scandinavian countries, but also compared with the Europe-wide average and the average for central-European countries. The difference is quite large and the trend does not hint at any significant improvement. The only exception is breast cancer, where the difference compared with other countries has diminished somewhat. Although the incidence of breast cancer is increasing, mortality has remained practically unchanged since 1995. In 1977, when the National Oncological Register was established, deaths caused by malignant neoplasm of the breast constituted 14.4% of all deaths caused by malignant neoplasm in women, whereas in 2000 the figure was only 3.6%. The reduction in the mortality caused by this most

frequent malignant disease in women was achieved due to early diagnosis and better treatment, by women being better informed and by preventive checks and mammography screening, which has been fully covered by the statutory health insurance since 2002 for all at-risk age groups *(5)*.

There has been a continuous drop in the mortality rate for the third largest group of deaths, i.e. those attributable to external causes. But it is alarming that the proportion of injuries of children up to the age of 14 caused by traffic accidents grew in the years 1990–2001, numbering 24 388.

A favourable development is evident in the mortality caused by diabetes mellitus. Standardized data available show that mortality caused by this disease in the Czech Republic has changed: this rate dropped significantly, so that in spite of a certain worsening of the situation in the last 4 years, this indicator is still more favourable in the Czech Republic than in the other countries mentioned.

In spite of the fact that the change in mortality caused by diabetes mellitus is rather favourable, which undoubtedly serves as evidence of the quality of care for this group, the incidence of that disease is not declining. The continuously growing trend in the number of treated diabetics was first stopped in 2001, when, for the first time since 1975, fewer diabetics were noted than in the previous year. But only the future will show whether this was a random variation or the beginning of a more positive development in its incidence. The share of recorded diabetics in 2001 for the Czech population was 5.9% for men and 6.8% for women, which represents 636 treated diabetics per 10 000 inhabitants. The vast majority of diabetics fall into the "diabetes type 2" category.

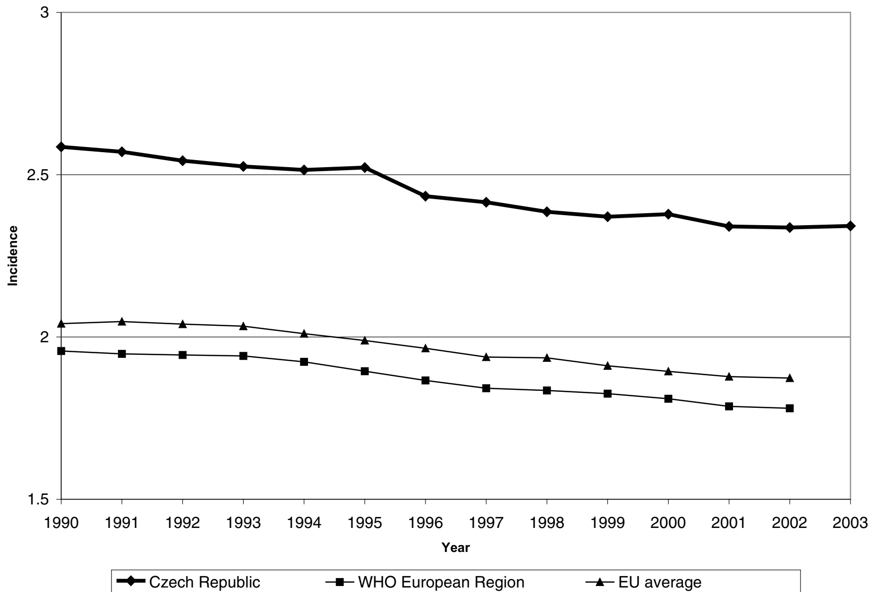
In the case of the diseases of the circulatory system, the results of several independent surveys indicate continuous growth in the prevalence of hypertension disease. Interesting from this point of view are the results of the MONICA (Multinational MONItoring of trends and determinants in CArdiovascular disease) survey conducted by the WHO from the mid-1980s until the mid-1990s.

Those data show that during that period, the incidence of hypertensive disease was much higher in the Czech Republic than the average of all the monitored countries, for both genders. It is interesting and relevant that, in men, there was a decline in the number of such cases, by 0.4% per year, and in a long-term survey even by 0.9% per year, whereas in women, there was a growth of 2.1% per year, and in the longer period even 4.9% a year. The survey also detected a higher incidence of risk factors of these diseases than is the average for all of the monitored countries. For men, there was a decline in smoking (–0.75% per year), as well as in other factors, with the exception of body mass index (+0.05% per year), whereas for women, there was a decline of all the risk

factors with the exception of smoking, the prevalence of which grew annually by 0.32% and was 18% higher than the average of the monitored countries.

Data show that the acceleration of growth of the incidence of neoplasms in the Czech Republic has been higher not only than that in the EU and all of Europe, but also higher than that in the Scandinavian countries, in which the incidence of neoplasms had previously been the greatest (Fig. 4).

Fig. 4. International comparison of the overall incidence of neoplasms (standardized per 1000 inhabitants)



Source: WHO Regional Office for Europe health for all database, January 2005.

The most numerous neoplasms for both men and women have been, in the long-term, malignant skin tumours, but they are associated with low mortality. The second most frequent malignant disease for men is neoplasm of the bronchi and lungs (88 cases per 100 000 men), for which the mortality rate continues to approximate 100%. It is likely that the slightly positive trend in smoking habits that has been noted in the Czech Republic in recent years will continue and will gradually be reflected in a lower incidence of this fatal disease. In women, breast cancer continues to have a high incidence (88 cases per 100 000 women). Special attention should be paid to the high incidence of colorectal carcinoma. In this respect, the Czech Republic holds a sad worldwide primacy, as it is the country with the highest incidence of that disease (70 cases per 100 000 men and 48 cases per 100 000 women). The causes of that situation have yet to be fully elucidated, as relevant epidemiological studies are lacking. Aside from

genetic causes, a combination of several factors is suspected as causative, of which nutritional habits, smoking and excessive beer drinking are probably among the most significant.

As measured by the number of examinations in psychiatric outpatient offices, mental diseases have been growing slightly in the last five years. The year-on-year growth in 2000–2002 was 4.4% *(6)*. Women predominate among those patients, constituting 60% of all treated patients. In the long term, the largest group of ambulatory patients are those with neurotic deficiencies. The most frequent cause of hospitalization due to a mental disease in 2001 was schizophrenia, followed by deficiencies caused by alcohol. The third most frequent reason for psychiatric hospitalization was neurotic disorders (84 per 100 000 inhabitants). Surprisingly, in the same year, for the first time in eight years, the number of persons hospitalized due to drug addiction dropped.

As to the emotional well-being of the Czech population, 71% of men and 65% women were free of mental disorders *(7)*. In all types of emotional disorders studied, the prevalence in women was higher than in men. The emotional well-being of both genders declines with age, and there is a positive correlation with higher income. We may thus hope that with the expected increase in the standard of living after the country's accession to the EU, there is a chance for an improvement in the mental well-being, and therefore in the overall quality of life, of Czech citizens.

Historical background

Czechoslovakia became independent in 1918 after the First World War, when the first Czechoslovak Republic, the direct predecessor of the present-day Czech Republic (established on 1 January 1993), was constituted. Czech health policies can be dated back to that time. Policy was strongly influenced by the political tradition of the Austro-Hungarian Empire of which the Czech lands were a part until 1918. This comprised a Bismarckian system of social and health insurance.

The first social insurance system was established in 1924. In the first years of independence, a health insurance act was adopted, which provided insurance coverage for employees (more than one-third of the inhabitants of the State) in case of illness. Step by step, the system of state health insurance was complemented by other forms of insurance and by the work of charities. This system continued to function, with few modifications, until 1951.

In 1948, shortly after the Second World War, substantial political changes took place in the country. The political system became a "people's democracy"

and the country was governed by communist ideological principles, linked both politically and economically to the former Soviet Union. As a result, the proportion of nationalized property (including various forms of collective ownership) reached nearly 100%. This influenced many institutions, including the health care system.

At that time, two possible systems of health care were considered as models. One was a national insurance system, more or less based on previous tradition; the other was the newly designed "System of unified state health care".

In 1948, the first model was implemented, and health and social insurance were unified into a compulsory system of insurance for all citizens. The Central National Insurance Fund was founded, which covered all health care and sickness benefits. Insurance, amounting to 6.8% of wages, was paid entirely by the employer.

Four years later, in January 1952, the centralist system of unified state health care was introduced. The State took over all health care coverage and financed it through taxes. All health care was provided free of charge. At the same time, all health care providers were nationalized and subsequently incorporated into regional and district institutes of national health. The Czech part of Czechoslovakia had 8 regions and 75 districts. Every district had a district institute of national health and every region had a regional institute of national health. District institutes of national health consisted of medium or small hospitals, as well as polyclinics and health care centres for outpatient care, pharmacies, centres of hygiene, health care centres for the workplace, divisions of emergency and first-aid services and nursing schools.

The system proved reasonably effective in dealing with the post-war problems of the early 1950s. During that time, a high infant mortality rate, tuberculosis, other serious infections and malnutrition diminished rapidly. By the beginning of the 1960s, Czechoslovakia had very good health status in international terms.

From the late 1960s, these positive trends reached a turning point. Such a centralist and, in many cases, rigid system was not able to respond flexibly to new health problems caused mainly by the lifestyle of the population and by the environment. Thus, both the health care system and health status indicators stagnated from the late 1960s to the late 1980s. Temporary political reforms in 1968, when the Federation of the Czech and Slovak Republics was proclaimed, affected the health care system only in as much as they separated the Czech and Slovak parts, creating two separate ministries of health. The health care delivery system itself was unaffected. In 1966, the Law on Care of People's Health was approved; this is still an existing piece of legislation for the health care system, although many changes were applied and approved after 1989.

In 1990 and 1991, in the midst of the democratization process, a dramatic liberalization of the health care system took place. The principle of free choice of health care facility was introduced. The huge regional and district health authorities were dismantled. In 1991, new laws were approved, especially the General Health Insurance Act (No. 550/1991 Coll.) and the Act on the General Health Insurance Fund (No. 551/1991 Coll.). Since then, the health care system has moved towards a compulsory health insurance model, with a number of insurers financing health care providers on the basis of contracts.

From the early 1990s, considerable changes have been implemented in the Czech health care system. The majority of the planned changes have taken place and the implementation process has been remarkably smooth. A complete reconstruction of the health care facilities and authorities has been achieved and a health insurance system has been created. A Medical Chamber, a Stomatological (Dentists') Chamber and a Pharmacists' Chamber were established and there was a re-emergence of medical professional societies and associations of societies of nurses and other health care professionals. A new system of home care has been established. At the same time, there was an almost complete privatization of primary health care, the pharmaceutical industry, pharmacies, health care support firms, spa facilities, etc.

Liberalization opened the door to a rapid introduction of a new system of health care financing and to the start of privatization. In 1992, the health insurance system was adopted as the principal means of financing health care. The General Health Insurance Fund (GHIF) and, subsequently, branch health insurance funds were established. There were up to 27 health insurance funds at one period in the mid-1990s; at the beginning of 2000, the number had decreased to nine. Both state and private health care facilities increasingly made contracts with health insurance funds, involving payment from the outset on a fee-for-service basis. For payment purposes, an extensive list of health care procedures was created and it is continually amended by negotiations among legally nominated partners. Not all of the reforms have been successful. Some were controversial and today the Czech health care system is facing a number of problems resulting from the process. One of these is over-utilization of services.

Throughout recent history, health care workers have continuously expressed frustration with their relatively low incomes. As a result, they have had very high expectations of the reform. When policies did not have immediate financial effects, workers became sceptical and frustrated. Thus, physicians have resisted plans to reduce the numbers of doctors or hospital beds (in the latter case they were supported, in particular, by regional politicians who refused to close down local hospitals), which has posed a difficult problem for the Government.

At the beginning of the second half of the 1990s, these problems suggested the need for new regulatory mechanisms following the period of rapid liberalization. There had been a gap between the development of Czech health care reform and the beginning of regulation of this newly adopted and implemented system, particularly in the field of health care financing. It took almost five years to have an effect: simple fee-for-service payments in primary health care were combined with capitation fees, a new mode of payment for hospitals was introduced and the fee-for-service payments were modified for ambulatory specialists. Act No. 48/1997 Coll., which enabled these changes, was originally limited to two years but this limitation was twice prolonged and finally cancelled by Act No. 459/2000 Coll., i.e. the 1997 law remains in force.

Organizational structure and management

Organizational structure of the health care system

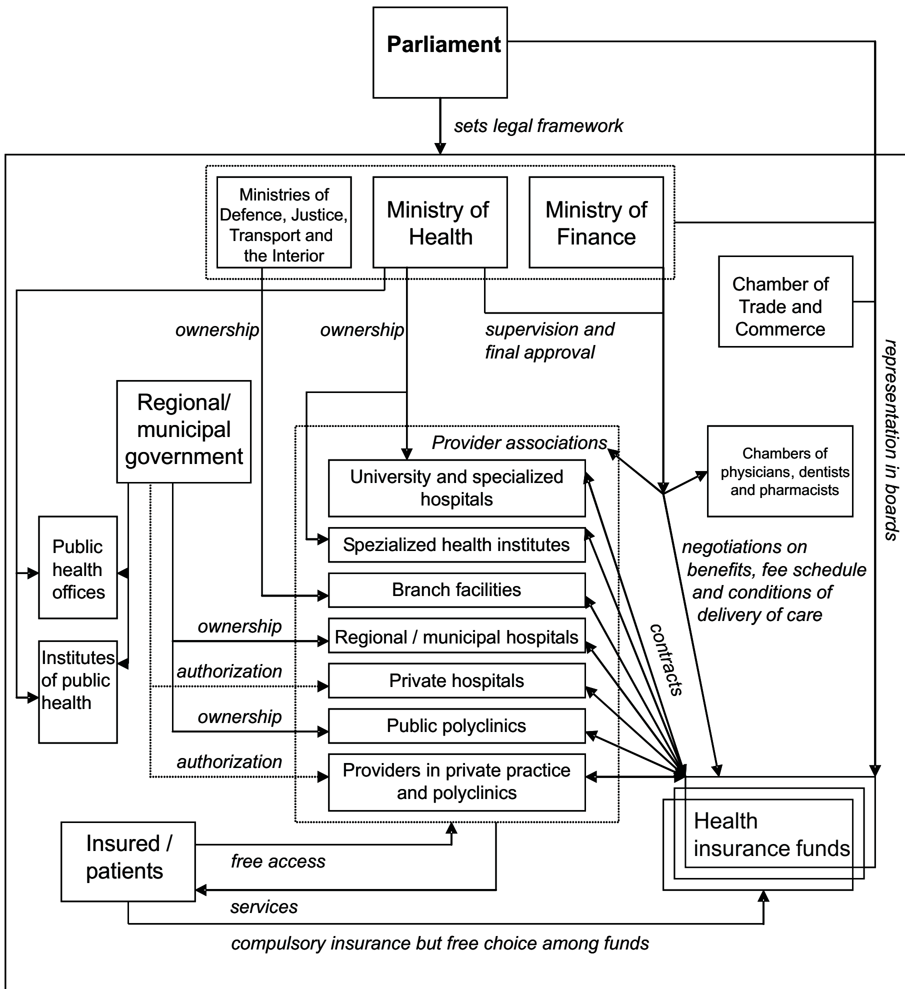
The three main features of the health care system in the Czech Republic are as follows: social health insurance with universal membership, funded through contributions by individuals, employers and the State; diversity of provision, with mainly private ambulatory care providers and public hospitals which have contractual arrangements with the insurance fund; and joint negotiations by key players on coverage and reimbursement issues. The Government supervizes the negotiations and ultimately has to approve the result; it may act on its own if the parties fail to agree. Fig. 5 depicts the major players in the Czech health care system, as well as their interrelationships.

The national government

The Ministry of Health directly manages and controls certain health care institutions and bodies engaged in the protection of public health (see below), but also large hospitals with regional or supra-regional spheres of influence.

The Ministry of Health is a central administrative body created by a statute, and its framework of responsibilites is specified to include health care, the protection of public health, scientific research in health care, health care facilities under its direct management, the search for, protection of and use of natural curative sources, natural curative spas and the sources of natural mineral waters, drugs and health care technology for disease prevention, diagnostics and cures, health insurance and the health care information system. The Ministry of Health is managed and its responsibiliti es carried out by the Minister of Health. The minister may delegate some of his/her powers to the ministry leadership staff. That, however, does not mean that he/she thereby sheds the

Fig. 5. Organizational chart of the Czech health care system



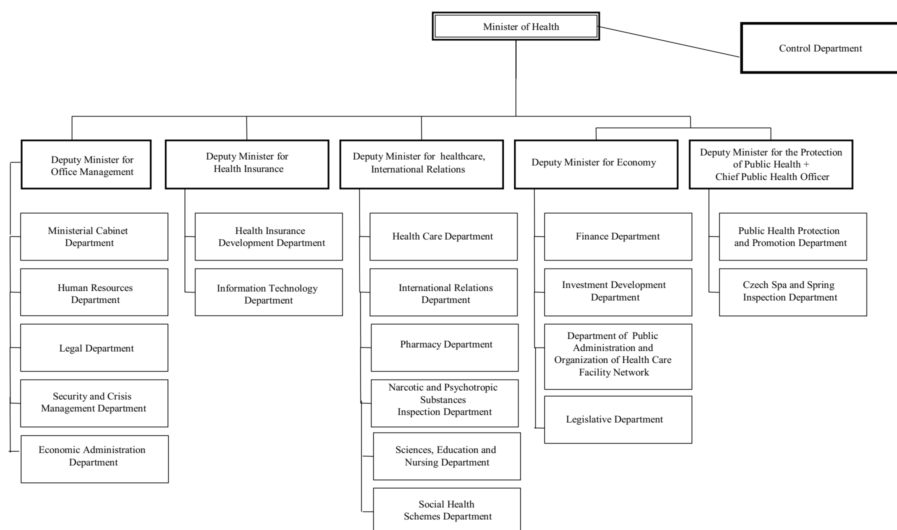
This information was compiled by the editors.

responsibility for the work of the ministry. The organizational structure and functional tasks of the various sections of the Ministry of Health are regulated by the Organizational Rules, the publication of which is within the remit of the minister. The current structure (2004) of the Ministry is depicted in Fig. 6.

Immediately subordinate to the minister are the Office Director, the deputy ministers, the Chief Public Health Officer of the Czech Republic, the Director of the Control Department, and the Head of the Public Relations Department. The Public Relations Department takes care of communication with the media, compiles overviews of the ministry's activities, and deals with requests for the provision of information pursuant to Act No. 106/1999 Coll. (Free Access

to Information). The Control Department is responsible for the organization, management and coordination of the ministry's control activities and for the investigation of complaints; in cooperation with specialized departments, it performs an internal audit of the ministry, and public (follow-up) inspection of organizations founded by the ministry, and of the recipients of public financial support. It administers financial inspection in the health care sector and issues methodological instructions concerning the financial control of state health care facilities. The Office Director is responsible for creating conditions for the fulfilment of the minister's tasks.

Fig. 6. Structure of the Ministry of Health, 2004



Source: Ministry of Health, 2005.

The deputy ministers and the Chief Public Health Officer (who is also a deputy) represent the minister – within the scope of their authority concerning their respective sectors – and issue decisions, provided that the obligations that arise do not exceed their authority. During the minister's absence, they represent him/her, in the area which he/she specifies, in the full extent of his/her rights and duties, with the exception of those rights and duties which are by the applicable legislation exclusively reserved for the minister, and with the exception of those rights and obligations that the minister has reserved for himself/herself. The minister may also set up consultative committees, which do not, however, have any decision-making powers. They present their proposals to the minister. In addition, the minister may order the setting up of consultative committees within the ministry: their work concerns the operation of the ministry.

Regional offices – "regional governments"

State administration at district level was abolished at the end of 2002. In certain cases, communities are the owners and operators of small hospitals. Several dozen small hospitals have been privatized in the form of commercial companies, but continue to be financed from statutory health insurance. The network of outpatient services and pharmacy services has been nearly entirely privatized. The owners of those facilities are doctors, pharmacists, and other operators. Facilities providing outpatient health care services are registered pursuant to Act No. 160/1992 Coll. (Health Care in Non-state Health Care Institutions). Registration is conditional upon the fulfilment of the specified conditions for the provision of health care services, and, if they are not adhered to, registration must be withheld. As of 2003, nearly all of the agenda has been transferred to the regions. In line with these reforms, debts from hospitals formerly operated by National Government have been passed on to the regional governments.

Health insurance funds

Health care in the Czech Republic is provided primarily on the basis of statutory health insurance, which is currently provided by nine health insurance funds. The largest health insurance fund, the GHIF, has 77 district branches – one in each former district of the Republic. Each is managed by a director, who is accountable to a supervisory board (consisting of three representatives of the insured and two of employers) and a board of directors (with five and four representatives from each of these groups, respectively). The representatives of the insured are elected by the respective district assembly, while the representatives of the employers are delegated by the District Chamber of Trade and Industry. At the national level, the supreme body is the Assembly of Representatives, which authorizes the annual report, the annual accounts and the annual budget before they are finally approved by the parliament (which also elects the GHIF director-general). Strategic plans and policy decisions are made by a board of directors that has 30 members: 10 each from the government (ministries of Finance, Health and Social Affairs), the insured (elected by the parliament) and the employers (delegated by the Chamber of Trade and Industry). The supervisory board consists of nine members: three representatives from each of the previously mentioned groups.

For all other health insurance funds, the number of members of both the board of directors and the supervisory board is not specified by law but membership must always be equally divided among the State (appointed by the Ministry of Health), the insured (elected by the parliament) and the employers (delegated by the Chamber of Trade and Industry). Unlike the GHIF, in these cases, the board of directors has the power to appoint a director.

In order to start a new health insurance fund, an application for permission must be made to the Ministry of Health and to the Ministry of Finance. The fund must have a minimum of 50 000 people insured and a financial reserve as laid down by law.

Any person with a permanent residence in the Czech Republic is entitled to health insurance, as are people who do not have their permanent residence there but are employed by an employer whose registered base is in the country. Every health insurance fund has the obligation to accept any client who meets the conditions for participating in statutory health insurance. Anyone who does not meet the conditions for participation in statutory health insurance may take out contractual health insurance. An entitled person has the right to choose any health insurance fund once every 12 months.

Those who do not comply with the conditions for participating in statutory health insurance may take out voluntary health insurance with the GHIF. But voluntary health insurance only serves as a supplementary form. This type of insurance may only be taken out with the GHIF: free choice of health insurance funds in this case is not possible in the Czech Republic. The conditions under which such insurance is taken out, the scope of insurance coverage, the rights and obligations of the insured persons and of the health insurance funds, and the manner of payment of contributions are stipulated in the General Insurance Terms and Conditions issued by the GHIF. The list of health care facilities which provide health care on the basis of this voluntary health insurance is available at all district branches of the GHIF. The provision of voluntary health insurance is regulated by the Insurance Act (Act No. 363/1999 Coll.)

