HiT summary Czech Republic

Government and recent political history

The Czechoslovak state was a communist state from 1948 until 1989. A legal separation of the Czech and Slovak Republics took place in 1992, and the Czech Republic, a multiparty parliamentary democracy headed by a president, was established on 1 January 1993.

Population

The estimated population is 10.28 million (1999), of which about 65% live in urban areas. In 1994, the number of deaths exceeded the number of births for the first time since 1918, and the population is continuing to decline.

The Czech Republic is one of the healthiest of the central and eastern European (CEE) countries.

Average life expectancy and infant/maternal mortality

Life expectancy, at 71.1 years for men and 78.1 years for women (1998), and infant mortality at 5.2/1000 live births (1998), are better than in most CEE countries, but are worse than in western Europe.

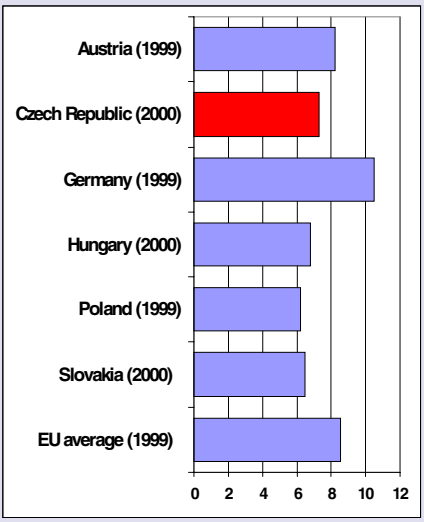
Leading causes of death

Diseases of the circulatory system (especially ischaemic heart disease) remain by far the most important cause of death, although they have decreased in recent years. The standardized death rate is higher than in any European Union country.

Recent history of the health care system

In 1990 and 1991, a dramatic liberalization of the previously centralized Semashko health care system took place, and the system began moving towards a compulsory social insurance model, with a number of health insurance funds financing health care providers on the basis of contracts.

Fig. 1. Total health care expenditure as % of GDP, comparing the Czech Republic, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

Reform trends

Reform decisions were made as a result of concerns in the late 1980s and early 1990s, about efficiency and raising the social status of providers, leading to fee-for-service reimbursement and privatization. However, these decisions resulted in problems such as overuse of services, especially specialist care, along with financial deficits and inadequate regulation. Measures are

European Observatory on Health Care Systems
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen
Denmark
Telephone: +45 39 17 14 30
Telefax: +45 39 17 18 70
E-mail: observatory@who.dk
www.observatory.dk

being considered to address these, for example, by gatekeeping, introducing DRGs for hospitals and reducing the number of specialists.

Health expenditure and GDP

Total expenditure on health accounted for 7.2% of GDP in 1998, higher than the average for CEE countries, but less than the average for western European countries.

Overview

The system is a Bismarckian social health insurance system with mandatory insurance for the whole population and a public/private mix for the provision of health care. This system, a contractual one with a clear separation between financing and provision, replaced the previous Semashko health care system. Many physicians have their own private practices and work under contract with the health insurance funds, which offer a basic package of curative and preventive services, but compete for members. This system has changed quickly and its achievements outweigh its mistakes, although it is still facing challenges.

Organizational structure and management

The three main features of the health care system are *compulsory health insurance*, funded through contributions by individuals, employers and the state*; diversity of provision*, from mainly private ambulatory care providers and public hospitals with contractual arrangements with the insurance funds; and *joint negotiations by key actors* on coverage and reimbursement issues.

The state guarantees health care and the health insurance system and participates in supervisory boards of the insurance funds. The state guarantee is included in the Czech constitution, yet the state has only some of the tools required to enable the government to fulfil this function.

The Ministry of Health is responsible for the preparation of health care legislation; health and medical research; licensing of pharmaceuticals and medical technology; and the management of two training institutes and regional and university hospitals. It also organizes the joint negotiations and is entitled to act if no agreement can be reached.

There are currently nine health insurance funds, which collect the contributions, contract providers and reimburse providers for their services. The largest health insurance fund is the General Health Insurance Fund (GHIF).

The state health administration was incorporated into the district in the form of health offices, although the legislative and financial powers of these offices have not been clearly defined. The district health offices are responsible for ensuring that accessible health services are provided to their population.

The preferred method of decentralizing health care provision has been through privatization. The great majority of primary care providers are now private, along with spas, pharmaceutical companies and pharmacies. A number of polyclinics and small-sized hospitals have also been privatized, although most hospitals, especially larger ones, are still owned by the state.

