European Observatory on Health Systems and Policies

HiT summary

Czech Republic

Introduction

Government and recent political history

The Czechoslovak State was a communist country 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

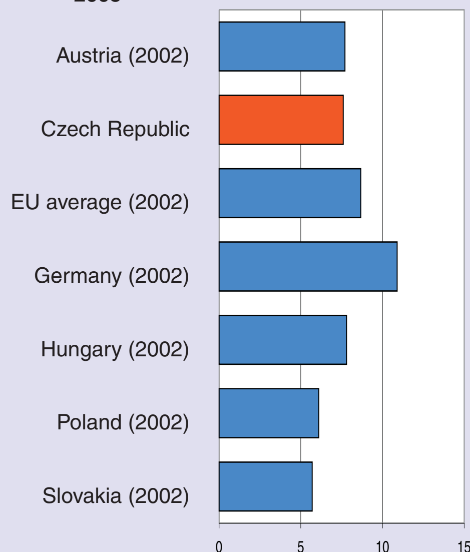
The estimated population is 10.2 million (2002), and about 65% live in urban areas. The population consists of 94% ethnic Czechs, 1.9% Slovaks, 0.5% Poles and 0.4% Germans. In 1994, the number of deaths exceeded the number of births for the first time since 1918, and the population is continuing to decline. This seems to suggest an ageing of the population.

The Czech Republic is one of the healthiest in central and eastern Europe (CEE).

Average life expectancy and infant/maternal mortality

Life expectancy is 72.2 years for men and 78.8 years for women (2002), and infant mortality is 4.15 per thousand live births (2001). These data show that the Czech Republic is above the average for most CEE countries, but falls below average when compared to other western European countries.

Fig. 1. Total health care expenditure as a % of GDP, comparing the Czech Republic, selected countries and EU average, 2003



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

Leading causes of death

Diseases of the circulatory system (especially ischaemic heart disease) remain by far the most significant cause of death, affecting 456 per 100 000 people (2002). While still high, this figure has dropped by more than 30% in the past 15 years. The standardized, or average, death rate is higher than in any European Union (EU) country.

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Recent history of the health care system

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

Reform trends

Reform decisions were made as a result of important interests in the late 1980s and early 1990s, namely efficiency and raising the social status of providers, leading to fee-for-service reimbursement and privatization. However, resulting problems with these decisions – such as overutilization of services, dissatisfaction among health professionals, financial deficits and inadequate regulation – point to new challenges that need to be addressed. There are measures being considered to address these, for example gatekeeping, introducing diagnosis related group (DRG) payments for hospitals and reducing the number of specialists.

Health expenditure and Gross Domestic Product

Total expenditure on health accounted for 8.6% of Gross Domestic Product (GDP) in 2002, which was higher than the average for CEE countries, but, equally, 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 Semasko 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 significant challenges for the future.

Organizational structure and management

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

Any person with a permanent residence in the Czech Republic is entitled to health insurance. An entitled person has the right to choose any health insurance fund once every 12 months. Also, since the Czech Republic is now a member of the EU, those insured by Czech health insurance funds are entitled to receive services in other European countries and vice versa, according to European law.

The state guarantees health care and the health insurance system, and participates on the insurance funds' supervisory boards. The state guarantee is included in the Czech constitution, yet the state only has 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, for health and medical research, for the licensing of pharmaceuticals and medical technology and for the management of two training institutes and regional and university hospitals. It also organizes joint negotiations (see later) and is entitled to act if no agreement can be reached.

There are currently nine health insurance funds, which collect the contributions, contract with providers and reimburse providers for their services. The largest health insurance fund is the General Health Insurance Fund (GHIF), which has 77 district branches. There are also currently more than 25 000 (mainly private) health care providers in the Czech Republic.

State administration at district level was abolished at the end of 2002 and ownership was transferred from the national government to the regional governments. Now the regional governments are the owners and operators of public hospitals. Regional governments are also allowed, under the Act on Regions (No. 129/2000 Coll.), to use their assets as they deem necessary. This includes the right to establish or found their own organizational units, contributory organizations, and companies.