Depending on the term for which the client wants to take out voluntary health insurance, and on the scope of care paid for by that insurance, the customer may enter into either a short-term health insurance policy or a long-term one. Short-term policies (in cases of stays under 365 days) are suitable for short-term stays in the country, i.e. for tourist or business purposes. Long-term health insurance policies (in cases of stays over 365 days) may be taken out by foreigners who are staying in the country on the basis of a visa exceeding 90 days (with the exception of foreigners with a visa exceeding 90 days, granted for employment purposes, if their employer's registered base is in the Czech Republic – since they participate in the statutory health insurance system).

Since the Czech Republic is now a member of the EU, those insured by Czech health insurance funds are entitled to demand services in other European countries and vice versa according to European law.

Health care facilities

There are currently more than 25 000 (mainly private) health care providers in the Czech Republic. The network of health care providers is composed of the following:

- general practitioners for adults
- general practitioners for children and adolescents
- primary health care gynaecologists
- primary health care dentists/stomatologists
- ambulatory specialists
- hospitals
- other bed-care facilities
- emergency and first-aid services
- home-care services
- pharmacies
- public health offices
- institutes of public health.

The Czech Ministry of Health is the operator of faculty hospitals and specialized tertiary-care facilities. Most hospitals in the country before the end of 2002 were set up by district offices; after 1 January 2003, the role of the operator was transferred to the regions. The powers of the regions after January 2003 arise from the fact that all activities performed by health care departments of district offices were handed over to them. There seems to be a basic problem, however, as these powers are not clearly defined, especially with respect to the creation of the network and the monitoring and evaluation of the quality of the health care. The resulting legal situation is unclear and it is therefore possible that some regions are considering transferring the legal status of hospitals into private for-profit companies, and that other regions are waiting to see how things develop. The Ministry of Health has so far not achieved legal uniformity for hospital care. So far, there are several dozen hospitals in the form of limited liability companies in the Czech Republic.

Aside from hospital care, bed care is also provided by a network of specialized medical institutions, such as facilities for the long-term ill, psychiatric institutions, rehabilitation institutions, sanatoria and night sanatoria, medical institutions for the cure of tuberculosis and respiratory illnesses, and spa medical houses.

The network of medical institutions also includes pharmacies and other medical facilities that issue drugs and provide health care technology.

Other players

Membership of a chamber is compulsory for every doctor who works in medical and preventive care, for every professional who works as a dentist and for every pharmacist who works in a pharmacy.

The most significant trade-union organizations in health care in the Czech Republic include the Union for Health Care and Social Care (Odborový svaz zdravotnictví a sociální péče), which has regional councils, the Medical Union Club – Association of Czech Doctors (Lékařský odborový klub – Svaz českých lékařů) and the Professional Sector Union of Health Care Staff (Profesní a odborová unie zdravotnických pracovníků).

The Association of Wholesale Distributors of Drugs (Asociace velkodistributorů léků) enjoys a significant position among the suppliers of drugs. It is a voluntary association of the wholesale distributors of drugs and health care material, and was founded in 1993 for the purpose of protecting and supporting the interests of its members. Currently, it represents four wholesale pharmaceutical companies which have a 70% share in the total volume of drugs distributed in the Czech Republic. It represents its members in negotiation with state administration, the Czech Parliament and other institutions involved in the field.

Organization of public health

State administration concerning the protection of public health in the Czech Republic is performed by the following bodies: the Ministry of Health, regional public health offices, the Ministry of Defence and the Ministry of the Interior. Furthermore, the position as Chief Public Health Officer has been set up at the Ministry of Health, for issues concerning the protection of public health.

The responsibilities of the Hygiene Service itself have been, as of 1 January 2003, divided into two areas: the execution of public administration (public health office); and the independent measurement of health-related indicators (institutes of public health). Public health institutes have thus become only a kind of a “laboratory”, without any control or inspection powers. The supreme executive body within the Hygiene Service is the National Institute of Public Health, whose role is to perform specialized scientific work for public administration, to examine the effectiveness of health measures and to support preventive medical education.

Planning, regulation and management

The Ministry of Health is responsible for procuring uniform professional management of public health care, for managing health care in a standardized fashion, and, for that purpose, issues generally binding legal regulations for the organization and execution of health care; it oversees the level of that care (section 70 of Act No. 20/1966 Coll.).

The Czech Republic has, after more than 10 years, renewed public administration at regional level and has thus created conditions for the use of standard management tools (planning, regulation, control), which are useful not only for management at the level of organization, but also primarily in the public administration system. The current public administration reform consists not only of the shift of powers, but its third statement has also set goals with respect to the necessary career development of public administrative staff, and their further education. This promises a necessary, and somewhat overdue, modernization.

The health insurance funds are relatively independent bodies responsible for entering into contracts with health care providers. With the exception of some special cases, health care facilities are direct contractual partners of the GHIF, which is the largest health insurance fund in the Czech Republic, and the other health insurance funds. Contracts are generally for a two-year period.

In accordance with health insurance legislation, there are regular – usually every six months – negotiations among the health insurance funds, providers (hospital associations, hospitals and private physicians) and professional chambers. These bodies negotiate various issues:

- the range of services to be covered under the compulsory health insurance system as well as the number of reimbursement points per service in the fee schedule;
- the monetary value of points used, to determine actual reimbursement;
- conditions for delivering care in the major sectors of health care.

The values of points and the amount of health care paid for by health insurance funds are set during negotiations between representatives of the GHIF and other health insurance funds and the appropriate professional associations of providers as the representatives of contractual health care facilities. The ministry then evaluates the results of such negotiations as to their compliance with legal norms and public interests. If it finds that they comply, the results are binding for health care facilities and insurance funds. The government is also entitled to make the necessary decisions if no agreement can be reached.

The list of medical procedures, with the number of points assigned to them, is put together in negotiation with the representatives of health insurance companies, the representatives of professional associations of providers (representing contractual health care facilities), the representatives of professional organizations set up by law, the representatives of specialized scientific organizations, and with the representatives of insured persons. This list of medical procedures is subsequently evaluated by the ministry, for compliance with legal regulations and the public interest.

In 1997, the process of bed-care restructuring was launched. The restructuring of bed care was intended to resolve the problem of over-extensive acute hospital care. The main goals of restructuring were to decrease the number of beds in acute hospital care, to increase the number of beds for long-term bed care, and to decrease the staff count. The main impetus for this step were the previous problems in the financial management of the hospitals.

In 1997, an opportunity arose in the form of the need to replace Act No. 550/1991 Coll. (General Health Insurance) with Act No. 48/1997 Coll. (health insurance). Sections 46 to 52 were inserted into the draft during deliberations, which established the process of so-called tenders for health care services. All existing and newly created health care facilities were to be subject to the tendering process. But even this legislative step has many gaps and mistakes which decreased the effectiveness of restructuring, and there was even a clash between the provisions of Act No. 48/1997 (sections 46–52) and Act No. 20/1966 Coll. (Care of People’s Health), sections 42 and 71. According to these provisions, the Ministry does not bear any responsibility for the outcomes of the tenders, as it does not recognize them as its own and shifts all responsibility to health insurance funds and their relations with health care providers.

Now, regional offices and the Ministry of Health are responsible for the creation of the network of health care facilities. The regional offices cooperate in the creation of the network of health care institutions in the region and perform tasks related to the establishment and management of health care facilities in their respective territories, with the exception of large hospitals. Those tasks they execute as part of their own (regional) powers. As part of the powers transferred to them, regions decide on the issuing, changing or withholding of the registration of non-state health care facilities, keep records of the capacities of health care facilities, and enter into contractual relationships for the provision of necessary health care services with respect to first-aid medical services and rescue services.

The role of the regulator of public outpatient health care services has been entrusted, by law, to the statutory health insurance system. But at the beginning

of the 1990s there were two years when health insurance funds were obliged to enter into a contractual relationship with any health care provider who asked for it. The attempt of health insurance funds to optimize the number of health care providers in the mid-1990s, however, did not lead to any substantial change. In 1998, a special agreement was even reached between the Czech Medical Chamber and the director of the GHIF on retaining the current situation. Between 1990 and 2002 the number of outpatient specialists grew to twice the number, i.e. from 6 outpatient specialists per 1000 inhabitants to 12.

In the health care system, programmes of asset-management exist, which are co-financed from the state budget. The programme comprises a set of material, temporal and financial conditions for the acquisition or technical improvement of a tangible or intangible asset (short- and long-term), its maintenance and its repair. Participation of the state budget means either purpose-oriented funds from the state budget (individual subsidies, system subsidies, refundable financial aid), or the provision of a state guarantee for loans. The extent of state budget participation in the financing of a programme is specified upon the evaluation of programme documentation. This documentation must include the programme identification data, a summary of needs and sources of programme financing, and a specification of programme goals, including technical and economic rationalization, and an evaluation of the effectiveness of the invested financial funds. All information about the programme is recorded in the Asset Management Information System administered by the Czech Ministry of Finance.

A change in the approach to planning, regulation and management in the past few years may be noticed at several levels and in several areas. At central level, the attempt of the Ministry of the Interior is designed to unify and standardize access to public services. The renewal of regions and their legal regulation led to a significant measure of development in the approaches and tools used for planning. Regions formulated action-development plans. For this purpose, a special statute was enacted. At regional level, significant options are available for the development of planning tools and management in health care services. This improvement is, however, strongly negatively influenced by the ambiguities of health care law at a national level. Regions thus can take very different approaches to health care, based on their party, political and ideological orientation. About one third of the regions remain very liberal in approach, liking the idea of hospitals in the form of for-profit companies. Other regions have taken a more careful approach and will probably be interested in using planning tools in the sphere of health care.

The development of the legal framework, as contributed to by other ministries, points to a greater level of responsibility at ministerial level. The responsibilities of the Ministry of Finance, for example, are indicated by Act No. 218/2000 Coll.

(Budgetary Rules) and Ministry of Finance Regulation No. 40/2001 Coll. (on state budget participation in the financing of asset-management programmes). This development also includes Act No. 320/2000 Coll. (Financial Control). Between 2002 and 2003, significant discussion took place in the country about the reform of public finances. The first steps consist of restriction of public spending, but it is evident that further stages of the reform will have to focus on the efficiency and effectiveness of the expenditure part of public finance, in line with worldwide economic developments *(13)*. Popular political discussions about the income side of the public sector (involving various liberal proposals on tax reform) will then have to seriously and responsibly engage in considering the expenditure side. The need for such an approach is undoubtedly also relevant for the health care sector. In the future, this sector should be much more interested in the use of knowledge gained from the development of public administration, the role of the State, regulation of health care activities, planning and human resource management in health care, long-term sustainability in financing and payment for health care services, etc.

Decentralization of the health care system

Decentralization of hospitals in parallel with public administration reform

Since the launch of public administration reform in 1998, there have been changes to the legal framework of public administration; these have had an impact on the position of hospitals and on hospital care. Since 2000, public administration reform has been implemented, initiating the decentralization of executive power from national to regional level and also increasing the powers of the regions' self-administration. The implementation of state administration at district level was abolished at the beginning of 2003. The execution of that agenda partly shifted to the regional level, and partly to selected municipalities. These changes have had significant consequences for the execution of state administration in health care, primarily in the role of public administration as the operator of former district hospitals.

The following changes were implemented in connection with the issues of the status of hospitals, as of 1 January 2003, as part of the second stage of public administration reform:

- change in the ownership of district hospitals – transfer of hospital assets from the State to self-administered regions – and thus also a change to the act that regulates the use of assets such as a hospital; and

- change in the administration of district hospitals – the governors are now regions – specifically regional councils as the executive bodies of self-administration.

Dissolution of districts (1 January 2003) and transfer of assets

The second stage of public administration reform, i.e. the dissolution of district offices (with all of the resulting consequences for the organization of hospital care) was significant for the organizational and legal positions of Czech hospitals. On the basis of acts No. 157/2000 Coll., No. 290/2002 Coll., No. 10/2001 Coll. and No. 20/1966 Coll., the ownership was transferred, as of 1 January 2003, from National Government to regional governments. While, at the end of 2002, almost half of all hospitals (82 hospitals with 32 021 beds out of the 203 hospitals with 66 784 beds) were subordinated to district offices these hospitals were subordinated to the self-administrating powers of the regions. Since then regional governments have been the owners and operators of public hospitals.

So far, district offices have used state property in line with Act No. 219/2000 Coll. (Assets of the Czech Republic and Their Representation in Legal Relations). That act, compared to the applicable provisions of the Act on Regions, No. 129/2000 Coll., which, as of 1 January 2003, regulated the financial management of regions with assets transferred to them, ensured much more detailed, fuller and more careful regulation of the use of state assets. Act No. 219/2000 Coll. (Assets of the Czech Republic), specifically regulates the powers relating to the management of property, the acquisition of property, basic obligations concerning the management and disposal of property, decision-making and control mechanisms in the transfer of property, and procedures concerning the fulfilment of obligations (e.g. assets used by organizational units cannot be subject to bankruptcy) and control mechanisms.

According to the Act on Regions (No. 129/2000 Coll.), the financial management falls to the self-administrative powers of the regions and is regulated by sections 17–23 of the Act. One of the basic elements of self-administration is the right of self-administrative units to use their own assets as they deem necessary.

Changes in the administration of hospitals – regional offices

Act no. 290/2002 Coll., started the transfer of the roles of administration and of asset rights from the district offices to the regions. Thus a change in the legal position of health care facilities, which had, until 31 December 2002, been

operated as state contributory organizations, has thus occurred. Act No. 20/1966 Coll. (Care for the People's Health), states (Section 39) that the establishment of health care facilities by the regions is part of their self-administrative powers, and Act No. 250/2000 Coll., on the budgetary rules for regional budgets in section 23 1, enshrines the right of the regions to establish or found their own organizational units, contributory organizations, companies and generally for-profit companies. The act concerning regions – No. 129/2000 Coll. (section 59 (1i)) – thus reserves the execution of the administrative role to the regional council as the region's executive body in the sphere of its self-administrating powers, with respect to legal entities and organizational units established by the region or transferred to it. The regional government may then decide, within its self-administrative powers, to set up and wind down legal entities and contributory organizations and organizational units of the region. Regions generally have the right to seek other organizational options for their hospitals, e.g. shifting the administrative powers from the region to private for-profit or not-for-profit companies.

In the execution of their self-administrative roles, regions are governed by statutes or other legal regulations issued on the basis of a statute, but not by government resolutions and directives of central bodies which district offices had to follow in their work, i.e. also in their role as the operator of hospitals. The State supervises only issues of legality, since the application of any other criteria, e.g. the material propriety or purpose, would unduly limit the self-administrative rights of municipalities and regions. In the case of regions, supervision is performed by the appropriate ministries and other authorized central administrative authorities. Previously, the work of district offices was managed by the government and, in the course of their activities, they had to adhere not only to laws and other legal regulations issued on the basis of statutes, but also to government resolutions and directives issued by central administrative bodies. The transfer of the role of operator of hospitals from district offices to regions thus significantly limited the powers of the State to influence the further development of hospitals.

Although regions have a broad sphere of power, from 1 January 2003 act no. 290/2002 Coll., Sec. 3 introduced a blocking mechanism, i.e. upon the transfer of responsibility for a hospital to a region, there is an obligation to provide health care in the given facility for at least another 10 years, and, should the region wish to dispose of the facility, sell it or privatize it prior to the expiration of that deadline, it must first offer it, free of charge, to the State (i.e. to the Ministry of Health). Only if the ministry does not accept the offer within a period of three months can the region sell its assets as it chooses. This point has been cancelled by Judgement 211/2003 Coll.of the Constitutional Court (enacted on 1 January 2004).

From the point of view of legal norms in the sphere of hospital care, the public administration reform seems absolutely unprepared. The availability and quality of these public services is not regulated legally. The applicable legal regulation of the organizational and legal arrangement of hospital care, by the regions, is largely ambiguous and allows for several options in terms of further development. A question arises as to whether the situation corresponds to the provision of section 71 of Act No. 20/1966 Coll., which includes the condition of uniform provision of public health care services. The Ministry's approach to the preparation of the second stage of public administration reform is deemed as being, at the very least, problematic by some experts. A way of remedying the existing situation would be to enact a new law on public hospitals, or at least to make an amendment to Act No. 20/1966 Coll. to specify the obligations of self-administration and state administration more precisely.

Health care financing and expenditure

Main system of financing and coverage

The process of transition from a tax-financed system to one financed through health insurance was accelerated by pressure from health professionals who expected increased levels of income with health insurance. A new health insurance system was introduced on 1 January 1993, financed through compulsory health insurance. Currently, nine health insurance funds administer the system.

The system is based on solidarity and equity. It is financed by contributions from individuals, employers and the State (on behalf of the unemployed, pensioners, children and dependants up to 26 years of age, students, women on maternity leave, men serving in the military, prisoners, and people receiving social welfare). Approximately 56% of the population is insured by the State. The State also acts as guarantor of the system.

Population coverage is based on permanent residence and is broadly based. It includes foreign nationals if they are either employed by organizations based in the Czech Republic or are permanent residents. There are no excluded groups and no changes in population coverage have taken place in recent years; nor are any such changes expected in the near future. Opting out of the insurance system is not permitted in the Czech Republic.

Contributions are defined by law as a percentage of wages (before tax): employees pay 4.5% and employers 9% (13.5% altogether). There is a ceiling on contributions, which is set at about six times the average salary in the Czech Republic. This makes the funding system mildly regressive. The self-employed pay the same total percentage (i.e. 13.5%) but only on 35% of their profits. There is also a legally defined minimum contribution for the self-employed which may be adjusted according to the inflation rate; this was 905 Czech koruny

(approx. €28) per person per month in 2004. Since almost 80% of the self-employed are not making (or declaring) any annual profit, they only have to pay this minimum contribution. As a result, possible changes to this part of the health insurance legislation are currently under discussion.

The Ministry of Finance contributes the same percentage (13.5%) monthly "wage" for the state-insured is set up by statutory order; in 2003 it was 3458 Czech koruny (approx. €108), i.e. the State contributes 467 Czech koruny (approx. €15) per person per month.

The choice of insurer is made by individuals (rather than by their employer) and the insured may change funds on an annual basis (initially, the insured could change funds every three months). The GHIF is legally obliged to insure everyone. If an insurance fund goes bankrupt, its clients usually pass to the GHIF. The other health insurance funds are also legally required to insure all applicants, but there are reports that, in practice, they are able to select their members.

The GHIF is by far the largest fund, covering approximately 68% (2002) of the population, including almost all non-wage earners. Its solvency is guaranteed by the State. Children and pensioners can register with any health insurance fund, but most are registered with the GHIF. Both the Ministry of Internal Affairs (police) and the Ministry of Defence (military) have their own insurance funds, which evolved from the parallel health care systems existing under the communist government. The remaining insurers are generally organized through large companies or around certain categories of employees (miners, bank employees, etc.). In recent years, 18 health insurance funds have disappeared from the market. Some of them went bankrupt, while others were abolished by the government for not meeting legal requirements. The causes of these problems were diverse: for example, inadequate underwriting for small funds, high overhead costs for small funds, and too many special programmes (e.g. for the chronically ill, such as asthmatics). Some of the funds merged and others closed down. Many of the insured reinsured themselves with the GHIF, which has therefore remained the main insurer with about 68% market share.

The bankrupted funds are also part of the cause for the debts in the system – debts which accumulate when unpaid providers cannot pay their staff or their suppliers. Financial difficulties were concentrated mainly in the hospital sector, where the majority of hospitals were operating at some degree of deficit. The cumulative deficit at the end of 2003 is estimated at 6 billion Czech koruny (about €220 million) or nearly 4% of total annual health expenditure *(8)*.

The initial idea that the health insurance funds would compete by offering different services proved to be a mistake. At first, various services were offered in addition to a basic package in the competition for members. However, it

became evident that many health insurance funds did not have sufficient money to cover even basic health care services. Reimbursement of services in addition to the basic package was restricted by law in 1994 and the scope for competition among funds based on supplementary benefits was completely abolished by legislation in 1997.

Health insurance funds are not permitted to make a profit. Any surplus goes to a special account called the Reserve Fund. The health insurance funds are no longer allowed to offer additional services to their clients, as this had contributed to the bankruptcies. In cases of financial difficulty, only limited assistance is available from the State, but the insured are protected from loss of coverage by the existence of the GHIF safety net. The Ministry of Labour and Social Affairs, the Ministry of Finance and the Ministry of Health all participate in the boards of the funds, while the Ministry of Health is responsible for supervision, which, in practice, at least initially, has been fairly weak.

Health insurance contributions have been redistributed in order to lower the potential for risk selection and to ease the financial difficulties of health insurance funds with adverse risk structures. Thus, 60% of all contributions are liable to redistribution, which is administered by the GHIF according to a capitation formula. Members over the age of 60 are allocated three times the standard capitation rate available to those under the age of 60. No other adjustments are made. Despite reallocation, the smaller insurers receive disproportionately larger revenues per capita since, on average, they have better-earning members and keep 40% of contributions outside the redistribution mechanism. In 2003–2004, a political consensus was reached about the reform of the risk structure compensation scheme among the nine health insurance funds. Now there will be a gradual (2-year) interim period when all of the contributions (100% of the contributons) collected will be reallocated according to two criteria: one is age, and the other reflects the extent of resource utilization, e.g. in treating chronic disease or morbidity. However, it still does not seem clear as to which criteria exactly, apart from age, will be applied to the new risk structure compensation scheme.

In recent years, health insurance funds, especially the GHIF, have been experiencing increased financial difficulties. Problems have been caused by factors such as inadequate inspection and control of staff workloads, insufficient contribution levels and inadequate cost containment under the initial fee-for-service system (see the section on Financial resource allocation). The main cause may be the fact that the provider network is obviously too expensive. Health insurance funds and public administration are only slowly managing to restructure the health care service network and to actively purchase services with selective contracts *(14)*.

Changes to the legislation may be required to address problems brought about through weak administrative control mechanisms. For example, the system ensures that the vast majority of salaried employees and their employers pay contributions, but enables some of the self-employed – who should pay contributions – to avoid doing so or to pay very little.

Since the beginning of 2003, there has been some suggestion that the Ministry of Health is considering the possibility of introducing a deductible. Therefore it would follow a recommendation of a recent OECD report which also suggests the introduction of deductibles. The Ministry is also attempting to increase the cash flow into health care by lowering the compulsory reserve funds of health insurance funds and by some other measures.

Health care benefits and rationing

Health care services are covered by the health insurance funds, while sickness benefits (i.e. sick pay) are paid from the state-run social security fund, which is not part of the national budget. Some proposals exist for the unification of both systems, but these will probably not be implemented in the short term. The social security fund is a state institution responsible for sickness benefits, pensions, unemployment benefits and other social benefits. It is financed through social insurance contributions, which are 34% (26% percent is paid by the employer, and 8% is paid by the employee). A share of 4.4% is being spent on sickness insurance for sickness benefits. Sickness insurance is the only insurance that is not compulsory for the whole population, since the self-employed may opt out from this part of social insurance.

The following services are fully or partially covered by health insurance:

- preventive services (preventive examinations, screening, vaccinations following the recommended immunization calendar, etc.);
- diagnostic procedures;
- ambulatory and hospital curative care, including rehabilitation and care of the chronically ill
- drugs and medical devices;
- medical transportation services; and
- balneological (spa) therapy (if indicated and prescribed by a physician).