Planning, regulation and management

Regularly, there are negotiations among the health insurance funds, providers (hospital associations, hospitals and private physicians) and professional chambers (on behalf of their members). These actors negotiate on: the range of services; the monetary point value to determine reimbursement; and conditions for delivering care. The government has to ensure that the result meets legal requirements and the public interest before approving it. The joint negotiations followed by governmental approval may be considered a backbone of the health care system.

Health care finance and expenditure

Health care financing

The majority – 80.5% – of financial resources are obtained through compulsory health insurance.

Main system: health insurance scheme

Contributions are defined by law as a percentage of wages (before tax): employees pay 4.5% and employers 9%. There is a ceiling on contributions, making the system mildly regressive. The self-employed pay the same total percentage (13.5%), but only on 35% of their profits, and there is also a legally defined minimum contribution for the self-employed.

The Ministry of Finance contributes the same percentage of 80% of the minimum wage on behalf of the non-waged population (more than 50% of the insured).

Taxes

Taxes are the second most important source of financing, contributing 11.4% of the total (1988). Taxes are used to cover expenditures on the national as well as the district and municipal levels (e.g. capital investments of hospitals, public health services, training, etc.).

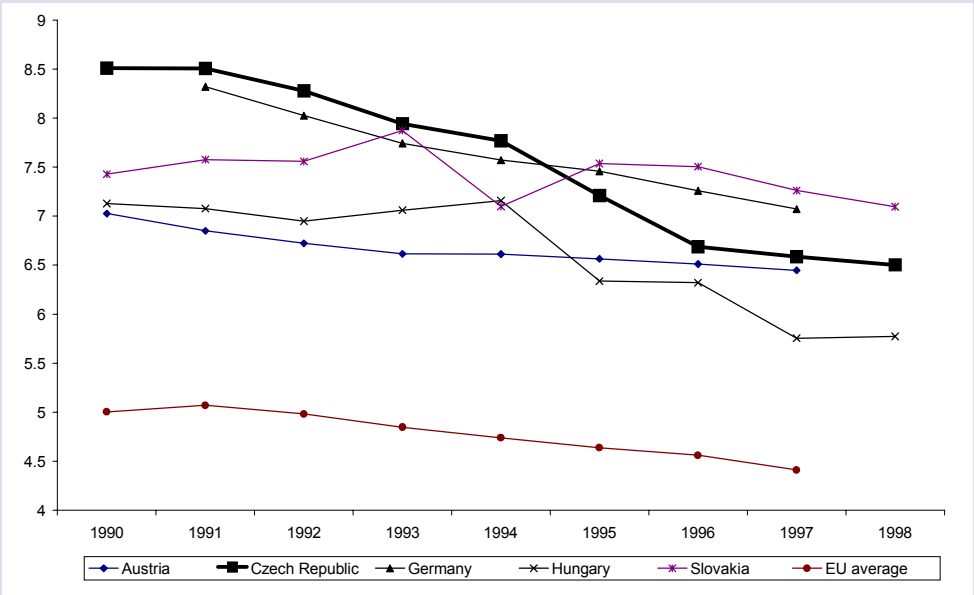
Complementary sources of finance

Out-of-pocket payments represented around 8% of total health care expenditure in 1998.

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. In principle, the health care benefits package is very broad and any treatment required for the cure of illness or to improve health status is approved for reimbursement. There are regular negotiations among the health insurance funds, providers,

Fig. 2. Hospital beds in acute hospitals per 1000 population, the Czech Republic, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

professional chambers, scientific organizations and patients' associations to determine the covered services in detail.

The following services are fully or partially covered by health insurance: preventive services; diagnostic procedures; ambulatory and hospital curative care, including rehabilitation and care of the chronically ill; drugs and medical devices; medical transportation services; spa therapy (if indicated and prescribed by a physician). Only a limited number of services are excluded: purely cosmetic surgery; certain kinds of dental care (e.g. dentures); and specific prostheses, spectacles and hearing aids. 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.

Health care expenditure

One of the most striking features of the Czech health reforms has been the rapid rise in health expenditure, especially following the introduction of the health insurance system.