In principle, any treatment required for the cure of illness or to improve health status is approved for reimbursement. In addition, insurance legally covers regular preventive examinations of infants and children (nine during the first

year of life, at 18 months of age, at 3 years of age and afterwards every 2 years) as well as those for adults (every 2 years). Prophylactic dental treatment once a year (twice a year for children) and some standard dental treatments are free. Rehabilitation, fertility treatments and psychotherapy (with some restrictions) can still be obtained under the state system. Under certain circumstances, spa treatments (balneological therapy) may be reimbursed either partially or fully. If medically indicated, abortions are also covered (while others have to be paid for privately).

In every case, the cheapest available treatment is fully covered. The respective health insurance fund, represented by a review doctor, can examine the circumstances and agree to the full reimbursement of a more expensive treatment.

Pharmaceuticals are classified into three lists. Those on the generic list are covered, but any others generally require out-of-pocket payments. Non-generic drugs may be approved for reimbursement if the doctor from the health insurance fund claims that there are no alternatives.

The health care benefits package is very broad in the Czech Republic and even includes spas and over-the-counter drugs (if prescribed by a physician), which are not reimbursed in many other countries. As mentioned, there are regular negotiations among the health insurance funds, providers (hospital associations, hospitals and private physicians), professional chambers, scientific organizations and patients' associations to determine, in detail, the services covered; these are then listed in the fee schedule together with the number of points for reimbursement. In its supervisory role, the Ministry of Health has to ensure that the result meets legal requirements as well as the public interest before it issues it as an order.

Initially (i.e. until 1997), insurers were allowed to offer additional services, but not to offer less than the basic package. Utilization rates of health care have risen markedly since the socialist period. As a result, the benefits package is unlikely to be broadened in the future, and some consideration is being given to having a more prudent and restricted set of services.

Only a limited number of services are excluded from the statutory health care system. Cosmetic surgery for non-medical reasons and selected services made at the patient's request (primarily various medical certificates) are not covered. A small number of services, including certain kinds of dental care (particularly dentures), require co-payment. Prostheses, eyeglasses and hearing aids may be either partially or fully reimbursed.

Social care is not included in the statutory health insurance system and is paid for partly by patients and partly by the Ministry of Social Affairs.

Complementary sources of financing

At the beginning of the reform process, a multi-source system of financing was proposed. Five financial sources were expected for health care financing at the beginning of the 1990s:

- health insurance
- state budget
- municipal budgets
- out-of-pocket payments
- donations.

Voluntary supplementary insurance is still under consideration. At present, statutory health insurance is clearly the main source of financing, being at slightly more than 80%. Taxes, the second most important source (a little over 10%), cover both non-investment and investment expenditure in both state and local government budgets (Table 4).

Table 4. Percentages of main sources of finance, 1991–2002

Source of finance	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Public	96.8	95.4	94.8	94.0	92.7	92.6	91.9	91.9	91.9	91.6	91.4	91.7
Taxes (direct expenditure)	96.8	95.4	19.1	16.5	16.5	12.5	11.8	10.9	11.1	10.5	9.5	10.2
Statutory insurance (total)	–	–	75.7	77.5	76.2	80.1	80.1	81	80.8	81.1	81.9	81.5
Private	3.2	4.5	5.2	6.0	7.2	7.4	8.1	8.1	8.2	8.4	8.6	8.3
Out of pocket	3.2	4.5	5.2	6.0	7.2	7.4	8.1	8.1	8.2	8.4	8.6	8.3
Private health insurance	–	–	–	–	–	–	–	–	–	–	–	–
Other	–	–	–	–	–	–	–	–	–	–	–	–

Source: state budget for 2003, Ministry of Health (expenditures of other sectors included, i.e. Ministry of Defence, etc.).

Taxes

Taxes are used to cover expenditure at both national and regional level. At the national level, the Ministry of Health finances the capital investments of facilities it directly manages, such as regional hospitals, university hospitals and specialized institutions for research and postgraduate education. Public health services are also financed directly by the Ministry of Health. Direct funding from the Ministry of Health covers part of the cost of training medical personnel and

of running specific specialized health programmes. These programmes include AIDS prevention, drug control, the operating costs of long-term care institutes, and research and postgraduate education. Social care is paid for partly by the Ministry of Social Affairs and partly by users of the services.

Out-of-pocket payments

Cost-sharing is required mainly for selected drugs, dental services and some medical aids. So far, there is hardly any co-payment in the Czech Republic, which is quite unusal compared to other OECD countries. Out-of-pocket payments represented only 5% of total health care expenditure in 1993 and increased to around 8.3% by 2002 (8.6% according to OECD health accounts in 2002). However, the Czech Republic has the lowest share of out-of-pocket payments of all OECD countries. This share is only about one-third of the share of other central European countries like Hungary (26.3%) and Poland (27.6%) (Fig. 7). However, informal payments are not included in the share of out-of-pocket payments in the Czech Republic.

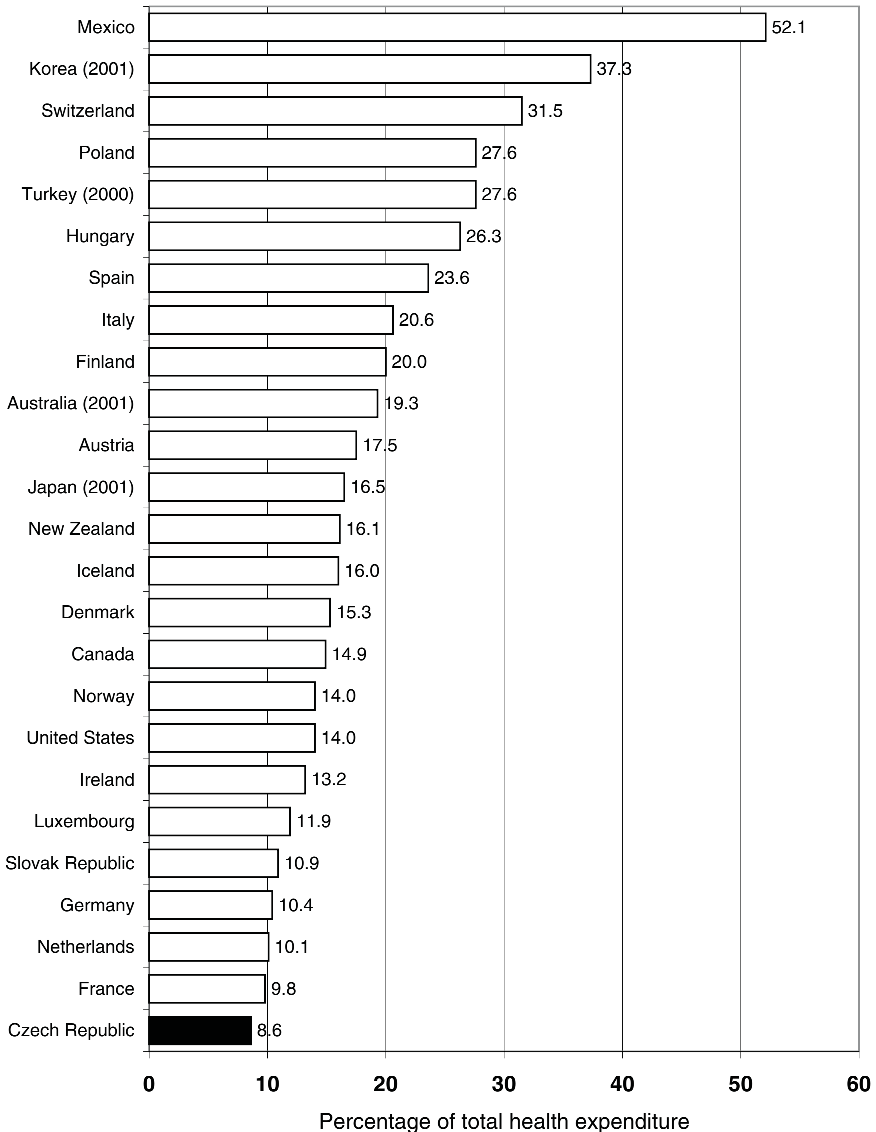
Voluntary health insurance

At present, there is only a very small market for voluntary insurance (not even 0.1% of health expenditure). This includes coverage for health care when travelling abroad, for foreign nationals who are not eligible for the statutory health insurance system, and for certain services not provided under the state system (e.g. cosmetic surgery or some kinds of dental care). The level of benefits covered by the statutory health insurance is very high, even including spas and over-the-counter drugs, and thus there is no demand for any supplementary private health insurance.

Health care expenditure

In all countries, the percentage of GDP spent on health is considered to be an important economic indicator. In the Czech Republic, health expenditure grew from 5% in 1990 up to a peak of 7.8% in 1994 and then started to decrease again, and was at 6.8% in 2001 (Table 5). The significant increase in expenditure was directly related to the introduction of the health insurance system. (N.B. Other sources which set the percentage at around 0.7% lower do not include private health expenditure.)

Fig. 7. Out-of-pocket health care expenditure as a percentage of the total health expenditure for the OECD Region, 2002



Source: OECD Health Data 2004.

Czech expenditure as a percentage of GDP is higher than the 5.8% average for central and eastern European countries but equally less than the 8.9% average for western EU countries (Fig. 8). If compared to neighbouring countries, the

Table 5. Trends in health care expenditure in the Czech Republic, 1995–2002

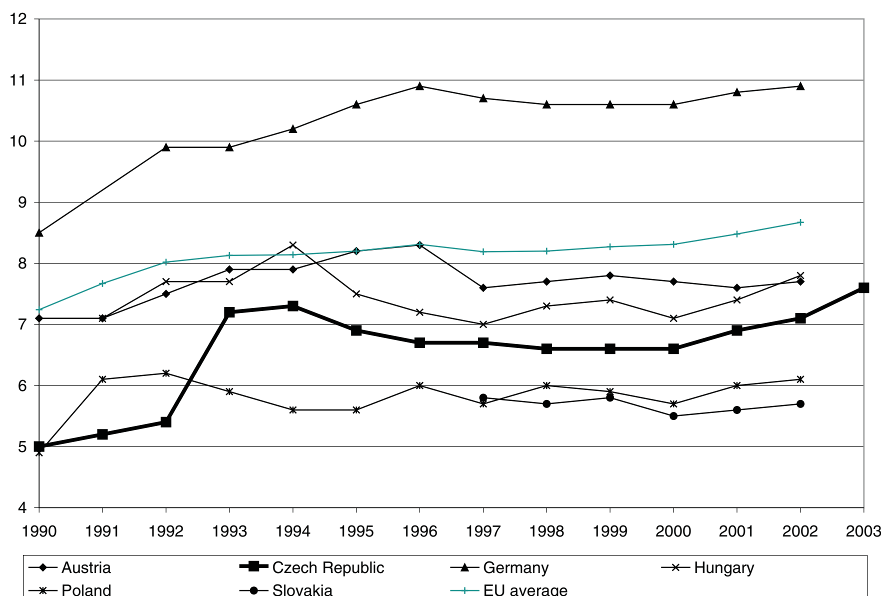
	1995	1996	1997	1998	1999	2000	2001	2002
Value in current prices, KCS (millions)	100.7	110.7	118.9	129.9	134.9	141.9	158.7	168.5
Share of GDP (%)	7.3	7.1	7.1	7.1	7.1	6.6	6.8	7.0
Public share of total expenditure on health care (%)	92.7	92.5	91.7	91.8	91.5	91.4	91.4	91.4

Source: Zdravotnická ročenka ČR 2002, Institute of Health Information and Statistics of the Czech Republic (UZIS: Ústav zdravotnických informací a statistiky České republiky).

trend is similar to that found in Slovakia and Hungary, while the rate in Poland is lower, in Austria slightly higher and in Germany much higher (Fig. 9).

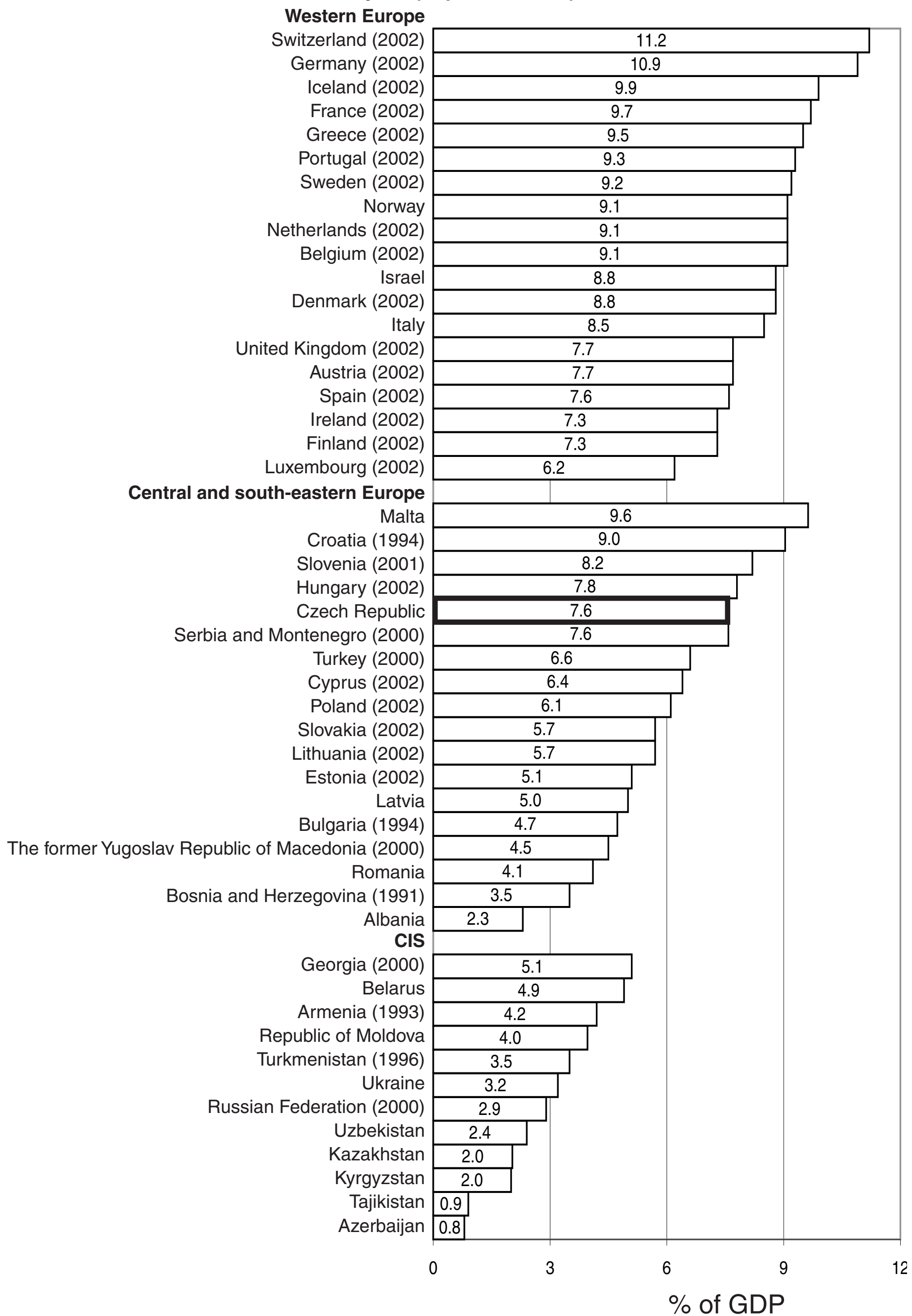
Of course the differences are much more pronounced if per capita expenditure is used as a basis (Fig. 10). The Czech Republic's public expenditure as a percentage of total health expenditure is lower than that in most other central and eastern European countries, but is higher than that in western countries that use social insurance (Fig. 11).

Fig. 8. Trends in health care expenditure as a proportion of GDP (%) in the Czech Republic, selected countries and EU average, 1990–2003



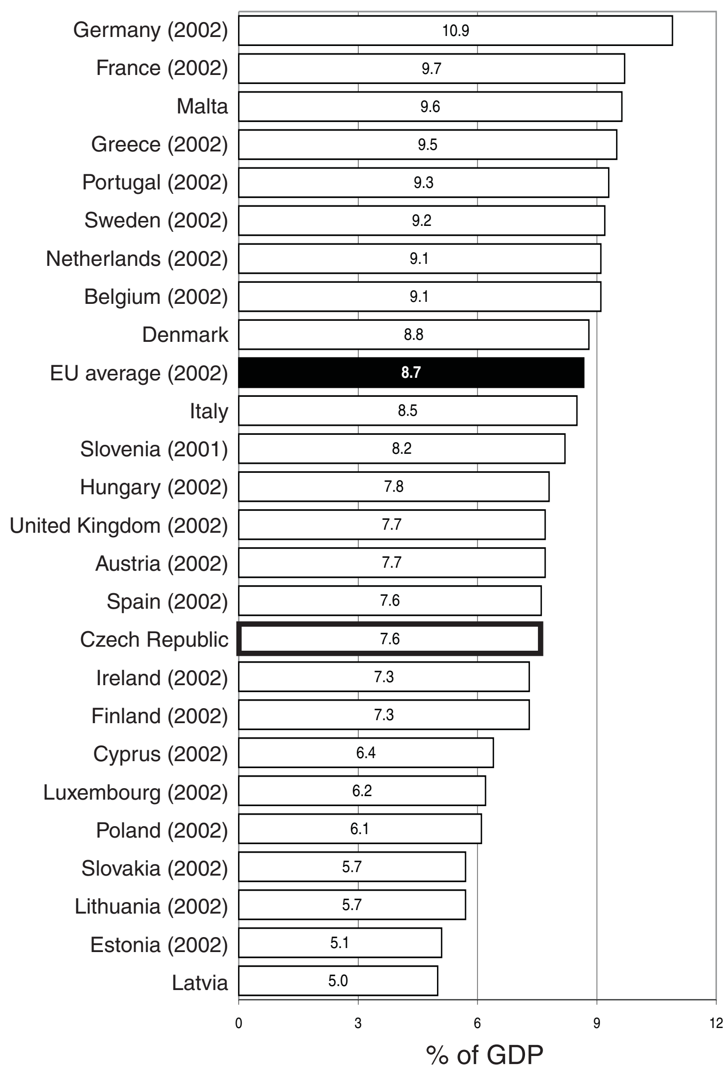
Source: WHO Regional Office for Europe health for all database, January 2005.
Note: EU: European Union.

Fig. 9a. Total expenditure on health as a % of GDP in the WHO European Region, 2003 or latest available year (in parentheses)



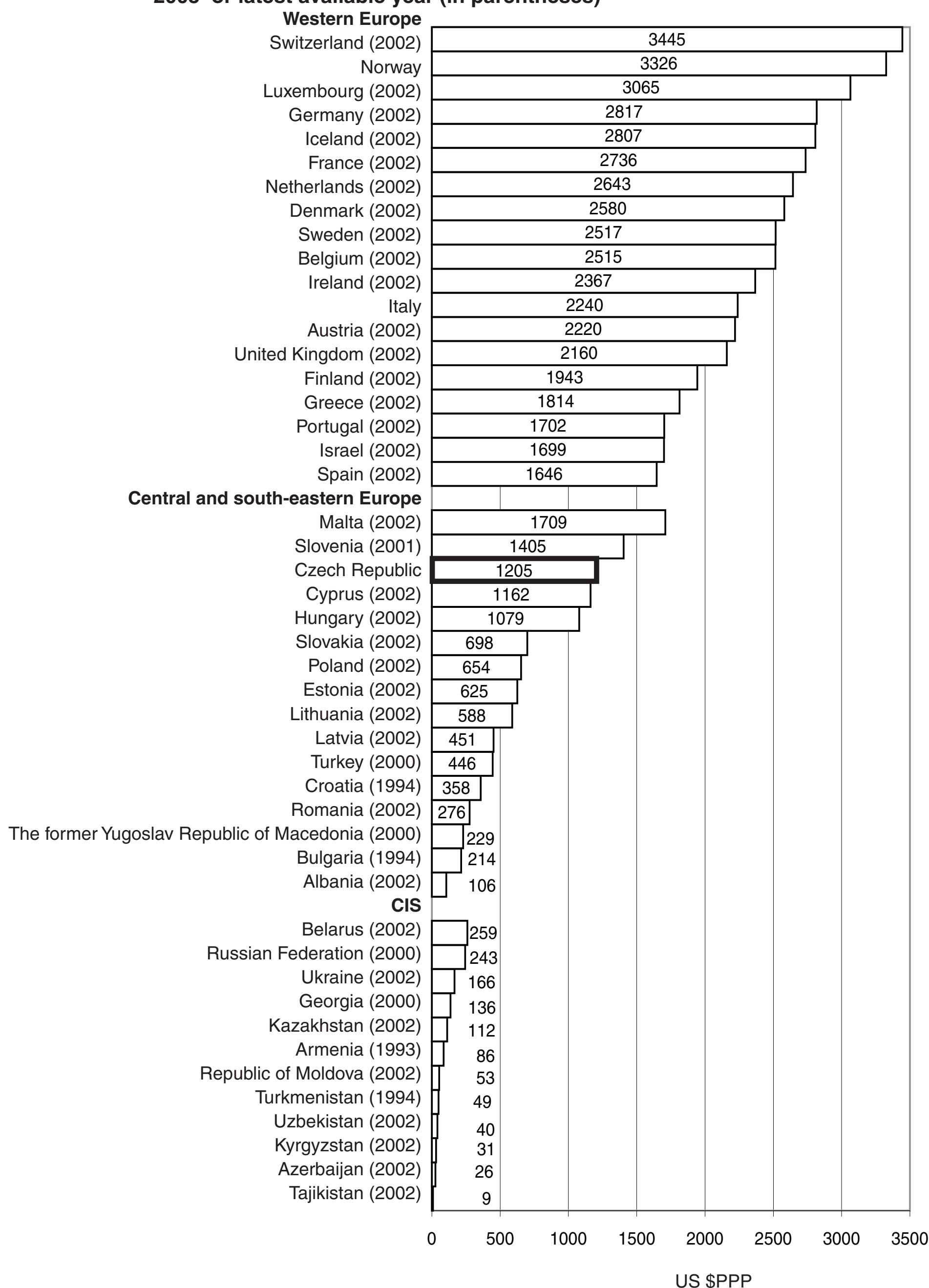
Source: WHO Regional Office for Europe health for all database, January 2005.
Note: CIS: Commonwealth of independent states; countries without data not included.

Fig. 9b. Total expenditure on health as a % of GDP in the European Union, 2003 or latest available year (in parentheses)



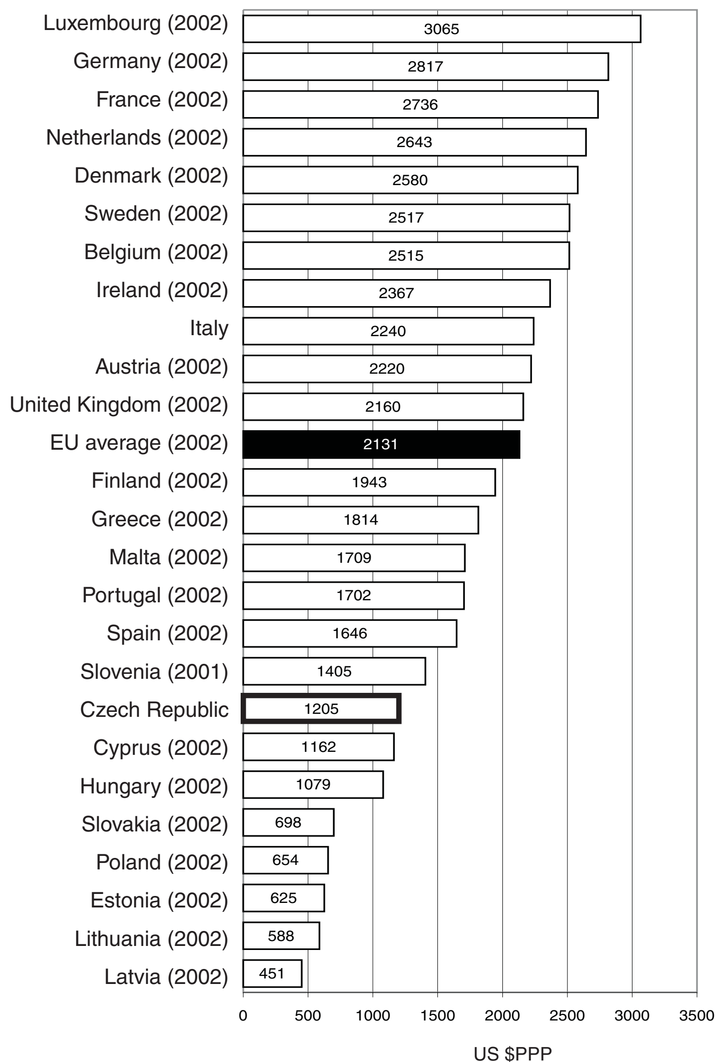
Source: WHO Regional Office for Europe health for all database, January 2005.
Note: EU: European Union.

Fig. 10a. Health care expenditure in US $PPP per capita in the WHO European Region, 2003 or latest available year (in parentheses)



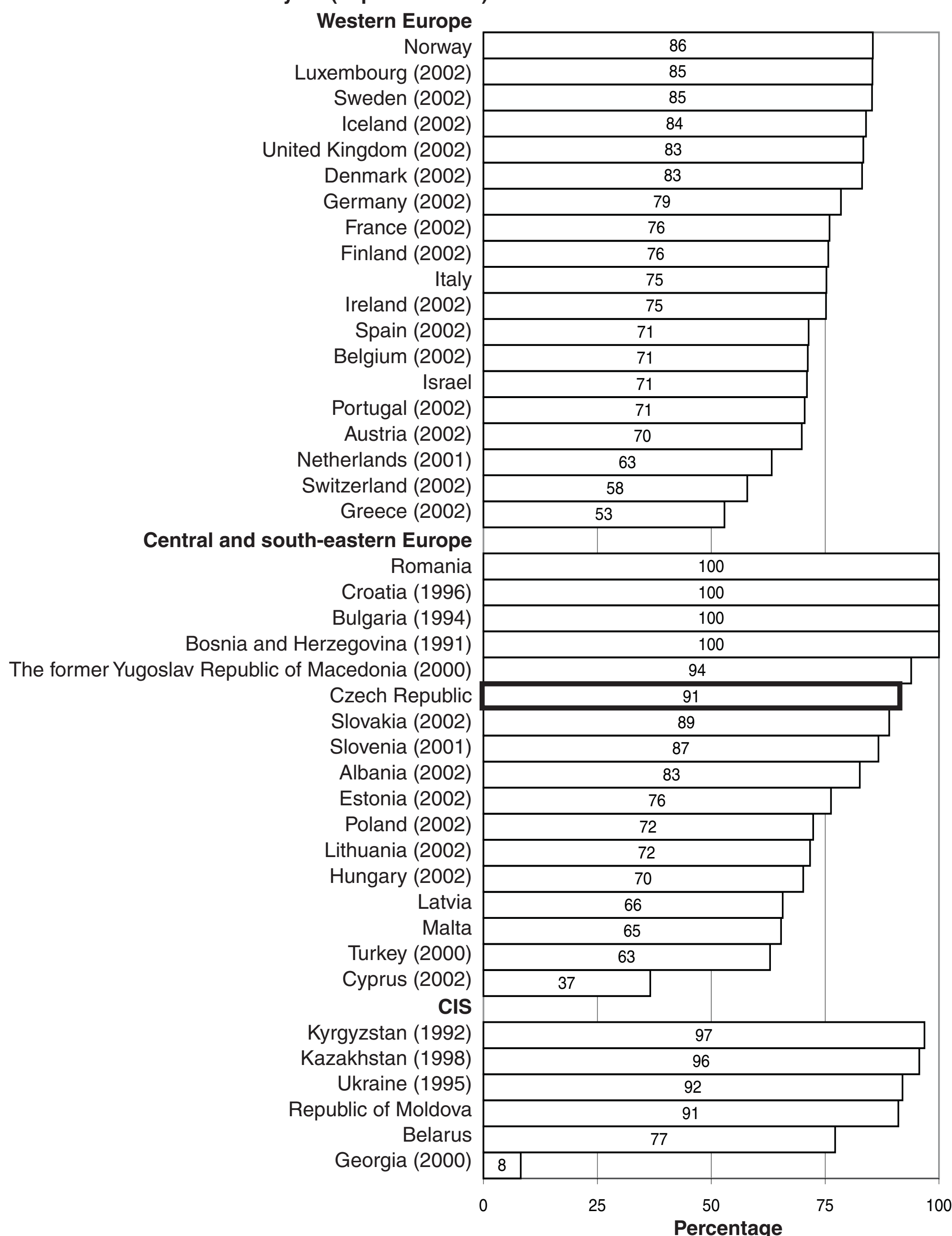
Source: WHO Regional Office for Europe health for all database, January 2005.
Note: CIS: Commonwealth of independent states; countries without data not included.

Fig. 10b. Health care expenditure in US $PPP per capita in the European Union, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database, January 2005.
Note: EU: European Union.

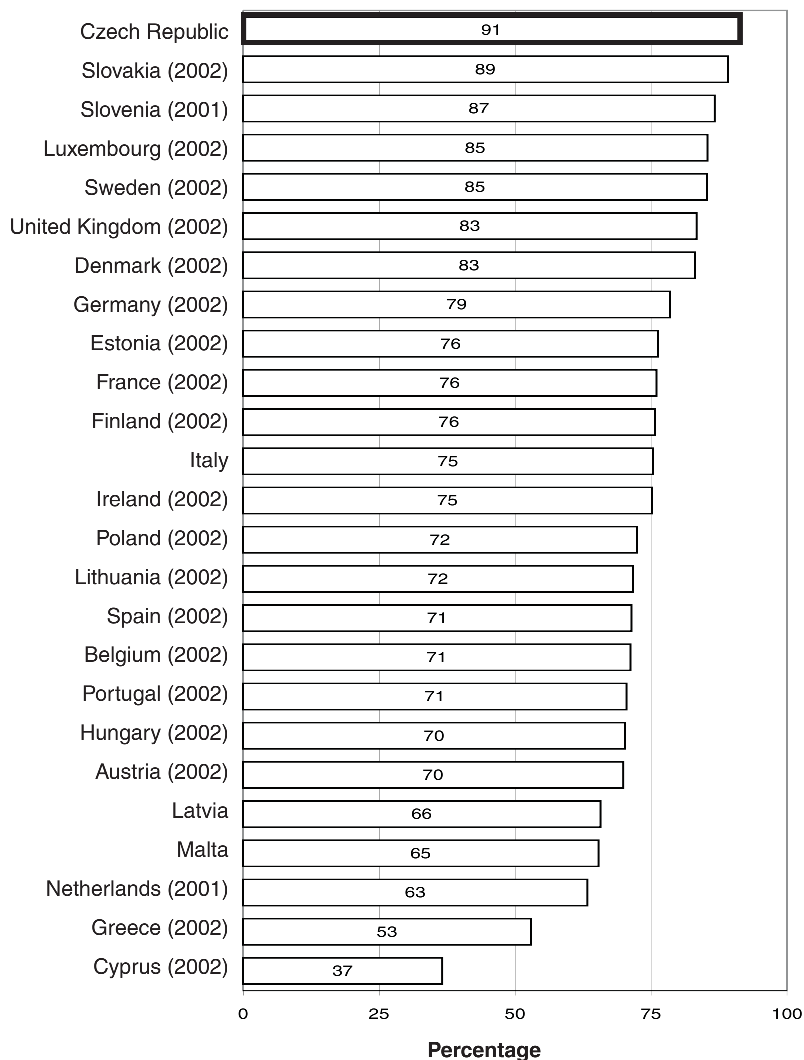
Fig. 11a. **Health care expenditure from public sources as a percentage of total health care expenditure in countries in the WHO European Region, 2003 or latest available year (in parentheses)**



Source: WHO Regional Office for Europe health for all database, January 2005.

Note: CIS: Commonwealth of independent states; countries without data not included.

Fig. 11b. Health care expenditure from public sources as a percentage of total health care expenditure in countries in the European Union, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database, January 2005.

Inpatient care and pharmaceuticals constitute the categories which consume the largest share of health care expenditure – the latter beingwell above the average for OECD countries. Direct public investment expenditure fell below 5% in 2001 (Table 6).

Table 6. Health care expenditure by category (as a percentage of total expenditure on health care), 1985–2002

Category	1985	1990	1995	1996	1997	1998	1999	2000	2001	2002
Inpatient care	–	–	29.6	33.8	35.6	35.4	33.9	34.6	36.6	39.3
Pharmaceuticals	–	–	25.6	25.5	25.3	25.5	22.7	22.0	21.9	24.6
Investment	–	–	–	10.5	9.5	8.9	8.3	4.6	4.1	4.6

Source: WHO Regional Office for Europe health for all database, October 2004.

Health care delivery system

Public health services

In the early 1950s, a network of district and regional public health (Hygiene Services) was established, with each district institute serving approximately 100 000 inhabitants in the provision of public health services. Regional public health offices replaced district public health offices as public health authorities regarding public administration reform in January 2003. Regional public health offices are responsible for decisions, certifications and authorizations and other tasks concerning public health, as well as epidemiological surveillance (including infectious diseases) and immunization logistics (such as the supply of vaccines). Institutes of public health are health facilities and examine and measure life and work conditions, the quality of products and biological material, etc.

They share public health duties with other parts of the former state health care system. Primary health care facilities, for example, are responsible for preventive services, immunization and antenatal services (these activities are financed by the health insurance funds). Health promotion and education programmes are usually organized and funded directly by the Ministry of Health. A set of national priorities was identified in the National Programme of Health Restoration and Health Promotion in 1992, a medium-term programme to improve national health status. These priorities emphasized smoking cessation and diet as activity areas, as well as programmes for healthy schools, homes, workplaces and cities. A long-term strategy, the National Health Programme, was submitted for government approval in 1995. Its implementation is the responsibility of the National Health Board, led by the Minister of Health. Any organization (public or private) can submit a health promotion project for funding under the National Health Programme.

Legislation prohibiting smoking in public places was enacted in 1989 and legislation regulating advertising of tobacco in radio and television was established in 1995; wider restriction of tobacco advertising was put in force from 1 July 2004 (by Act No. 132/2003 Coll.). At the same time, a new law on tobacco and tobacco-product control was in preparation. The National Environmental and Health Action Plan was approved by the Czech Government in December 1998. The National Environment and Health Board, chaired by the Minister of Health, started working in 1999 on the implementation of the plan at national and local levels. Screening programmes for adult diseases (for example, cervical cancer, breast cancer or colorectal cancer) have been reimbursed from public insurance since 2000.

Regarding health indicators, rates for the major immunizable diseases vary between 99% and 95%, which are high percentages if compared with those of most western European countries (Fig. 12). The global child-immunization programme covers tuberculosis, diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps and rubella. Immunization against hepatitis A and B, tick-borne encephalitis, haemophilus influenzae B and meningococcal disease is available upon request and requires full payment. A mass immunization strategy against hepatitis B is under consideration for adolescents from the age of 12 and against haemophilus influenzae B for young children. Since 1990, efforts to change the existing system have emerged both from within and from outside the Hygiene Service.

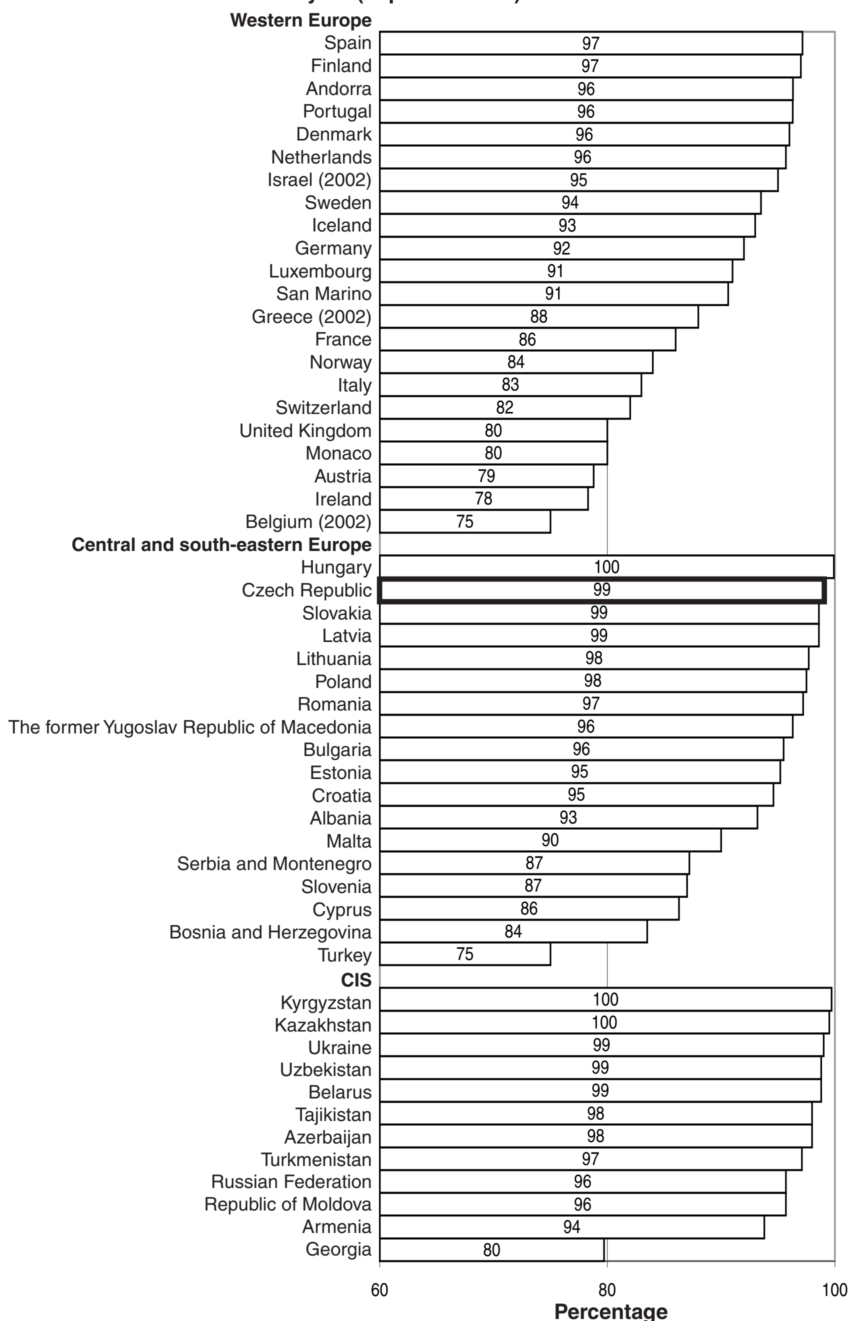
Plans to reform state and locally financed public health services are primarily oriented towards increasing their efficiency. Excess capacity is being reduced step by step in a controlled manner. Some parts of public health facilities, especially various auxiliary laboratories, are being privatized. A new Health Protection Act (Act No. 258/2000 Coll.) was enacted in January 2001.

In June 2000, the Czech Republic signed the Framework Convention on Tobacco Control. It is therefore expected that the Framework will soon be implemented in the Czech Republic.

Primary health care

Responsibility for the organization of primary health care is not specified clearly in the legislation. Authority is currently divided among state, regions and health insurance funds. A law is under preparation. Citizens register with a primary health care physician of their choice and can re-register with a new physician every three months. There are no restrictions on patients' choice of primary health care physicians or on access to them. If the patient's state of

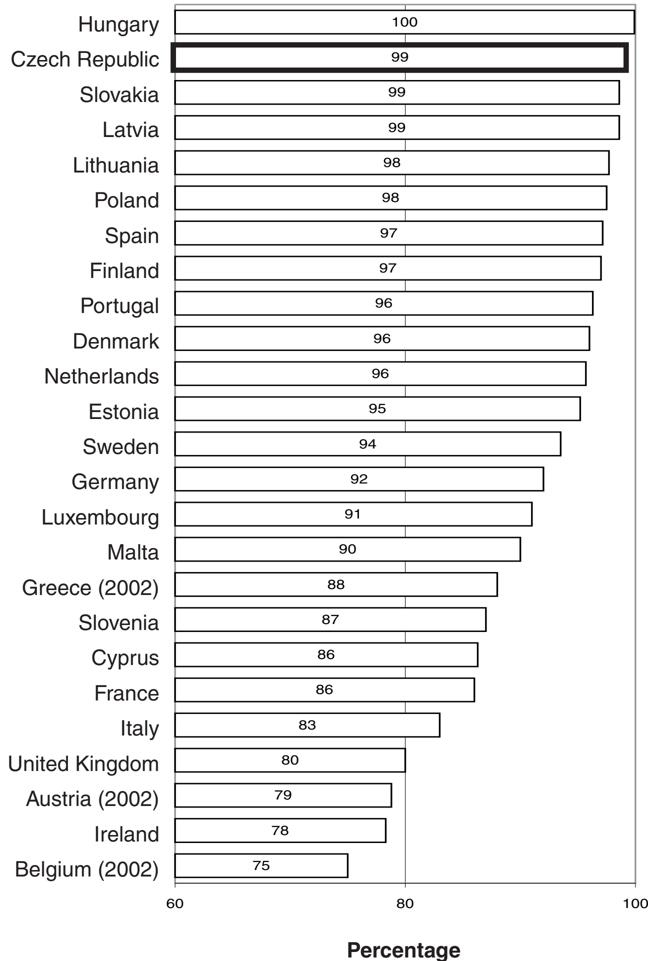
Fig. 12a. Levels of immunization for measles in the WHO European Region, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database, January 2005.

Note: CIS: Commonwealth of independent states; countries without data not included.

Fig. 12b. Levels of immunization for measles in the European Union, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database, January 2005.

health requires specialized care which his/her primary care physician, with whom he/she is registered, cannot provide, the primary care physician refers him/her to an appropriate specialized health care facility which has a contract with the patient‘s healthcare insurance fund. The physician substantiates his/her decision and informs the specialist, in writing, about the results of the examinations he/she has performed thus far. The specialist then informs the registering physician about his/her findings and the steps taken during treatment, and may recommend further actions or provide a recommendation concerning

the patient‘s ability to work. In the case of a visit to a specialist the patient again has the right of free choice, and does not need a referral from a general practitioner (GP) in order to see a specialist. A visit to a general practitioner and a referral to a specialist is recommended, however. Visits to stomatologists or gynaecologists are always direct and without referral.

There are four groups of doctors in the Czech health care system with which patients have the first point of contact: GPs for adults; GPs for children and adolescents (paediatricians); ambulatory gynaecologists; and dentist/stomatologists. In 2002, primary care physicians constituted 51% of the total number of outpatient physicians. This proportion is lowest in Prague (38.6%) and highest in the Zlín region (59.2%) *(9)*. In 1994, there was one GP for approximately 1670 inhabitants over the age of 15 and one ambulatory paediatrician for approximately 1150 children and adolescents. On average, there were 4840 women per gynaecologist and 1760 persons per dentist/stomatologist. In 1998, the numbers were as follows: 1780, 1170, 4890 and 1770, respectively, i.e. the number of adults cared for by each GP increased, while the other ratios remained more or less constant.

At the end of 2002, there were 5186 (full-time equivalent) adult GPs registered. On average, there are 1650 inhabitants aged over 14 per physician post. At the end of 2002, there were 22 001 registered GPs for children and adolescents. On average, there are 1050 persons aged 0–19 per physician post. At the end of 2002, there were 5947 registered general stomatological practitioners, with an average of 1700 inhabitants per stomatologist post. At the end of 2002, there were 1184 registered general gynaecological practitioners, with an average of 4400 women per gynaecologist post. Given the long-term decline in the number of inhabitants, a slight improvement is shown in the manner in which primary care is secured in the Czech Republic. Only gynaecological practitioners showed a slight increase. There are regional differences in the numbers of physicians in the Czech Republic. The highest number of outpatient physicians per 10 000 inhabitants (basic and specialized care) is in Prague *(49)*, while the lowest numbers are in the Central Bohemian region (22), the Ústecký region *(23)* and the Vysočina region *(22)*. The nationwide average is 28 *(10)*.

About 95% of primary health care was privatized in 2002. The entry of doctors into primary health care practice is controlled through licensing by the Czech Medical Chamber and the issuing of authorization permits by the regional authority. Doctors then contract with health insurance funds (health insurance funds should play a regulatory role in this sense). The private practices are managed differently depending on the local situation. Most primary health care physicians work alone. A group of primary health care physicians may work together in health centres, or they may decide to work in one of the few

polyclinics that provide primary health care in addition to specialist care. The centres are owned by the local community (municipality) and are run by a director. Primary health care physicians who are in private practice pay rent for using the facilities of the centres; in general, these rents are quite high. The full range of primary health care services includes general medical care, maternal and child health, gynaecology, dentistry/stomatology, home care by nurses, 24-hour emergency coverage and a number of preventive services (immunization, screenings, etc.). Health centres tend to be well equipped; most have electrocardiograms, ultrasound (and often X-ray) equipment. They also have some diagnostic laboratory facilities and employ nurses and physiotherapists. Primary health care doctors who work alone have direct access to fewer facilities. Working conditions for primary health care physicians depend on the population, local conditions and whether the location is largely urban or rural.