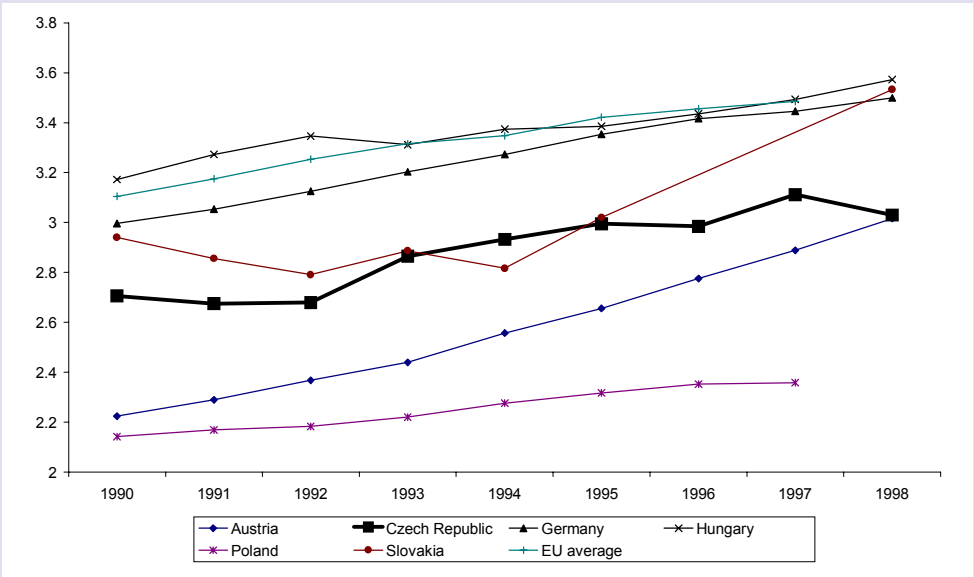
The percentage of GDP spent on health is 7.2% (1998), higher than the 5.4% average for CEE countries, but less than the 8.5% average for western European countries. At 92% of the total, public expenditure is lower than in most other CEE countries, but is higher than in western social insurance countries. Inpatient care and pharmaceuticals account for the largest share of expenditure, and the latter is well above the OECD average.

Health care delivery system

Public health services

Hygienic stations, which share public health responsibilities with other parts of the former state health care system, are responsible for epidemiologic surveillance, immunization logistics and safety measures. Primary care facilities provide preventive services, immunization and antenatal services. Health promotion and education

Fig. 3. Physicians per 100 population, the Czech Republic, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

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, and a long-term strategy, the National Health Programme, was developed in 1995. Screening programmes for adults have not yet been organized at national level.

Primary health care

Primary health care is organized at district level, and the district health office is responsible for ensuring that accessible primary health care services are available in the district. Citizens register with a primary health care physician of their choice, and can re-register with a new doctor every 6 months. There is one general practitioner (GP) for about 1780 inhabitants over 15, and one ambulatory paediatrician for every 1170 children (1998). The number of patient/physician contacts is one of the highest in Europe at 4.4 per year (1998).

By 1994, approximately 80% of primary health care physicians and 90% of dentists were in private practice and, by 1999, more than 95%. Most PHC physicians, who contract with health insurance funds, work alone, either in health centres owned by the local community (municipality) or in polyclinics, and they pay rent for use of the facilities. Health centres tend to be well-equipped. A large part of PHC physicians' work involves certifying absences from work, although efforts are under way to strengthen their role.

Secondary and tertiary care

Specialized ambulatory medical services are provided in various forms: in solo practices; in polyclinics; and in hospital outpatient departments, all of which function according to a contract with the health insurance funds. Patient access is not restricted by a gatekeeping system.

There are three kinds of hospitals: regional and university hospitals; district hospitals; and local hospitals. These hospitals are owned by a public-private mix. While the national government owns only 27 facilities (13%), these are large hospitals; on the other hand, 30% of the total are in private hands, but these are mainly small hospitals, with only 9% of beds.

Hospitals are managed by directors, usually physicians who have become managers or economists. The director is directly accountable to the municipality or Ministry of Health, but it has now been proposed that there should be a board or committee to supervise the hospital director.

The physical quality of hospitals is good, as almost all local and district hospitals are new or have been rebuilt in the last 20 years. Regional or teaching hospitals are more mixed: some are old, while others are new but are burdened with debts.

The Czech Republic has a cautious programme for a long-term decrease in the number of hospital beds, with the aim reducing acute beds and increasing long-term beds. In 1998, the number of beds had been reduced to 8.6/1000 (a 20% reduction from 1990). Average length of stay decreased even more sharply during these years, from 12.5 to 8.8 days, although it is still rather high compared to most western European countries. The Czech Republic has decreased its bed numbers more rapidly than other CEE countries, but still has one of the highest numbers of acute hospital beds. The occupancy rate, on the other hand, has remained comparably low.

In 1997, the Ministry of Health launched a programme to limit specialized health care providers and restructure hospitals. There is a move towards substituting hospital care with less expensive alternatives, and home care and day surgery are both increasing.