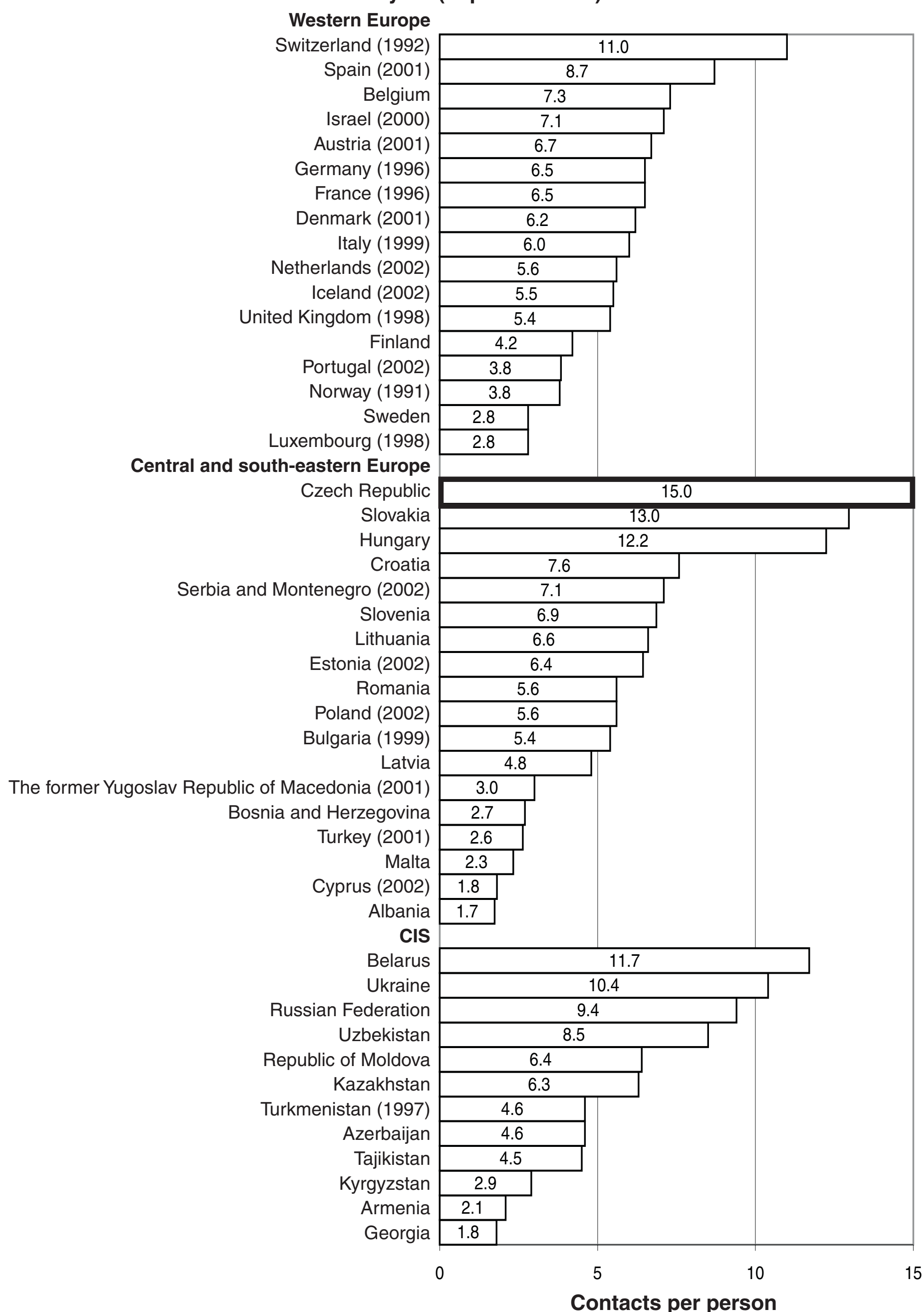
A large part of the work of these physicians involves certifying absences from work. In addition, referral rates to specialists are high. There were plans to strengthen the role of primary care physicians by introducing self-certification for short periods of illness. Since there are now financial incentives for primary health care physicians to take on more tasks, some are providing more specialized services to their patients. To prevent wasteful services, it was decided that the main kind of reimbursement would be through capitation, but services that are much in demand would be reimbursed through fee-for-service. The number of patient–physician contacts is among the highest in Europe (Fig. 13).

Secondary and tertiary care

The Czech Republic inherited a wide network of hospitals and polyclinics covering the entire country. These were formerly managed directly by the Ministry of Health under a three-tiered system of regional, district and municipal health institutes. The situation has changed as a result of the public administration reform. In the late 1990s, a process of restructuring commenced which was to resolve the problem of excessive demand for acute bed care. The main goals were to decrease the number of basic acute-care beds, to enhance the number of long-term-care beds, and to decrease the number of physicians.

Currently, the Czech network of health care facilities for secondary and tertiary care consists of the offices of specialized outpatient physicians, hospitals, and specialized bed facilities. At the end of 2002, there were a total of 26 270 health care facilities registered in the Czech Republic; 13 198 of them were in secondary and tertiary care *(10)*. Each year, the number of health care facilities

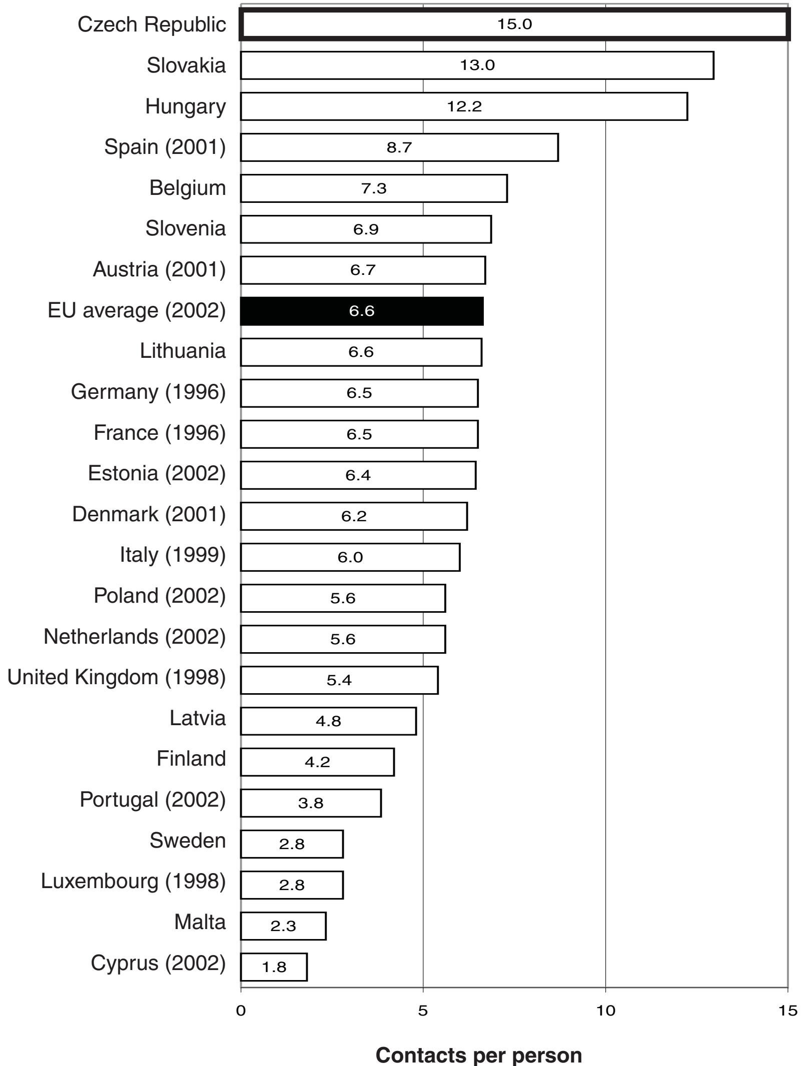
Fig. 13a. Outpatient contacts per person in the WHO European Region, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database, January 2005.

Note: CIS: Commonwealth of independent states; countries without data not included.

Fig. 13b. Outpatient contacts per person in the European Union, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database, January 2005.

Note: EU: European Union; countries without data not included.

(consisting primarily of independent offices of pharmacies and outpatient specialisms) grows, but, since 1995, the increase has slowed. Whereas the vast majority of outpatient physicians have become private in recent years, most bed facilities remain public, but their status is undergoing dynamic changes in relation to the public administration reform. The vast majority of health care

facilities have contracts with health insurance funds, among which the GHIF set up by the government, has a prominent position.

A precondition for the setting up of a health care institution is a licence issued by the Czech Medical Chamber, which also serves as the guarantor of health care quality. Outpatient care is provided by independent practitioners, at polyclinics with several specialists, and in outpatient sections of hospitals. At the end of 2002, a total of 28 482 physicians (full-time equivalent) and 54 980 mid-level health care staff (full-time equivalent) worked in outpatient care. On average, there were 28 outpatient physicians (both in basic and specialized care) per 10 000 inhabitants. The city of Prague plays an important role in this respect, as it has five faculty hospitals which provide narrowly specialized outpatient care to patients from the entire country. If we looked at the entire country with the exception of the capital, the previous figure would drop and there would by 25.3 outpatient physicians per 10 000 inhabitants. There were, on average, 1.9 mid-level health care staff (including laboratory and rehabilitation staff) per outpatient physician.

About three quarters of the outpatient facilities have been privatized. Of the total number of outpatient physicians in 2002, 25.8% worked in outpatient sections of hospitals and 73.8% worked in independent outpatient facilities (primarily independent private practices). Specialized curative institutions (including spas) provide only 0.4% of narrowly specialized outpatient care tied to narrowly specialized bed care *(10)*. Because of the introduction of a mixed capitation and flat-fee payment, the drain of narrowly specialized outpatient care from hospitals into private specialist practices was stopped in 1997, but the number of private specialist offices keeps growing, and leads to a duplication in the provision of outpatient care, which makes health care more expensive.

Patient access is not restricted by a "gatekeeping" system. Currently, hospitals are owned both by the State and by private for-profit and not-for-profit organizations, and we can therefore distinguish among hospitals managed directly by the Ministry of Health, regional, municipal and town hospitals, private hospitals and church hospitals. Faculty hospitals have a specific status (regulated by Act No. 111/1998 Coll. (on Higher Education Institutions), Act No. 20/1966 Coll. (Care for People's Health) and, primarily, by Ministry of Health Regulation No. 394/1991 Coll. (Position, Organization, and Work of Faculty Hospitals), which, in addition to their health care function, also perform educational and research roles. The complexity of the problems of faculty hospitals is due to the twofold hierarchy of its management, because faculty hospitals are under two ministries – the Ministry of Education and the Ministry of Health. Both management and finances come from two centres, each of which has different ideas, demands and powers. Before the end of 2002, 80 hospitals were owned by districts, which were handed over to the

regions and municipalities as a result of the public administration reform. Based on their size and equipment, hospitals provide both outpatient and bed care (basic, specialised, highly specialized diagnostic and curative care). A patient is accepted into the care of a hospital upon referral by a physician; this referral must contain the physician's written substantiation of his/her application and other important information about the patient's state of health. In certain cases (compulsory cure, life-threatening situations or situations which seriously endanger the patient's health, e.g. concerning childbirth) a patient must be accepted even without a referral.

At the end of 2002, there were 201 hospitals in the Czech Republic (11 faculty, 168 other acute-care hospitals, and 22 subsequent-care hospitals; see below) with a total of 66 668 beds, of which 61 489 were acute-care beds and 5179 were subsequent-care beds (specialized therapeutic institutes e.g. rehabilitation institutes, long-stay therapeutic institutes and psychiatric institutes, are not included in this number). One hundred and ninety-four facilities belonged to the Ministry of Health and seven facilities (1907 beds) belonged to other ministries (transportation, defence, justice). The Ministry of Health was the operator of 19 hospitals (11 out of those being faculty hospitals) with 17 929 beds, there were 82 district hospitals with 32 882 beds, 29 hospitals with 7910 beds were administered by regions, cities or municipalities, and 64 hospitals with 7040 beds were governed by private persons. Whereas the Ministry of Health administers only 19 hospitals, i.e. 9.5% of the total number of hospitals, they constitute 26.9% of the total number of beds, because they are primarily large hospitals. On the other hand, private hospitals, which constitute 31.8% of the total number of hospitals, have only 10.6% of the total number of beds (10).

The Czech Republic has a cautious programme for a long-term decrease in the number of hospital beds, whereby beds used for acute care are being restructured into beds for long-term care. In 1990, there were still 10.9 beds per 1000 citizens, but, in 1998, this number had been reduced by approximately 20%, to 8.6, but the process has not continued since (1998–2002) (Table 7). At the same time (1990–2002), the average length of stay (inpatient beds) decreased even more sharply during these years, from 16 to 11.3 days. The number of acute-care beds decreased between 1990 and 2002 from 8.1 to 6.3 per 1000 citizens, with a decrease in average length of stay (acute-care beds) from 12.5 to 8.5 days (2). The volume of hospital bed care provided to patients in 2002 grew in comparison to the previous year: 3.8% more patients were admitted to acute-care beds, and the number of treatment days grew by 1.5%. In the case of subsequent-care and nursing-care beds, 6.5% more patients were admitted, and the number of treatment days grew by 7.7%.

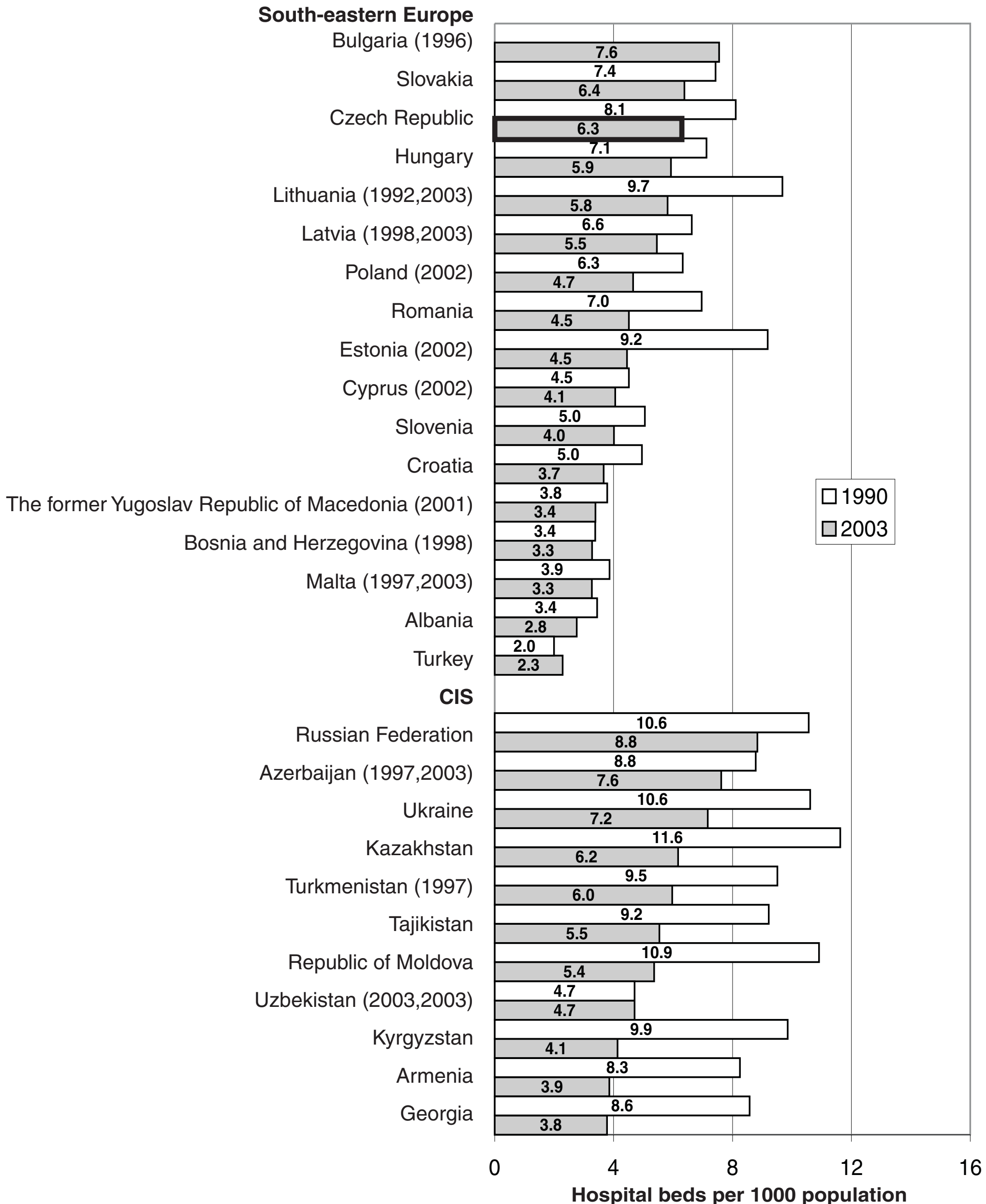
Table 7. Inpatient facility utilization and performance, 1980–2002

Inpatient facility	1980	1990	1995	1996	1997	1998	1999	2000	2001	2002
Inpatient beds	112 080	113 204	95 217	92 570	90 403	88 739	87 121	87 820	87 678	87 750
Inpatient beds per 1000 persons	10.9	10.9	9.2	9.0	8.8	8.6	8.5	8.5	8.6	8.6
Admissions (1000)	1 957	1 871	2 076	2 108	2 082	2 021	1 992	2 053	2 073	2 148
Admissions per 100 citizens	19.0	18.1	20.1	20.4	20.2	19.6	19.4	20.0	20.3	21.1
Average length of stay (days)	17.2	16.0	13.1	12.5	12.0	11.7	11.6	11.6	11.5	11.3
Acute care	1980	1990	1995	1996	1997	1998	1999	2000	2001	2002
Acute-care beds	84 063	84 054	71 499	68 984	67 878	66 959	64 970	65 153	64 524	64 398
Acute-care hospital beds per 1000 citizens	8.2	8.1	6.9	6.7	6.6	6.5	6.3	6.3	6.3	6.3
Admissions (1000)	1 794	1 733	1 931	1 958	1 962	1 899	1 867	1 924	1 940	2 012
Acute-care admissions per 100 citizens	17.4	16.7	18.7	19.0	19.1	18.4	18.2	18.7	19.0	19.7
Average length of stay (days)	14.2	12.5	10.3	9.7	9.2	8.8	8.7	8.8	8.6	8.5
Occupancy rate (%)	82.5	70.5	73.4	74.1	71.8	70.8	67.7	70.7	70.5	72.1

Source: WHO Regional Office for Europe health for all database, October 2004.

Starting from a level well above the central and eastern European average in 1990, the Czech Republic has decreased its bed numbers more rapidly than other central and eastern European countries but still has one of the highest densities of acute hospital beds (Fig. 14). The decline has been steeper than that of its direct neighbours, but bed density is now average for this group (Fig. 15). The Czech average length of stay is still rather high compared to most western European countries, while the occupancy rate has remained comparatively low. Aside from hospitals, specialized therapeutic institutes (i.e. institutes for long-term patients, institutes for tuberculosis and respiratory diseases, psychiatric institutes for children and adults, etc.) work in the sphere of secondary care; there were 169 such institutes at the end of 2002, with a total capacity of 23 352 beds, but 68 spas (with 22 000 beds) are not included in this number *(10).* Their network does not undergo changes, with the exception of nursing homes. The cause is the unified financing of hospitals and nursing homes applied since 1998, and the reduction of acute hospital beds since 1997, in favour of subsequent and nursing-care beds. There is a move towards substituting hospital care with less-expensive alternatives. Home care and day-care surgeries are both increasing. The effect of this is to shift demand for care towards primary health care settings. Accident and emergency care is a special type of care delivered at the location of injury or sudden sickness, and/or during transportation to the hospital. First-aid medical care ensures the treatment of acute conditions.

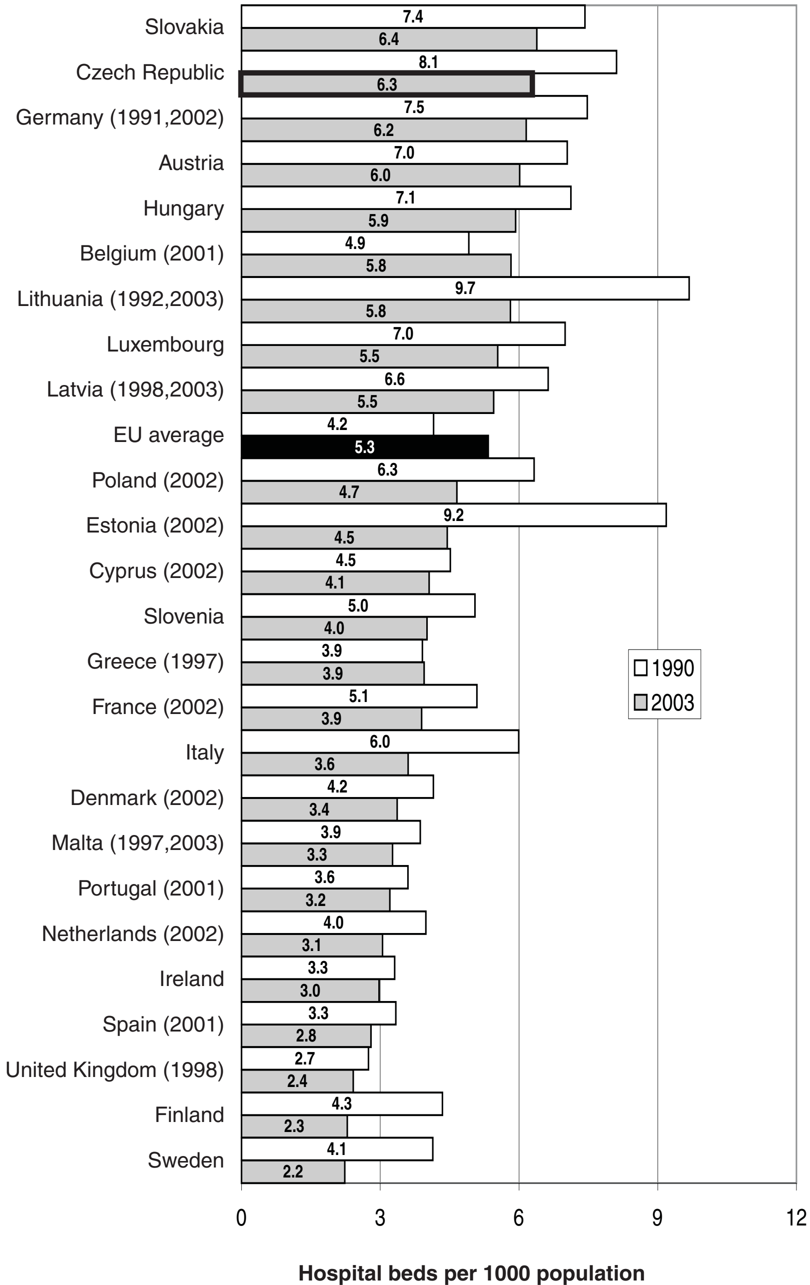
Fig. 14a. Hospital beds in acute hospitals per 1000 population in central and south-eastern Europe and CIS countries, 1990 and 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database, January 2005.

Note: CIS: Commonwealth of independent states; countries without data not included.

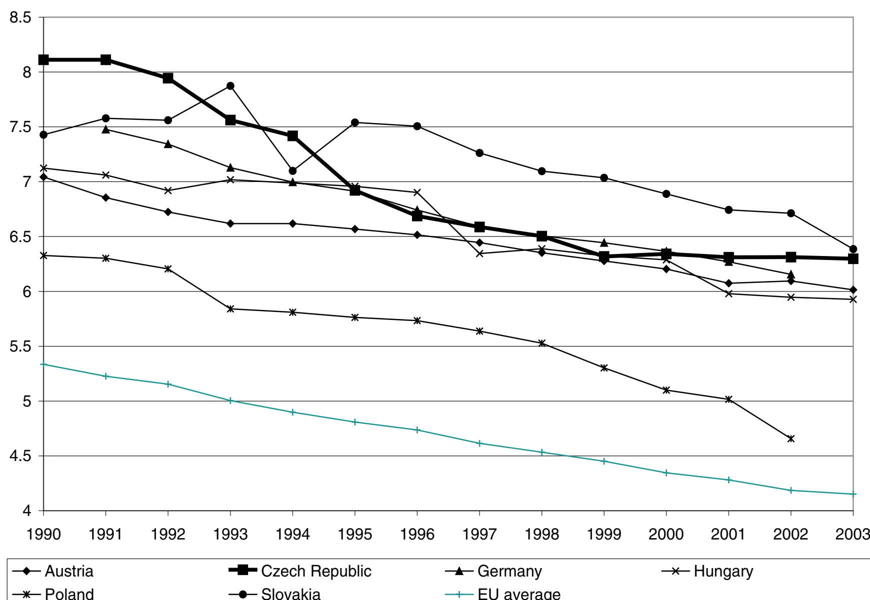
Fig. 14b. Hospital beds in acute hospitals per 1000 population in the European Union, 1990 and 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database, January 2005.

Note: EU: European Union; countries without data not included.

Fig. 15. Hospital beds in acute-care hospitals per 1000 citizens in the Czech Republic, selected countries and EU average, 1990–2003



Source: WHO Regional Office for Europe health for all database, January 2005.
Note: EU: European Union.

Social care

Social services were poorly developed under Socialism, and non-medical care of patients often used to be given in hospital beds. Provision is still not sufficient to meet demand and there are gaps in services. Social care is provided as part of social services. It is financed by the state budget and administered from the social budget of districts or municipalities. Only strictly medical services are paid for by health insurance funds (e.g. care in psychiatric hospitals). The situation has improved in the last few years, with a trend in communities towards establishing numerous smaller social or community care facilities on a non-governmental and non-profit basis. Long-term care of the mentally ill takes place in psychiatric hospitals (which are financed like all other hospitals). A move to community-based care is taking place slowly, along with education of the public about mental illness. The present system offers satisfactory services to many patients; nevertheless, insufficient care is provided to patients with chronic mental illness. Mental health care is fragmented and is more episodic than continuous. Many types of services and working methods common in developed countries are not sufficiently applied and sometimes unknown in the Czech Republic. For this reason, rehospitalizations and extensive hospitalizations

for many years, or even for life, occur frequently, especially in the case of chronically ill patients. These problems resulted from the low priority afforded to this group of individuals, and are maintained by the absence of coordination between health and social care systems. Long-term care facilities for the elderly generally have long waiting lists, and the quality of the care they provide varies considerably. These institutions are financed from the state budget, not by health insurance funds. If long-term medical care is needed, it is provided in hospitals for the chronically ill, which are financed by the health insurance funds. There is, however, a significant gap in services as nursing homes are generally not available. In 1997, the provision of long-term care facilities was opened up to public competition, which is believed to have raised the number of long-term beds to approximately 20 000.

The main change to Czech social policy occurred at the end of the year 2002, when the legal competence of the state district offices was transferred to municipalities. The process of decentralization of the social services was thus completed, albeit without proper legislation and a definition of the quality of the services or planning system. There were 998 residential establishments for "vulnerable people" in the Czech Republic in the year 2001. There were 346 retirement homes with 36 200 beds (the State founded 229 of them (26 627 beds), municipalities founded 90 of them (8293 beds) and the church founded 19 (891 beds)) and 150 long-term care accommodation facilities for pensioners (12 432 beds). There were 75 social-care establishments for handicapped adults (6336 beds), four institutions for misusers of alcohol (161 beds), five institutions for the mentally ill (562 beds), 181 social-care accommodation facilities for mentally handicapped young people and children (13 161 beds) and 62 asylum homes (2047 beds) for homeless people. Home care was provided for about 114 203 people, especially the elderly or handicapped. Of the 998 residential institutions mentioned, 269 were transferred from state authority to the regions (only four of them to the municipalities) on 1 January 2003 *(1)*. In the year 2002, the Ministry of Labour and Social Affairs of the Czech Republic defined quality standards for social services, but they are yet to be approved by the parliament.

Comprehensive home care (CHC) is an integrated form of care and assistance provided to clients in their own social environments. It was first introduced in the Czech Republic at the beginning of the 1990s. An integral component of CHC is home health care, which, based on established legal norms, is a particular form of outpatient care provided on the basis of the attending physician's recommendation. A further integral component of CHC is social care, based on a patient's social diagnosis. Voluntary help also plays a role in health care and social care (self-care, or the participation of family members or volunteers in providing general care and assistance).

Within the CHC framework, there are various forms of local health care, social care and general care. The extent of such activities is determined by the patient's current health condition, the condition of his or her social environment, and the levels of knowledge and competence of individual members of multidisciplinary teams and home care support agencies. CHC is one of the functional elements of primary care. In this context, primary care is viewed as the first line of contact between the client and the health and social care systems. Consequently, the CHC philosophy is guided by the principle of stable bonds and the interaction of the individual with his or her own personal social environment, with the accent on the individual's perception of quality of life.

The number of home care agencies increased from 27 in 1991 to 483 in 2002 *(11)* (162 in 1993, 372 in 1995, 480 in 1997). There are still some problems providing a comprehensive package of social care, primarily because of a lack of communication among the non-governmental, governmental and private providers. There is no clear distinction between health and social services.

Human resources and training

The number of health care employees, particularly physicians, is relatively high. This has contributed to rising health care costs and, thus, a strategy to reduce the numbers of physicians has been implemented. There are currently seven medical schools, three of which are at the Charles University in Prague. Although there is no numerus clausus (i.e. no limitation in number), the number of entrants to medical faculties and nursing training is decreasing and will decrease further in the next few years. While the number of graduating physicians is decreasing after a peak in 1995 (Table 9), the number of practising physicians has risen slowly but fairly consistently since 1991. This increase is, however, much less pronounced than that in neighbouring countries. Compared to these countries, the number of physicians in the Czech Republic is average, and remains below the average for the EU (Fig. 16). On average, there were 3.5 physicians per thousand inhabitants (full-time equivalent) in 2002; there are significant regional differences among the (14) regions. The number of nurses per thousand inhabitants was, on average, 9.71 in 2002. On the other hand, it is important to note that the average age of physicians in the Czech Republic is relatively young and that almost two-thirds are specialists.

Of the total number of physicians, 13% worked in general medicine (GPs); this proportion has been relatively stable for several years. Of the total number of physicians, 55.4% were women; the female-dominated fields are primarily paediatrics, dermato-venerology and stomatology. The Czech Republic does

not have any visible medical unemployment (the number of officially registered unemployed doctors was 445 in 1999 and 261 in 2002). The average wages in health care were lower than the national average for all wages. In 2002, the year-on-year growth of the average wage in the health care industry was higher than the growth in the overall economy, by 7%; for the first time since 1996, the average wage in health care exceeded the national average for all wages, by nearly 7%. In an overall recalculation, the real wage in health care was higher than the wage level in the national economy *(10)*. It is likely that this trend will continue after 2004.

Salaries of doctors are twice as high as the average national income, but in all specialties, doctors in private practice earn four times as much. Nevertheless, both physicians and nurses argue for relatively higher incomes. The existing surplus of specialists is to be reduced, by retraining specialists to work in other fields such as public health or general practice. This plan has not yet been implemented. The number of working nurses has increased in recent years.

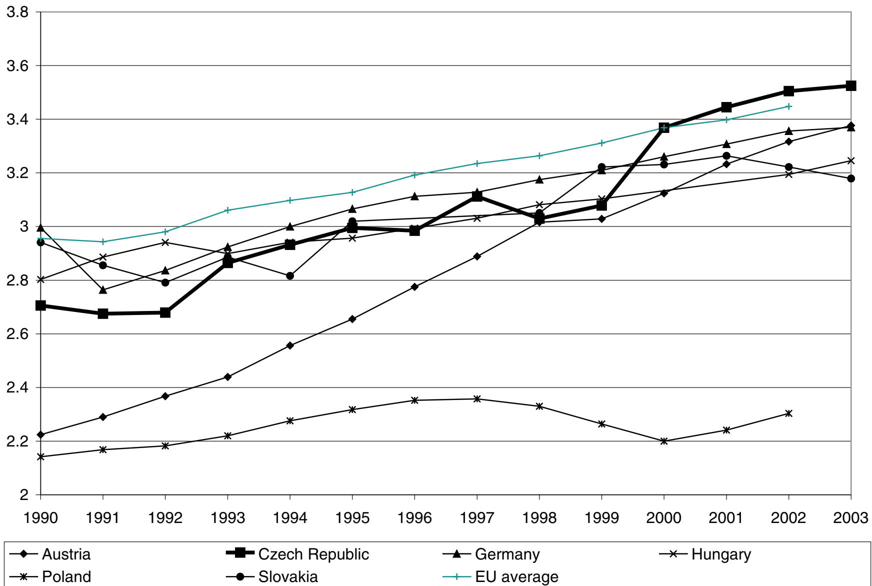
The number of graduating nurses rose sharply in the first half of the 1990s (from 0.45 per 1000 citizens in 1990 to a peak of 0.71 in 1994), before falling back to the old level (Table 9). Table 9 shows that, in 2000, an unusually low number of nurses completed their studies at health care secondary schools. This phenomenon was caused by a change in the elementary education system: all students went to grade nine for the first time in the 1995/1996 school year (before, elementary education took eight years). The total number of nurses per capita is among the highest in central and eastern Europe (Fig. 17) and is higher than that in most neighbouring countries (Fig. 18).

Table 9. Health care personnel per 1000 citizens, 1980–2002

Group	1980	1985	1990	1995	1996	1997	1998	1999	2000	2001	2002
Physicians[a]	2.26	2.58	2.71	3.00	2.98	3.11	3.03	3.08	3.37	3.45	3.50
Dentistsb	0.46	0.52	0.54	0.60	0.61	0.63	0.62	0.62	0.65	0.66	0.66
Nursesb	7.31	8.14	8.69	8.92	8.97	8.86	8.86	8.92	9.20	9.49	9.71
Midwivesb	0.43	0.48	0.51	0.49	0.47	0.46	0.45	0.45	0.46	0.48	0.49
Pharmacists[b]	0.38	0.39	0.38	0.36	0.36	0.43	0.44	0.47	0.49	0.51	0.53
Physicians graduating	0.14	0.14	0.09	0.13	0.12	0.11	0.09	0.09	0.08	0.07	0.07
Nurses graduating	0.37	0.41	0.45	0.63	0.48	0.42	0.42	0.41	0.17	0.48	0.44

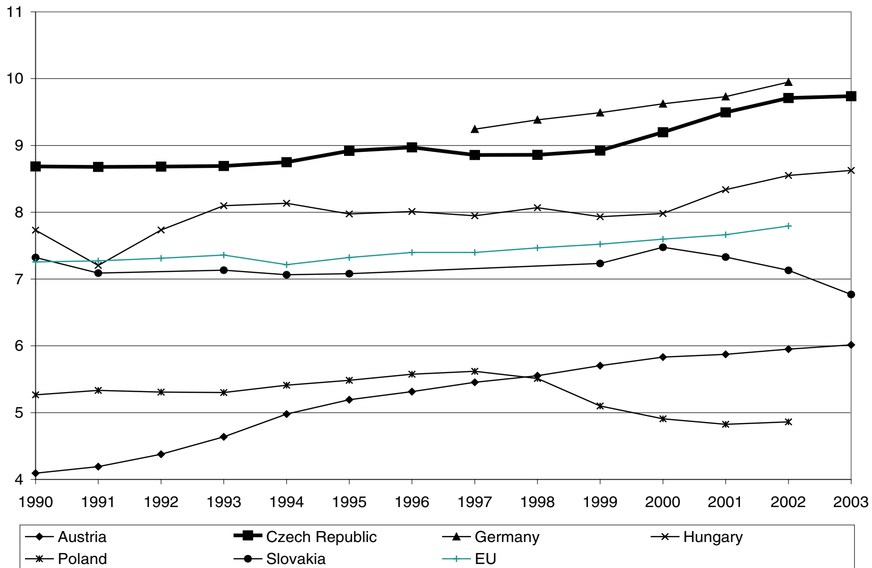
Source: WHO Regional Office for Europe health for all database, October 2004.
Notes: [a] full-time equivalent; [b] physical persons.

Fig. 16. Physicians per 1000 citizens for the Czech Republic, selected countries and EU average, 1990–2003



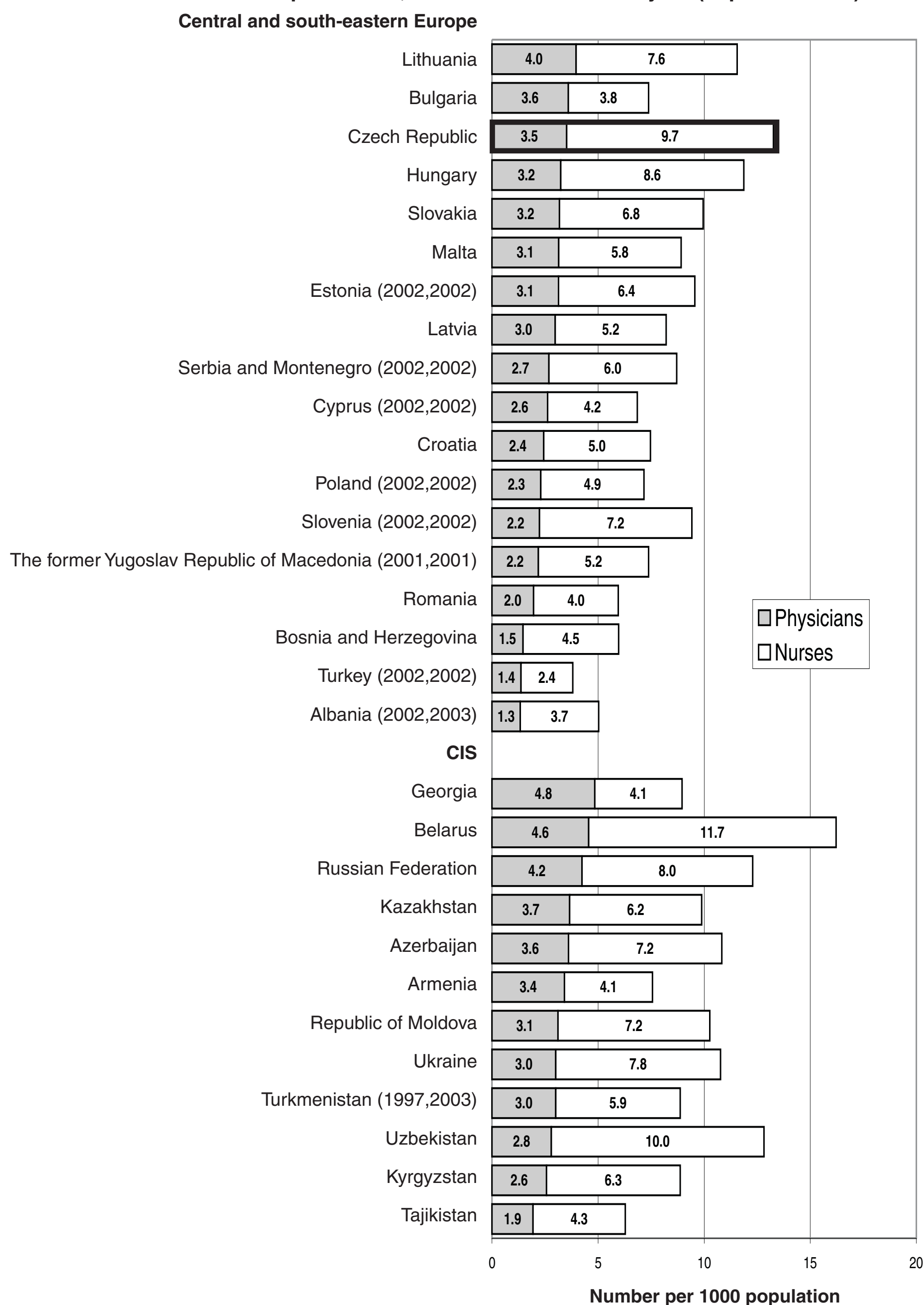
Source: WHO Regional Office for Europe health for all database, January 2005.
Note: EU: European Union.

Fig. 17. Nurses per 1000 citizens for the Czech Republic, selected countries and EU average, 1990–2002



Source: WHO Regional Office for Europe health for all database, January 2005.
Note: EU: European Union.

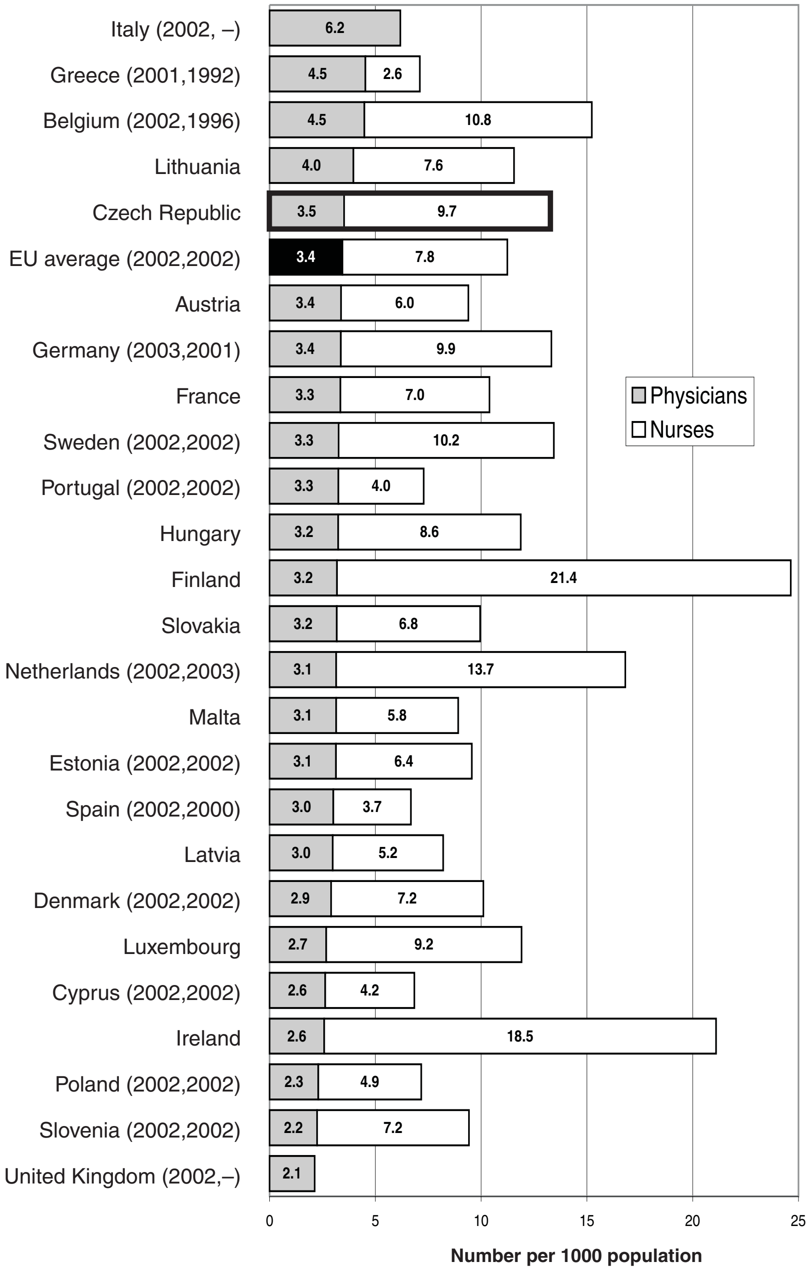
Fig. 18a. Number of physicians and nurses per 1000 population in central and south-eastern Europe and CIS, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database, January 2005.

Note: CIS: Commonwealth of independent states; countries without data not included.

Fig. 18b. Number of physicians and nurses per 1000 population in the European Union, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database, January 2005.
Note: EU: European Union.

The geographical distribution of physicians and nurses has been homogeneous across the country for a long time. In the last few years, the situation has become more complicated. Currently, there is an excess of physicians and a shortage of nurses, mostly in urban areas. There are differences among medical fields, between rural and urban areas, and between industrial and non-industrial parts of the country. Ongoing reform of health care affects the quantity as well as the career structure of health care workers. There are seven medical and two pharmaceutical faculties in Czech universities. Whereas the Ministry of Education is responsible for the education and training of physicians and nurses towards their degrees, the Ministry of Health is responsible for postgraduate medical and nursing education. Universities are gradually implementing curriculum changes in the training of physicians and nurses. University medical studies consist of 6 years of training; dentistry/stomatology and pharmacy take 5 years. There are two specialized institutes for postgraduate education and training of health professionals (Prague, Brno) in the Czech Republic, affiliated to the Ministry of Health. Since 1981, physicians have had to complete the first level of specialization before they enter general practice (which takes 30 months). Further specialization after the first level is optional and usually takes between three and five years. The Institute for Postgraduate Medical Education (Prague) is responsible for postgraduate specialty training of physicians.

The Czech Medical Chamber requires continuing, life-long education of its members; over every 5 years, each physician must acquire a certain number of points for completing education-related activities (seminars, workshops, symposia, congresses; active participation, i.e. a lecture, etc., is awarded a higher number of points) or publication activities. The Czech Stomatological Chamber and the Czech Pharmacists' Chamber have analogous requirements. In the spring of 2002, the EU Expert Commission concluded that the number of dentists in the Czech Republic causes concern. The plan is for the number of stomatologists to grow so that the number of inhabitants per stomatologist falls from the current figure (1750) to the optimal figure of 1500–1550. In relation to the country's EU accession, the field of stomatology will be transformed into dental medicine; from September 2004, there should have been a new study programme at medical faculties; it is still being prepared (medical faculties suffer from a chronic lack of middle-aged and young teachers, one of the causes being the low salaries of educators). Also, there should be a change in the academic title earned by a dental doctor upon completion of his/her studies at the medical faculty, from the current MUDr. to MDDr. New acts (Act No. 95/2004 Coll. and Act No. 96/2004 Coll.) concerning physician and non-physician occupations has just been passed by the Parliament and is in the process of being implemented.

The education of nurses takes place at several levels. Basic education consists of four years of vocational training at a secondary school for nurses (starting at the age of 15). This is divided among several specialties, such as general nurse, laboratory worker (for biochemistry, immunology, pharmacy, etc.) or dietary nurse. There is the possibility of a two-year training programme, after graduation from any high school, for specialties such as paediatric nursing, midwifery or radiology laboratory work. It is also possible to undergo a two-year training programme at the Health Care Educational Institute (Brno) after graduating from high school. A number of universities offer Bachelor degree courses in nursing, which take three years. There is also a five-year Master of Nursing programme. Until 1998, some nurses completed their university studies at the Faculty of Philosophy (offering a combination of two subjects, nursing and pedagogy). Postgraduate specialty education and training of nurses is organized at the Health Care Educational Institute in Brno. Specialization is possible in a number of areas and there is a further two-year course in organization and management. There are plans to raise the age for entry into nursing to 19 years (after graduation from high school), since girls (the vast majority of nurses are female) who start at 15 years of age often leave the profession. Salaries for nurses have increased significantly since 1990 and, at present, the incomes of nurses are almost the same as the state average for employed persons.