Social care

Social care provision is insufficient and there are problems surrounding the provision of a comprehensive package of social care, due mainly to a lack of communication among the different providers (private, nongovernmental, etc.) At the same time, health and social services are financed differently, as social care is financed by the state budget and administered from the social budget of districts or municipalities. Only strictly medical care is paid for by the health insurance funds.

The situation regarding social care has improved in the last few years, but there are still areas for improvement.

Insufficient care is provided to patients with chronic mental illness, who are often hospitalized for many years and sometimes for life. These problems stem from the lack of priority given to this area, and the lack of coordination between health and social care.

Long-term facilities for the elderly, funded from the state budget, have long waiting lists and quality varies considerably.

A positive development in social care has been comprehensive home care (CHC), an integrated form of care provided in the home, which was introduced in the early 1990s. This care integrates primary care, home care, and social care, depending on the patient's health condition and the condition of his/her social environment.

Human resources and training

The number of health care workers is relatively high compared to most other CEE countries but roughly at the EU average (3.0 physicians and 8.9 nurses/1000, 1998).

However, in some geographic areas there are shortages of nurses and excesses of doctors, mainly in urban areas. Physicians on average are young, and two thirds are specialists. There are plans to reduce the surplus of specialists by retraining in other specialties such as public health, although this has not yet been implemented.

Salaries of doctors are twice as high as the average national income, and in all specialties doctors in private practice earn four times as much. Dissatisfaction with income, however, is still an important issue for physicians.

The Ministry of Education is responsible for the education and training of physicians and nurses towards their degree, and the Ministry of Health is responsible for postgraduate education. Universities are gradually implementing curriculum changes, with more emphasis on general practice and management skills. New legislation is focused on reconciling Czech legal norms and administrative procedures with those of the European Union.

Pharmaceuticals

The Ministry of Health in consultation with the Ministry of Finance and the General Health Insurance Fund carries out the licensing of pharmaceuticals and allocation of drugs or medical aids for reimbursement.

There are three categories of pharmaceutical products for ambulatory care: the first is fully reimbursed and includes the cheapest effective preparations (often domestically produced) of all essential drugs; the second and third are partially or fully paid by patients, and insurers reimburse the cost of the generic equivalent. There is also a positive list of drugs for hospitals.

The pharmaceutical industry has been almost completely privatized in recent years, and domestically produced drugs are very important to the health care system. The main difficulty now with pharmaceuticals is cost escalation: since 1995, pharmaceutical expenditure has represented around 25% of the health care costs. Measures have been implemented to control costs, such as only allowing specialists to prescribe certain drugs.

In addition, a reference pricing system, introduced in 1995, has helped slow growth in expenditure. The reimbursement level is calculated on the basis of the amount of substance contained in each pharmaceutical product.

A law defines specific conditions for reimbursement, and a 1997 "drug decree" defines the level of reimbursement. The decree is updated regularly, based on recommendations from an external advisory body of the Ministry of Health. The Ministry of Finance determines both the reference prices and the combined mark-ups by pharmacies and wholesalers. On the basis of these decisions, the General Health Insurance Fund issues a drug list in which every reimbursable product is enumerated.

Health insurance funds themselves have a role in the regulation of pharmaceutical expenditure, as they set spending limits for drugs and can impose penalties on providers for over spending.

Problems which remain in the pharmaceutical sector include: further reducing drug expenditures; improving the level of detail of drug categorization; creating a separate system of drug payments for outpatient and inpatient care; controlling multiple payments for drugs; and motivating providers towards a more rational use of drugs.

Health technology assessment

Drugs and medical technology are registered with the Drug and Technology Control Institute, directly managed by the Ministry of Health. This institute assesses the costs and benefits of medical technology. However, comprehensive technology assessment is in its infancy and there is no body as of yet to evaluate new medical techniques.

Financial resource allocation

The insurance funds collect and spend around 90% of public financial resources, making them by far the most important actors in resource allocation.

Reimbursement for GPs, specialists and hospitals has changed in the last few years, and has altered incentives, lessening the tendency for unnecessary, costly care. However, it should be noted that the total amount of financial means has not changed and for several groups of doctors it has even increased.

Payment was originally on a pure fee-for-service basis, with a maximum point value per reimbursement point set in the fee schedule by the Ministry of Finance. This system led to problems, as until 1994 there were no volume limits. Providers tried to compensate for decreasing reimbursement rates for higher volumes by increasing volume of services delivered even more. After 1997, new volume limits were imposed, payment schemes other than fee-for-service were permitted, and point value was determined through joint negotiations between insurance funds and providers, with approval from the Ministry of Finance.