There will be changes in the education of non-physicians; the existing four-year matriculation category “general nurse” will be changed to a new matriculation category – “health care assistant”. The Czech educational system is unique in Europe, as graduates seem to be among the youngest in Europe. The category “health care assistant” will be offered by more highly specialized schools and as a Bachelor programme, the category “midwife” will only be offered at universities. Education for the categories health care laboratory worker, dietetic nurse, dental technician and pharmaceutical laboratory worker will be completed at secondary schools, and at higher health care schools the categories occupational therapist, radiological assistant, hygienic-service assistant, physiotherapist and midwife will transfer to universities; the categories paediatric nurse, psychiatric nurse and intensive-care nurse will be entirely abolished. There will also be changes in the education of caregivers, who have up to now studied at secondary health care schools – in the future, this will only be possible in accredited qualification courses. Other health care workers (clinical psychologists, speech therapists, physiotherapists, etc.) are educated within specialized university departments. They specialize after graduation in a manner similar to that of physicians, dentists and pharmacists.

Pharmaceuticals and health care technology assessment

The licensing of pharmaceuticals for the sale and allocation of drugs or medical aids to reimbursement categories is carried out by the Ministry of Health in consultation with the Ministry of Finance and the GHIF. The Czech Chamber of Pharmacists and representatives from the health care associations play a role in this process. In the case of ambulatory care, pharmaceutical products are classified into three categories. The first category is fully reimbursed and includes the cheapest effective preparations (often domestically produced) of all essential drugs. The second and third categories are partly or fully paid for by patients: insurers only reimburse the cost of the generic equivalent. Drugs and medical technology are registered with the Drug and Technology Control Institute, which is directly managed by the Ministry of Health. This assesses the costs and benefits of medical technology in a fairly narrow context. Along with spending on pharmaceuticals, purchases of medical equipment have risen in recent years. Between 1991 and 2001, the number of magnetic resonance imaging units rose from 2 to 19 and the number of computerized tomography scanners from 22 to 117 *(12)*. It is not clear if all these purchases were necessary.

In recent years, the Czech pharmaceutical industry has been almost completely privatized. Because of this change, the commercial strategy of these factories and their production methods has changed significantly. Despite price increases, the domestically produced pharmaceuticals are of substantial importance to the Czech health care system. Pharmacists are also predominantly private now, as is the distribution network for pharmaceuticals. At present, there is a limited range of products sold over the counter, but this area may become more important in the future. The problem of the poor supply of pharmaceuticals under the socialist system has largely disappeared and the main difficulty with pharmaceuticals now is cost escalation. The level of consumption of pharmaceuticals has risen slowly since 1991. However, as prices have increased dramatically during the same period, spending on pharmaceuticals has also risen rapidly. In 2000, drug expenditure constituted 25.2% of total health care expenditure.

The overall consumption of drugs grew from 33.3 billion (equal to million millions) to 44.2 billion Czech koruny between 1998 and 2001, and, expressed as defined daily doses per thousand inhabitants per day, it grew from 1105 to 1125 during the same period. Aside from the categorization of drugs for reimbursement and co-payment, certain other measures, as described below, have been implemented to control expenditure from prescription drugs. Some

drugs can be prescribed only by specialists. Since 1999, health insurance funds set financial limits for prescription by physicians. The introduction of financial limits contributed to drug expenditures stagnating in 2000, but in 2001, they again grew significantly.

Since 1995, a reference pricing system (maximum prices for reimbursement by the health insurance funds) is provided in the Czech Republic. It states that the reimbursement level is calculated on the basis of the amount of substance contained in each pharmaceutical product. The unit cost of each substance is defined by the "drug decree", while the basic principles are laid out by law. The reference pricing system has helped slow growth in expenditure: while the GHIF's per capita spending on drugs had risen by 39% in 1994 and even by 43% in 1995, the increase slowed to 13% in 1996 and to a mere 4% in 1997. The growth in subsequent years was never higher than 10% (it was about 10% in 2001). Act No. 48/1997 (on social health insurance) defines 521 groups of pharmaceutical products which can be reimbursed by the health insurance funds. The ATC grouping and the administering of drugs are used to define the groups. The law defines specific conditions for reimbursement in each group, e.g. the diagnosis of the patient, the specialization of the prescribing physician (e.g. cardiologist, oncologist) or the necessity for approval through the review doctor (which is an employee of the health insurance fund). Decree no. 57/1997 (the "drug decree") defines the level of reimbursement of those substances which are covered by law. The decree has been updated regularly, every three months until 1999, and every six months from 1 January 2000. The updating changes are based on recommendations from the Categorization Commission, which is an external advisory body of the Ministry of Health. It consists of medical and pharmaceutical specialists, economic specialists from insurance companies, employees of the Ministry of Health, and others.

In 2001, the new statute set up the Commission's Coordination Committee (comprising the leadership of the Ministry of Health and the GHIF director). The Co-ordination Committee assigns tasks to the Categorization Commission in line with the goals of the state drug policy. The setting up of this Committee, however, has not lead to the desired results in the form of clear political guidelines with respect. to drug policy. The Ministry of Health's leadership has recently, contrary to its past practice, decided, without any necessary substantiation, and in breach of the recommendations of the Categorization Commission in several cases, to cast considerable doubt on the transparency of the entire process.

The Ministry of Finance determines both the reference prices and the combined maximum amount of mark-ups by pharmacies and wholesalers after drugs leave the factory (ex-factory prices). The maximum mark-up is stated

for pharmacies and wholesalers together. On 1 August 1999, this total mark-up was lowered from 35% to 32%. This is the maximum amount; the actual surcharge applied may be lower. In practice, it reaches the maximum level; if a wholesaler supplies a drug with a lower surcharge than the competition, the pharmacy just tops it up to the permissible 32%. The representatives of pharmacists, distributors and health insurance fund come with proposals for the introduction of fixed prices, a differentiated surcharge and a variable margin. The new Minister of Health has expressed support for the proposal for firm price setting. On the basis of the decree and the decisions of the Ministry of Finance, the GHIF issues a drug list in which every reimbursable pharmaceutical product is enumerated. Also, the reference price, the maximum retail price and other limiting conditions are included. The health insurance funds themselves also have a role in the regulation of pharmaceutical expenditure: they set spending limits for drugs for each health care provider and impose penalties in case of overspending.

Independently of the Ministry's measures, the GHIF started to influence the prices of drugs in 1997 by price negotiation with the manufacturers and importers. In this negotiation, the GHIF tried to establish prices as close as possible to the lowest price charged in a market in a comparable European country. In recent years, several acts were enacted which relate to the drug market. In 2000, the act on drugs, passed in 1997, was amended; another amendment is currently being discussed in the Czech parliament. The aim of the amendment is to harmonize the rules regulating the drug market with EU law. Also, an amendment to the patent law was approved, which makes it impossible to undertake experimental work on the development of a generic product during patent protection of a drug. Last year, an amendment to the Advertising Act was also enacted.

Further problems concerning pharmaceuticals (and some possible solutions) are as follows:

- to keep drug expenditure at a moderate level (reveal and eliminate current waste, keep the increase in drug expenditure within the financial limits of social health insurance incomes);
- to improve the level of detail of drug categorization;
- to create a separate system of drug payments for inpatient and outpatient care;
- to control multiple payments for drugs, especially while patients are in hospital (i.e. to prevent pharmaceuticals from being obtained on prescription when they are included in hospital reimbursement).

Financial resource allocation

Third-party budget setting and resource allocation

The size of the overall health care budget is determined mainly by the level of personal income of the population (the insured), as funding is a proportion of income. Any remaining costs are covered from state and regional budgets. One of the most striking features of the Czech health reforms has been the rapid rise in expenditure on health care. This has risen every year since 1990, but especially between 1992 and 1993 following the introduction of the health insurance system (with an approximately 60% per capita increase). After that, the per capita expenditure increased less rapidly but still substantially, e.g. in the GHIF by 36% in 1994, by 21% in 1995, by 14% in 1996 and by 9% in 1997 (1993–1997: +105%). The insurance funds collect and spend around 90% of public financial resources in the health care system, making them by far the most important players in resource allocation (Fig. 19). As explained previously, health insurance funds contract hospitals and doctors for the provision of services. Payment was originally on a pure fee-for-service basis, with payments based on the fee schedule, which indicates a certain number of points per service. The number of points was then multiplied by the monetary value per point to calculate the reimbursement. The monetary value was determined by various factors, i.e. the allowed maximum, the contracted value and the overall level of activity to be reimbursed by an individual fund. At that time, the maximum point value was set by the Ministry of Finance.

As insurers contract separately, those with higher contribution incomes were able to offer higher payments per point. This meant that there were incentives for providers to encourage patients to move from one fund to another (i.e. so that they would obtain higher reimbursement levels). But in reality the differences

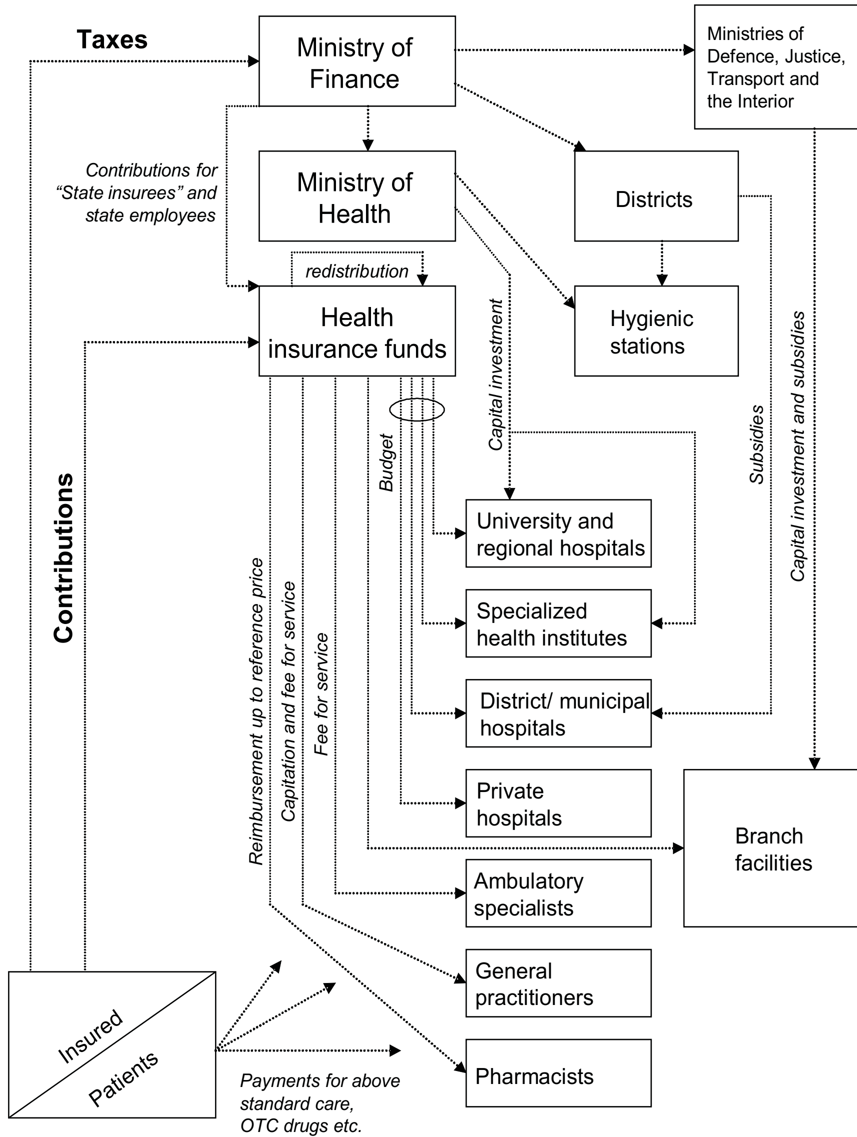
between insurance funds were not very large, because other funds often copied the value set by the GHIF. For all funds, an increasing level of reimbursed activity led, due to a ceiling on total point-related payments, to decreasing point values. Until 1994, health insurers did not have the authority to limit the volume of contracted services. They had to contract for an unlimited volume of health services. Therefore, they were not able to act as active purchasers of services but only as passive payers for services delivered by contracted providers. After the 1994 legislation, some volume limitation could be applied, albeit only to a limited extent, on the basis of decreasing reimbursement for services above the set volume (effectively introducing a third factor determining the point value).

This situation changed in 1997 with the introduction of Act No. 48/97 Coll. and additional legislative norms, which more clearly defined the imposition of volume limits in the contracts and permitted the use of payment schemes other than fee-for-service. This also changed the determination of the now uniform point value: it results from the process of joint negotiations between insurance funds and providers, but needs the approval of the Ministry of Finance. These were the most important changes in health care financing since the establishment of the insurance system in 1992–1993.

In July 1997, the Ministry of Health published a new list of procedures (items of services) with new point numbers. This list met criticism both from providers, who were convinced that the new point values would not allow them to cover the real cost of the provided services, and from the insurers as well, who argued that the insurance contributions collected would not be sufficient to cover the supposed volume of the health services, invoiced according to the new point values. At present (2003), there are about 3800 different services specified for reimbursement. The structure of expenditures has been changing since 1993 in relation to the following:

- the extent and reimbursement of "above standard" services by the health insurance funds;
- the growing number of private providers of all types and the increasing amount of newly acquired technology, which led to an increase in both the quantity and quality of care offered;
- the wider availability of imported drugs; and
- changes in the reimbursement method.

Fig. 19. Financial flow chart of the health care system



This information was compiled by the editors.

Payment of hospitals

Since mid-1997, hospital inpatient health care has been reimbursed according to a budget (or rather budgets, as funds contract hospitals individually) based on the relevant period of the previous calendar year, taking the inflation rate into account. The points from the fee schedule are used to determine the activity of the hospital or, in other words, to evaluate whether an equivalent activity has been delivered for the budget. The system of budgets was developed as a result of some problems with the previous points-based fee-for-service hospital reimbursement system, implemented from 1993 to 1997.

Under this system, invoices were submitted to the insurer, containing a patient-identification code and a list of the procedures carried out. A total list of up to about 4500 procedures was reimbursable with points supposedly based on the amount of time taken to carry out a procedure. Hospitals also invoiced a number of points (multiplied by the point value) for each day spent in the hospital; in addition they received a lump-sum payment for pharmaceuticals. The value of points was calculated as follows: direct charges for materials were reimbursed first and the remaining funds were divided by the total number of points. The value of a point was the same throughout the country, but, as calculations were carried out separately for each health insurance fund, point values could vary from one fund to another. This system had shortcomings: it stimulated considerable growth in services provided by hospitals (as well as in ambulatory care facilities), and it overvalued certain specialties – e.g. invasive specialties such as orthopaedics and ophthalmology – relative to others. In addition, there was no allowance for the fact that some providers faced higher labour costs than others (especially in Prague). As it also did not encourage a decrease in hospital length of stay, per diem payments were changed to a sliding scale from the end of 1994.

Since 2001, in addition to the budgets a flat fee is paid on the basis of the number of treated cases in each hospital. Regulations usually change quite often (twice a year) so only the main principles are described here.

- If, in the year concerned, the hospital treats fewer than 101% cases compared to the same time in the previous year, the flat fee per insured person treated in the given segment is paid in full.
- If the hospital treats more than 101% cases, but fewer than 105% compared to the same period of the previous year, the flat fee for the number of cases by which the threshold was exceeded is reduced to one half (up to 101%, the flat fee is paid in full).
- If the limit is exceeded by more than 105%, the flat fee for the number of cases by which the 105% limit was exceeded is reduced to one fifth

(up to 105%, the flat fees are calculated according to the rules mentioned above).

While the GHIF's per capita expenditure for inpatient care increased by 51% between 1993 and 1997 (and by 24% between 1998 and 2001), the increase was not as rapid as that in other sectors. Under the former fee-for-service system and the current budget system, the reimbursement payments are supposed to cover operating costs and include a depreciation allowance to finance capital expenditures. The capital investments of university and regional hospitals, however, are funded from the state budget, and many district hospitals receive support from the municipalities. These sources of funding are available only to public-sector institutions. If the privatization of health care facilities is to continue, an important challenge for the future will be to allow investments by all health care providers to take place under equal conditions.

Currently, preparations are being made for the introduction of diagnosis-related groups designed to address some ongoing problems. This will be a big change for hospitals, since they gain more than about 83% of their resources from payments by health insurance funds *(12)*.

Payment of physicians

There is a clear division in earnings between physicians in private practice and those employed by the State. The latter, mostly working in state-owned hospitals, are salaried and earn a wage that is above the Czech average. Physicians in private practice are paid according to the services they deliver. Originally, this was totally on a fee-for-service basis, as described above. Since the total amount of money available was limited, more services meant less reimbursement per service. In order to compensate for decreasing reimbursement rates, physicians, in turn, increased the number of services delivered (which lowered the reimbursement even further), especially those of specialists. From 1993 to 1997, GHIF's per capita expenditure on GPs increased by 31%, and the increase for ambulatory specialists was 258% (which was not explained by fewer ambulatory services delivered by hospitals, as outpatient expenditure per capita also rose by 67%).

To break this vicious circle, in 1997, the Ministry of Health and the GHIF prepared and introduced specific measures for GPs and for specialists. For GPs, capitation fees per patient were introduced. These are differentiated into 18 groups by age but not by gender, e.g. 0–4-year-olds have an index value of 3.8; 20–24-year-olds have one of 0.9, 60–64-year-olds have one of 1.5 and persons above 85 years have one of 3.4. The number of patients per physician is

equally limited and exceeding that limit means smaller per capita payments. In addition, some services of GPs, e.g. preventive examinations, visits to patients' homes, etc., continue to be paid under the fee-for-service system (with this comprising approximately 30% of their income). For services by ambulatory specialists, a system of lump-sum payments up to the level in the relevant quarter of 1996 (increased by the inflation rate) – similar to that of hospitals – was introduced into the system for the second half of 1997. Receipt of the total 100% lump-sum payment was dependent on a performance level of at least 70% of the volume of the health care supplied in the same quarter of the preceding year. This condition had been imposed by the insurers, on the basis of Ministry of Health information, according to which 20–30% of the provided health services were unnecessary, having been supplied just as a "hunt for points" and profit increases. The data, indeed, showed that in the second half of 1997, the volume of services dropped by approximately 20%. In January 1998, the system of reimbursement for specialized ambulatory services was changed again and a fee-for-service system was reintroduced. There are now, however, limits on the volume of services (enforced in 2001) so that specialists are not reimbursed without limits.

Additionally, the monetary point value for reimbursement depends on the number of hours worked, e.g. while up to 9 hours daily gives 1 Czech koruna per point, this amount decreases to 0.8 Czech koruna if the working time is up to 12 hours (in 1999). In contrast to office-based specialists, hospitals and other bed-based health care facilities are reimbursed for outpatient health care services by lump-sum payments. Since July 1997, dental/stomatological services have been reimbursed according to a special price list. The individual items of services are calculated directly in Czech koruny, not in points. Some of their procedures are aggregated. Procedures using above-standard materials are entirely paid by the patient; in this case, insurers do not reimburse the standard prices of the procedure or the value of the standard material. In summary, the above-mentioned changes in the reimbursement of GPs and ambulatory specialists, as well as hospitals, from mid-1997 altered the incentive structure for health care providers. The change removed the tendency for unnecessary, exaggerated care and procedures for each individual patient. In fact, the new reimbursement schemes motivated some physicians to minimize care. The idea that some patients are treated "free-of-reimbursement" (after the physician's "time-limit") still exists in the mind of these physicians. However, it is important to note that total budget available has not changed and for several groups of doctors it has even increased.

Health care reforms

Reform implementation

In the early 1990s a considerable amount of changes took place in the Czech health care system. The pace of reform was remarkably high and the implementation process was pretty smooth (for reforms before 1998, please refer to Historical background; the reforms since 1991 are listed in Appendix 1). But since the late 1990s the pace of reform in the Czech Republic has been somewhat slower. Between 1998 and 2004 only a few partial amendments were adopted in the field of health care provision and statutory health insurance.

The fundamental norm regulating the statutory health insurance, Act No. 48/1997 Coll., originally enacted as a temporary act with time-limited application, still remains in force even after another election. Partial changes responded to the most problematic areas of needs of the Czech health care system including its financing. However, they did not bring any major change to the financial situation of the statutory health insurance.

Another key piece of legislation making provision with respect to the health care system, namely the act entitled Care for the People's Health (No. 20/1966 Coll.), was amended several times during the period of 1998-2002. In April 2001 the Government presented a health care bill and a bill concerning health care facilities and their operation. However, in December 2001 the Chamber of Deputies dismissed these bills in the first reading. So far a new proposal has not been worked out.

Some legislative changes took place in relation to the accession of the Czech Republic to the EU, in particular, Act No. 123/2000 Coll. was adopted, which makes provision with respect to medical devices, together with Act No. 407/2001 Coll., amending the Addictive Substances Act and the Protection of Public Health Act (No. 258/2000 Coll.). In addition, the Transplantation Act

(No. 285/2002 Coll.) has also to be mentioned, as it is achieving urgently needed regulation of transplantation medicine by the Ministry of Health.

Aims and objectives

After the 1998 election the Czech Social Democratic Party formed a minority government. The election platform of this political party, called "Together for a Better Future", saw health as "a public property, source of the society's wealth and good living conditions and not just private property and goods". Any limitation of the principle of solidarity with citizens having low incomes, and with ill and elderly people, was unacceptable. The system of payments to health care providers was to include incentives to enhance effectiveness and maintain a high quality of care at the same time. These principles were later reflected in The Government's Policy Statement (1998) and Health Care Concept (March 1999).

Towards the end of 1999, internal problems at the Ministry of Health came to a head; in addition, they were accompanied by difficulties with which the Minister of Health had to deal on behalf of the Czech parliament. In response to this political pressure the Prime Minister relieved him of his functions. The new leadership of the ministry started to act in February 2000 and regarded the issue of calming the situation in the turbulent sector as its main task. No major reforms were on the agenda.

In June 2000, the Ministry of Health submitted, to the government, proposed amendments to the Statutory Health Insurance Act (No. 48/1997 Coll.), the Department, Field, Company, and Other Health Insurance Funds Act (No. 280/1992 Coll.), the General Health Insurance Fund Act (No. 551/1991 Coll.) and the General Health Insurance Contribution Act (No. 592/1992 Coll.). These amendments were aimed at making changes leading to the elimination of the shortcomings of the existing acts by aligning them with the Czech Social Democratic Party mission statement. However, for various reasons, the amendments were never passed and the Minister of Health withdrew the government proposal from being discussed in the Chamber of Deputies of the Czech parliament.

In 2000, the Ministry of Health also set up a Centre for International Reimbursements of Health Care Services provided in connection with the free movement of persons in the EU. The web pages of the centre (www.cmu.cz) offer important information both for the citizens of other countries and for Czech citizens. The web site publishes documents related to the provision of health care in other EU countries (regulations 1408/71 and 574/72, rulings of

the Court of Justice, international agreements on social security and a list of agreements on the provision of health care).