Payment of hospitals

Since mid-1997, hospitals are reimbursed according to a budget, based on the relevant period of the previous calendar year, taking into account inflation. This system of budgets developed as a result of problems with the previous points-based fee-for-service hospital reimbursement system. The point system, previously used for reimbursement, is now only a tool to measure hospital activity.

A combined daily charge incorporating diagnostic related groups (DRGs) is being considered for hospital reimbursement, and a pilot test is being conducted in 19 Czech hospitals.

Reimbursement payments are supposed to cover operating costs, including a depreciation allowance to finance capital expenditures. Capital investments of university and regional hospitals, however, are funded from the state budget, and many district hospitals receive support from municipalities. As this support is only available to public sector institutions, a challenge for the future will be to allow investments by all health care providers to take place under equal conditions.

Payment of physicians

There is a clear distinction between physicians working in private practice and those employed by the state. The latter, mostly working in state-owned hospitals, are salaried and earn a salary above the Czech average. Physicians in private practice are paid according to the services they deliver.

In 1997, the Ministry of Health and the General Health Insurance Fund introduced measures to break the vicious cycle that had

developed out of the previous fee-for-service reimbursement, which had created an upward spiral of increased services.

For general practitioners (GPs), capitation fees per patient were introduced (70% of income), along with fee-for-service (30%) for preventive and health-promotion related services.

For ambulatory specialists, starting in 1997, a system of lump sum payments was introduced. Receipt of the total 100% lump payment was dependent on a performance level of at least 70% volume of the health care supplied in the same quarter of the preceding year. Introduction of this system revealed the unnecessary health services provided previously, as the new system showed a drop in service volume of approximately 20%.

In 1998, the system of reimbursement for specialized ambulatory services was changed yet again, and fee-for-service was re-instituted, but with volume limits and with a monetary point value dependent on the number of hours worked.

Hospitals are reimbursed for outpatient care services by lump sum payments.

Health care reforms

The reform of the health care system was part of a general metamorphosis of the whole society after the 1989 revolution. Reform decisions were made as a result of important interests in the late 1980s and early 1990s: e.g. democratization, effectiveness, increasing status of physicians. These interests led to fee-for-service reimbursement and privatization (both expected to strengthen efficiency).

There is evidence of widespread support for changing the previous health care system, with 70% of the population endorsing privatization of primary health care as a means for improving quality.

The main current challenges are the financial debts and deficits in the system (partially due to many funds which went bankrupt in recent years, a situation triggered by fee-for-service reimbursement on the hand and granting benefits above the mandatory benefits package on the other), the perceived oversupply of ambulatory specialists, persisting dissatisfaction with salaries by health care personnel, cost containment, a focus on patients' rights, the need for improved regulatory mechanisms, and the completion of reforms through specific pieces of needed legislation. Quality assurance, accreditation procedures, the development of a strengthened public health system, reform of postgraduate education, technology assessment and harmonization of health care legislation with EU requirements need attention as well.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2000 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Austria	6.2	27.2	6.3	75.5
Czech Republic	6.3	18.7	8.8	70.7
Germany	6.4[a]	20.3[a]	10.7[b]	81.6[b]
Hungary	6.6	22.4	6.7	72.5
Slovakia	6.9	18.9	9.4	*71.0*
EU average	4.2[a]	17.1[e]	8.2[b]	77.0[b]

Source: WHO Regional Office for Europe health for all database.
Note: [a] 1999, [b] 1998, [c] 1997, [d] 1996, [e] 1995, [f] 1994, [g] 1993.

HiT summary Czech Republic

Conclusions

The Czech health care system has evolved rapidly and it is still evolving. Some reform decisions gave rise to problems: for example, fee-for-service encouraged overuse of services of physicians trying to increase their income; questionable financial incentives and inadequate regulation led to financial difficulties and the bankruptcy of many health funds. These form new challenges facing the system today. Some of these problems have already been addressed, for example by changing the reimbursement system and decreasing the number of acute hospital beds. Problems persist, however, and some solutions have been proposed, such as gatekeeping by GPs to prevent overuse of specialist services, DRG payments for hospitals, and reductions in the number of physicians, especially specialists. There are plans – not yet implemented – to retrain specialists in public health or primary care, and there is a move to substitute hospital care with primary health care and less expensive alternatives.

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

The European Observatory on Health Care Systems is grateful to Armin Fidler (World Bank) and Martin Dlouhy (Economics Department VSE) for reviewing the report and to Kamil Kalina (Czech Association for Health Services Research) for his role as reviewer and for his report on the Czech health care system which was written together with Jan Jaros and others and has informed this profile.

The full text of the HiT can be found in *www.observatory.dk.*

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

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, 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. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.