Two statutes enacted in 2004 are important for the harmonization of Czech legal norms with respect to the country's accession to the EU. The following statutes set out the rules for the acquisition and recognition of professional qualifications in health care occupations: Act no. 95/2004 Coll., on the conditions for acquiring and recognizing qualifications for the performance of the medical occupations of physician, dentist, and pharmacist; and Act No. 96/2004 Coll., on the conditions for acquiring and recognizing qualifications for the performance of non-medical occupations in health care and for the execution of activities related to the provision of health care and on changing certain related acts (Act on Non-medical Occupations in Health Care). The preparation and discussion of these two statutes took more than four years. Aside from a government draft, there was a version put forward by members of the parliament. Both drafts had a number of problems and questionable goals. Disputes arose due to the different interests of the various health care occupations, which in the end led to the adoption of two acts, one for medical occupations and pharmacists, and one for non-medical occupations.

Following the Biennial Collaborative Agreement between the Czech Republic and the WHO Regional Office for Europe, a Review of Health Promotion Policy and Infrastructures in the Czech Republic was conducted in 2002–2004. Its results were a critical reflection of the country's development and offer options which could be used for designing and implementing health promotion policy in the future. The Review of Health Promotion Policy and Infrastructures in the Czech Republic formulated a number of stimulating suggestions as to the further development of health promotion policy.

In 2003–2004, a political consensus was reached about the reform of the risk structure compensation scheme among the nine health insurance funds. Since the introduction of statutory health insurance, the allocation of collected contributions has not appropriately reflected the differences in morbidity structures among those insured by the health insurance funds. This led to growing surpluses of the "employee" insurance funds and, at the same time, to a growing loss by the GHIF. The existing system reallocated a mere 60% of collected contributions only according to two age groups of the insured – up to the age of 60 and above the age of 60. Now there will be a gradual (two-year) interim period in which 100% of the collected contributions will be reallocated according to the criterion of age and also according to another criterion reflecting the extent of utilized resources, e.g. in chronic disease or morbidity. However, it still does not seem clear as to exactly which criterion, apart from age, will be applied to the new risk structure compensation scheme.

In April 2004, the Minister of Health prepared a new concept for health care reform which included the introduction of higher co-payments, by the insured, concerning reimbursements for health care, in order to reduce possible over-utilization of health care resources. Besides this, the separation of health care and long-term care insurance was proposed together with the exclusion of certain benefits from statutory health insurance (which should be replaced by additional supplemental private health insurance). In addition, the establishment of a central health insurance administration, to supervise the present nine health insurance funds and control their activities, was planned.

Because of its electoral failure in elections for the European Parliament, the government resigned in mid-2004. Just after her appointment in August 2004, the new Minister of Health, Milada Emmerová, presented a policy document for the period 2005–2009 for the purpose of society-wide discussion. The concept was, once comments had been incorporated, presented to the government for discussion on 1 February 2005. The concept addresses the problems of the financial deficits of the statutory health insurance, presents a proposal for the creation of regional public health care service plans and for improving the efficiency of public administration in statutory health insurance, and proposes a new system for dealing with patients' complaints. The smaller sickness funds are trying to prevent those changes, as they fear that the system of multiple health insurance funds may be abolished. The government plans to enact a statute on health care institutions which would set the rules for the creation of public health care service plans. The aim of that statute is to optimize the structure of public health care services and to address the problems of their excess or inadequacy in various regions and in the city of Prague. Other measures focus on the application of tools aimed at the stability of the financial management of hospitals and sickness funds. This government, however, has only a limited time-frame for the implementation of its plans, i.e. until new elections in mid-2006.

Conclusions

The health care system of the Czech Republic has undergone considerable and rapid change since the early 1990s. The aims of the reforms have evolved, as their effects have been felt throughout the health care system. In 1989, a humanization and democratization of the health care system, as well as separation of the financing of health care from the state budget were considered to be the important issues. This was resolved by the introduction of single-source financing of health care through the introduction of statutory health insurance. It was also necessary to find resources as well as tools for the effective allocation of these resources. The chosen tools, such as fee-for-service reimbursement, were initially expected to strengthen the efficiency of the system but later turned out to provide incentives for excessive overutilization of health services.

The health care system in the Czech Republic has gone through major and fast change, especially during the early 1990s. The aims of reforms began to take shape as they operated throughout the whole health care system. As for the provision of health care, practically all such needs of the whole population are sufficiently covered. To date, the achievements have certainly outweighed any mistakes, but the Czech health care system is facing a number of problems that remain to be solved, creatively and dynamically, without any prejudice and with an emphasis on consensus building in health policy.

Up to now, the priorities of health care policy-makers have been primarily the problems of financial instability and deficits of the statutory health insurance system and of hospitals. The Czech Republic has been dealing with the pressures of the growing deficit in public finances. Thus far, the Ministry of Finance and central-level politicians have only looked at resolving the problem by limiting expenditure, but not by increasing efficiency in management or even by developing growth-enhancing activities in the public sector (e.g. research, education). The situation is worsened by the political pressures to decrease the

overall tax burdens. This leads to the risk of an increased social and economic burden for low- and mid-income groups. At the same time, useless health care expenditures are still being made due to inefficient use of resources and a superfluous capacity in certain services or in their geographic arrangements. It will be important for political representatives and other players to discuss the possibility of fundamentally changing approaches to the principles of health care policy. It concerns the possibility of implementing reform changes similar to those implemented in Slovakia under the influence of the World Bank. In that case, private for-profit health insurance companies (joint-stock companies) would manage the financial resources in statutory health insurance.

In 2004, the World Bank was also playing a role in the discussions in the Czech Republic. Thus, the Czech Republic is considering enhancing competition in the statutory health insurance system, as well as the autonomy of hospitals; in this context, there are attempts to develop corresponding mechanisms for payments for hospital care (Diagnosis Related Groups).

Currently it is being decided in what direction the Czech health care system is to go. Because of the great importance and sensitivity of this field in society, major political decisions have to be adopted and implemented consistently, hence leading to rationalization and higher effectiveness in all areas of the health care system, i.e. in the quality of health care, the financing of the health care system and the national health policy.

The development of health policy will be shaped by policy-makers' positions on the application or limitation of market principles in the provision of health services. One option would involve greater "commercialization" of the statutory health insurance system, freedom of contractual relationships, and competition between providers. This would involve a combination of the privatization of hospitals and a higher share of patient cost sharing – an approach that is currently called the "invisible hand". The other option is to preserve the current approach, i.e. to continue to rely on the "visible hand".

The most important issue for the coming period is to solve problems systematically, contrary to the former prevailing single-problem oriented approach. During the last decade, the situation was complicated by a lack of communication among health policy-makers, health care providers, health insurance fund representatives, representatives from various professional associations, patient associations and the public.

The system of statutory health insurance has brought about a definite separation from the state budget in the field of health care finance, leaving the state budget responsible only for investment subsidies for the health care sector. However, there are a few questionable financial incentives in the system which have to be addressed. The previously mentioned irregular subsidies to indebted

hospitals in the course of decentralization were not allocated in a very systematic way, encouraging hospital management to concentrate on political lobbying instead of the necessary structural and procedural changes. Another problem is that they are reimbursed on a retrospective basis, or, in other words, on the basis of past financial flows, which only partially reflect real production. Thus there is not enough economic pressure on the hospital management to increase productivity and ensure its financial health.

No matter whether the government wants to move towards more competition between health insurance funds or preserve the current structure, the introduction of a more advanced and equitable risk structure compensation scheme is urgently needed. The government has to consider more than just age as a risk-adjusters in order to reallocate resources more effectively and provide a fair chance for all health insurance funds. Incapacity for work could, for instance, be applied as additional risk-adjuster, since it significantly improves the reallocation formula.

The benefit catalogue of the statutory health insurance has to be reviewed thoroughly. There are too many luxury and unnecessary benefits covered, e.g. over-the-counter drugs, spas, etc., which in most other European countries are paid out of pocket or by supplementary private health insurance.

The fact that accident insurance has not yet been integrated into the statutory health system has been criticized. So far, there is no public accident insurance. Employers are obliged to insure their employees with the private insurance company “Kooperativa”. The integration of accident insurance is a step that has long been claimed as important, although in other countries statutory accident and health insurance are often separate schemes.

As in other countries, a further problem for the overall health care system is that the staff of health insurance funds often lack the necessary qualifications (knowledge of health economics, law, health insurance theory, epidemiological methods and actuarial calculations). Whereas health care staff abroad undergo a rather long qualification process in preparation for their jobs, no requirements are set for health insurance funds in the Czech Republic; their staff acquire the requisite knowledge primarily on the job. The process of the creation and implementation of health care policy in this sphere is marked by slow progress in terms of knowledge, staff qualifications and the formulation of requirements with respect to such qualifications. The new knowledge necessary is not being sufficiently well integrated into undergraduate or graduate educational programmes (of health care staff, economists and lawyers).

A striking problem in the Czech Republic is the fact that the development of the entire statutory health insurance system is not being evaluated or publicized sufficiently. The focus of the existing annual reports is not satisfactory in this

respect. Therefore an initiative should be started to make the Czech health care system and its processes more transparent for Czech citizens as well as for other Europeans, e.g. by publishing comprehensive annual reports in Czech and English.

Appendices

Appendix 1. List of newly enacted health care legislation (including constitutional court judgements)

Act no.	Name of the act	Applicable as of:
	June 1990–July 1992	
220/1991 Coll.	ACT of the Czech National Council of 8 May 1991 on the Czech Medical Chamber, Czech Stomatological Chamber, and Czech Chamber of Pharmacists	1.6.1991
548/1991 Coll.	ACT of the Czech National Council of 5 December 1991, changing and amending Act No. 20/1966 Coll., on Care for People‘s Health, as amended by the Act No. 210/1990 Coll.of the Czech National Counciland Act No. 425/1990 Coll. of the Czech National Council	1.1.1992 (1.4.1992)
550/1991 Coll.	ACT of the Czech National Council of 6 December 1991 on General Health Insurance	1.1.1992 (1.1.1993)
551/1991 Coll.	ACT of the Czech National Council of 6 December 1991 on the General Health Insurance Fund	1.1.1992 (1.1.1993)
160/1992 Coll.	ACT of the Czech National Council of 19 March 1992 on Health Care in Private Health Care Institutions	15.4.1992
280/1992 Coll.	ACT of the Czech National Council of 28 April 1992 on Department, Field, Company, and Other Health Insurance Funds	1.7.1992 (1.1.1993)
July 1992–July 1996		
592/1992 Coll.	ACT of the Czech National Council of 20 November 1992 on Contributions for General Health Insurance	1.1.1993

161/1993 Coll.	ACT of 19 May 1993 on changes in General Health Insurance and about changing and amending certain other acts	1.7.1993
324/1993 Coll.	ACT of 3 December 1993, changing and amending the Czech National Council Act No. 550/1991 Coll., on General Health Insurance, as amended by subsequent norms, full-text version in Act No. 295/1993 Coll., Czech National Council Act No. 592/1992 Coll., on Contributions for General Health Insurance, as amended by subsequent norms, full-text version in Act No. 296/1993 Coll.	1.1.1994
241/1994 Coll.	ACT of 7 December 1994, changing and amending Czech National Council Act No. 589/1992 Coll., on Social Security Payments and Contributions for the State Employment Policy, as amended, Act No. 100/1988 Coll., Social Security Act, as amended, Act No. 54/1956 Coll., Employee Sickness Insurance Act, as amended, Act No. 88/1968 Coll., on Extending Maternity Leave, on Maternity Benefits and Child Support Payments from Sickness Insurance, as amended, Czech National Council Act No. 582/1991 Coll., on the Organization and Execution of Social Security, as amended, Czech National Council Act No. 550/1991 Coll., on General Health Insurance, as amended, and Czech National Council Act No. 592/1992 Coll., on Contributions for General Health Insurance, as amended	1.1.1995
59/1995 Coll.	ACT of 17 March 1995, changing and amending Czech National Council Act No. 550/1991 Coll., on General Health Insurance, as amended, and Czech National Council Act No. 592/1992 Coll., on Contributions for General Health Insurance, as amended, Czech National Council Act No. 589/1992 Coll., on Social Security Payments and Contributions for the State Employment Policy, as amended, and Czech National Council Act No. 337/1992 Coll., on the Administration of Taxes and Fees, as amended	1.5.1995
60/1995 Coll.	ACT of 17 March 1995, changing and amending Czech National Council Act No. 551/1991 Coll., on the Czech General Health Insurance Fund, as amended, Czech National Council Act No. 280/1992 Coll., on Department, Field, Company, and other Health Insurance Funds, as amended, Act No. 20/1966 Coll., on Care for People's Health, as amended, and Czech National Council Act No. 185/1991 Coll., The Insurance Act, as amended	1.5.1995
160/1995 Coll.	ACT of 30 June 1995, Changing and Amending Certain Acts Related to the Enactment of the Pension Insurance Act	1.1.1996

149/1996 Coll.	ACT of 25 April 1996, changing and amending an act of the Czech National Council, No. 550/1991 Coll., on General Health Insurance, as amended, Czech National Council Act No. 592/1992 Coll., on Contributions for General Health Insurance, as amended, Czech National Council Act No. 551/1991 Coll., on the Czech General Health Insurance Fund, as amended, and Czech National Council Act No. 280/1992 Coll., on Department, Field, Company, and Other Health Insurance Funds, as amended	1.7.1996
	July 1996–July 1998	
206/1996 Coll.	JUDGEMENT of the Czech Constitutional Court	1.4.1997
48/1997 Coll.	ACT of 7 March 1997 on Statutory Health Insurance and on Changing and Amending Certain Related Statutes	1.4.1997 (1.1.1998)
79/1997 Coll.	ACT of 19 March 1997 on Drugs and on Changing and Amending Certain Related Statutes	1.1.1998
2/1998 Coll.	ACT of 2 December 1997, changing and amending Act No. 48/1997 Coll., on Social Insurance and on Changing and Amending Certain Related Statutes, as amended by Act No. 242/1997 Coll.	27.1.1998
127/1998 Coll.	ACT of 19 May 1998, changing Act No. 592/1992 Coll., On Contributions for General Health Insurance, as amended, Act No. 48/1997 Coll., on Social Health Insurance and on Changing and Amending Certain Related Acts, as amended, Act No. 551/1991 Coll., on the General Health Insurance Fund, as amended, Act No. 280/1992 Coll., on Department, Field, Company, and Other Health Insurance Funds, as amended, and Act No. 21/1992 Coll., The Banking Act, as amended	30.6.1998 (1.1.1999)
167/1998 Coll.	ACT of 11 June 1998 on Addictive Substances and on Changing Certain Other Statutes	1.1.1999
	July 1998–December 2003	
354/1999 Coll.	ACT of 9 December 1999, changing Act No. 167/1998 Coll., on Addictive Substances and on Changing Certain Other Statutes	30.12.1999
69/2000 Coll.	ACT of 1 March 2000, changing Act No. 551/1991 Coll., on the General Health Insurance Fund, as amended	29.3.2000
123/2000 Coll.	ACT of 15 April 2000 on Health Care Tools and on Changing Certain Related Statutes	1.7.2000
149/2000 Coll.	ACT of 16 May 2000, changing Act No. 79/1997 Coll., on Drugs and on Changing and Amending Certain Related Statutes, Act No. 20/1966 Coll., on Care for People's Health, as amended, and Act No. 455/1991 Coll., The Trades Licensing Act, as amended	1.8.2000
167/2000 Coll.	JUDGEMENT of the Czech Constitutional Court	1.1.2001
258/2000 Coll.	ACT of 14 July 2000 on Protection of Public Health and the change of certain related statutes	

459/2000 Coll.	ACT of 28 November 2000, changing Act No. 48/1997 Coll., on Social Health Insurance and on changing and amending certain related acts, as amended	31.12.2000
57/2001 Coll.	ACT, changing Act No. 167/1998 Coll., on Addictive Substances and on Changing Certain Other Statutes	1.2.2001
138/2001 Coll.	ACT of 28 March 2001, changing Act No. 592/1992 Coll., on Contributions for General Health Insurance, as amended	1.7.2001
260/2001 Coll.	ACT, changing Act No. 20/1966 Coll., on Care for People's Health, as amended	1.8.2001
407/2001 Coll.	ACT, changing Act No. 167/1998 Coll., on Addictive Substances and on Changing Certain Other Statutes	1.1.2002
49/2002 Coll.	ACT, changing Act No. 551/1991 Coll., on the General Health Insurance Fund, as amended, Act No. 280/1992 Coll., on Department, Field, Company, and Other Health Insurance Funds, as amended, and Act No. 592/1992 Coll., on Contributions for General Health Insurance, as amended	8.2.2002
120/2002 Coll.	ACT on the Conditions for the Introduction of Biocide Preparation and Active Substances on the Market and on Changing Certain Related Statutes	1.7.2002 (1.1.2004)
176/2002 Coll.	ACT changing Act No. 48/1997 Coll., on Social Health Insurance and on changing and amending certain related acts, and Act No. 592/1992 Coll., on Contributions for General Health Insurance, as amended	1.7.2002
285/2002 Coll.	ACT on Donating, Taking and Transplanting Tissue and Organs and on Changing Certain Other Statutes (The Transplantation Act)	1.9.2003
129/2003 Coll.	ACT of 2 April 2003, changing Act No. 79/1997 Coll., on Drugs and on Changing and Amending Certain Related Statutes, as amended, and Act No. 368/1992 Coll., on Administrative Charges, as amended	6.6.2003 (1.11.2003; 1.5. 2004)
130/2003 Coll.	ACT of 2 April 2003, changing Act No. 123/2000 Coll., on Health Care Tools and on Changing Certain Related Statutes, and Certain Other Statutes	1.9.2003 (1.5. 2004)
132/2003 Coll.	ACT of 11 April 2003, changing Act No. 40/1995 Sb., on Regulation of Advertising, and on Changing and Amending Act No. 468/1991 Coll., on Television and Radio Broadcasting, as amended	1.7.2003
148/2003 Coll.	ACT of 2 April 2003 on Preservation and Exploitation of Genetic Resources of Plants and Microorganisms Important for Nutrition and Agriculture, and on Changing Act No. 368/1992 Coll., on Administrative Charges, as amended	22.5.2003
211/2003 Coll.	JUDGEMENT of the Constitutional Court	1.1.2004

223/2003 Coll.	ACT of 26 June 2003, changing Act No. 167/1998 Coll., on Addictive Substances and On Changing Certain Other Statutes, as amended	26.7. 2003
274/2003 Coll.	ACT of 7 August 2003, Changing Certain Statutes of Public Health Sector	1.10.2003 (1.5. 2004)
455/2003 Coll.	ACT of 8 November 2003, changing Act No. 592/1992 Coll., on Contributions for General Health Insurance, as amended, Act No. 551/1991 Coll., on the General Health Insurance Fund, as amended, and Act No. 48/1997 Coll., on Social Health Insurance and on Changing and Amending Certain Related Statutes, as amended	1.1. 2004
95/2004 Coll.	ACT on the conditions for acquiring and recognizing qualification for the performance of the medical occupation of physician, dentist, and pharmacist.	1.1.2005
96/2004 Coll.	ACT on the conditions for acquiring and recognizing qualification for the performance of non-medical occupations in health care and for the execution of activities related to the provision of health care and on changing certain related acts (act on non-medical occupations in health care).	1.1.2005

Appendix 2. Conceptual documents in health care, 1998–2004

Document name	Presented by:	Date
Minister Z. Roithová (February–July 1998)		
Programme Declaration of the Czech Government		
http://www.vlada.cz	Government	January 1998
Minister I. David (July 1998–December 1999)		
Programme Declaration of the Czech Government		
http://www.vlada.cz	Government	July 1998
Czech Republic Action Plan for Health and the Environment	Ministry of Health Ministry of the Environment Ministry of Agriculture	December 1998 (approved by the government)
http://www.szu.cz (available in English)		http://www.szu.cz
Health Care Concept. Long-term Government Plan.	Czech Ministry of Health	March 1999 (discussed by the government)
V. Špidla (December 1999–February 2000)		
(charged with the management)		
Minister B. Fišer (February 2000–July 2002)		
Mid-term Concept of Social and Economic Development	Council of the Government for a Social and Economic Strategy (in cooperation with the Ministry of Health)	January 2001 http://www.vlada.cz
Mid-term Concept of Social and Economic Development (updated)	Council of the Government for a Social and Economic Strategy (in cooperation with the Ministry of Health)	January 2002 http://www.vlada.cz
Minister M. Součková (July 2002–April 2004)		
Programme Declaration of the Czech Government	Government	August 2002
www.vlada.cz		

A Long-term Program for Improving the Health of the Population of the Czech Republic – Health for All in the 21st Century (available in English)	Ministry of Health	October 2002 (approved by the government) www.vlada.cz
Theses of Mid-term Concept of Policy of the Ministry of Health in 2003–2006	Ministry of Health	February 2003 (discussed by the government) www.vlada.cz
Concept of Mid-term Policy of the Ministry of Health 2003–2006 – Concept of Health Care Reform	Ministry of Health	February 2004
Minister Jozef Kubinyi (April 2004–August 2004)		
	Ministry of Health	July 2004 (but never discussed by the parliament)
Minister Mileda Emmerova (August 2004–to date)		
New Programme Declaration of the Czech Government	Government	August 2004 www.vlada.cz

Appendix 3. Ministers of Health,1990–2004

Name	Period in office
1990–1992	
Pavel Klener	November 1989–June 1990
Martin Bojar	June 1990–July 1992
1992–1996	
Petr Lom	July 1992–June 1993
Luděk Rubáš	June 1993–October 1995
1996–1998	
Jan Stráský	October 1995–January 1998
Zuzana Roithová	February 1998–July 1998
1998–2002	
Ivan David	July 1998–December 1999
Vladimír Špidla	December 1999–February 2000
Bohumil Fišer	February 2000–July 2002
2002–to date	
Marie Součková	July 2002–April 2004
Jozef Kubinyi	April 2004–August 2004
Milada Emmerova	August 2004–to date

Appendix 4. Legal norms not mentioned in Appendix 1

- Act No. 20/1966 Coll., on Care for the People's Health
- Ministry of Health Regulation No. 394/1991 Coll., on the Position, Organization, and Work of Faculty Hospitals
- Decree No. 57/1997 (the "drug decree")
- Act No. 111/1998, on Higher Education Institutions and on the Ammendment and Supplement on other Acts
- Act No. 106/99, on Free Access to Information
- Act No. 363/1999 Coll., on Insurance and on Amendment to Some Related Acts (the Insurance Act)
- Act No. 129/2000 Coll., on Regions (Establishment of Regions)
- Act No. 157/2000 Coll., on the Transfer of Certain Items, Rights and Obligations from the ownership of the Czech Republic to that of the regions
- Act No. 218/2000 Coll., on Budgetary Rules
- Act No. 219/2000 Coll., on the Assets of the Czech Republic and Their Representation in Legal Relations.
- Act No. 250/2000 Coll., on the budgetary rules for regional budgets
- Act No. 320/2000 Coll., on Financial Control
- MF Regulation No. 40/2001 Coll., on state budget participation in the financing of asset-management programmes
- Act No. 10/2001 Coll., changing Act No. 157/2000 Coll., on the Transfer of Certain Items, Rights and Obligations from the ownership of the Czech Republic to that of the regions
- Act No. 290/2002 Coll. on the Transfer of Certain Other Items, Rights and Obligations from the ownership of the Czech Republic to that of the Regions and Municipalities, Civil Associations Active in the Sphere of Physical Education and Sport, and on Related Changes, and on Changing Act No. 157/2000 Coll., on the Transfer of Certain Items, Rights and Obligations from the ownership of the Czech Republic

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