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

The Ministry of Health is responsible for procuring uniform professional management of public health care, and issuing legal regulations for the organization and execution of health care.

The health insurance funds are relatively independent bodies responsible for entering into contracts with health care providers (usually for a 2-year period). There are regular negotiations (usually every six months) 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 outcome meets legal requirements and public interest before approving it. The joint negotiations, followed by governmental approval, might be considered as a backbone of the health care system.

Health care financing and expenditure

Health care financing

The majority (80.5%) of financial resources is obtained via compulsory health insurance. This is financed by contributions from individuals, employers and the state.

In recent years, health insurance funds 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. One of the main problems is the inadequate risk structure compensation scheme. Changes to legislation may be required to address problems brought about by weak administrative control mechanisms. The Ministry of Health is also attempting to increase the cash flow into health care by lowering the compulsory financial reserves of health insurance funds and by introducing other measures.

Since the beginning of 2003, there has also been some suggestion that the Ministry of Health may be considering the possibility of introducing a deductible.

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 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 (approximately €28 per person per month in 2004). The Ministry of Finance contributes 80% of the minimum wage for the state-insured (approximately €15 per person per month). Approximately 56% of the population is insured by the state.

Taxes

Taxes are the second most significant source of financing, contributing 10.2% of the total (2002). Taxes are used to cover expenditure at national level as well as at district and municipal levels (e.g. hospitals' capital investments, public health services, training, etc.).

Complementary sources of finance

Out-of-pocket payments and private sources of finance together represented around 8.3% of total health care expenditure in 2002.

At present there is only a very small market (less than 0.1% of health expenditure) for voluntary insurance. This is because the level of benefits covered by the statutory health insurance is very high, even including spas and over-the-counter drugs, eliminating the demand for any supplementary private health insurance.

Health care benefits and rationing

Health care services are covered by the health insurance funds, while sickness benefits (i.e. sick pay) are paid by 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 to cure illness or to improve health status is approved for reimbursement. There are regular negotiations among the health insurance funds, providers, professional chambers, scientific organizations and patients' associations to assess in detail the services covered.

The following services are fully or partially covered by health insurance: preventive services; diagnostic procedures; ambulatory and hospital curative care, including rehabilitation and care for the chronically ill; drugs and medical devices; medical transportation services; and 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, eyeglasses 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.

As mentioned above, the percentage of GDP spent on health is 8.6% (2002), higher than the 5.8% average for CEE countries, but less than the 8.9% average for western European countries. At 91.4%, public expenditure as a percentage of total health expenditure is lower than in most other CEE countries, but higher than in western European countries that have social health insurance. Inpatient care and pharmaceuticals constitute the categories with the largest share of expenditure (39.3% and 24.6% of total expenditure respectively in 2002), and the latter is well above the average recorded by the Organisation for Economic Co-operation and Development (OECD).

Health care delivery system

Public health services

In January 2003, regional public health offices replaced district public health offices. These offices are now responsible for epidemiologic surveillance, immunization logistics and safety measures. Primary care facilities provide preventive services, immunization and antenatal

services. 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, 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.

Plans to reform state and locally financed public health services are primarily orientated towards increasing their efficiency. Excess capacity is being reduced step by step in a controlled manner. Some parts of the public health facilities are being privatized.

Primary health care

Responsibility for the organization of primary health care (PHC) is currently divided among the state, the regions, and the health insurance funds. Citizens register with a primary health care physician of their choice, and can reregister with a new doctor every three months. There is one general practitioner (GP) for every 1650 inhabitants over 15 years old, and one ambulatory paediatrician for every 1050 children (2002). The ratio of patient–physician contact is one of the highest in Europe.

About 95% of primary health care was privatized in 2002. 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 to use 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. There are now financial incentives for them to take on more tasks, such as providing more specialized services to their patients. The main form of reimbursement to physicians is capitation, but services that are much in demand can be reimbursed through fee-for-service payments.

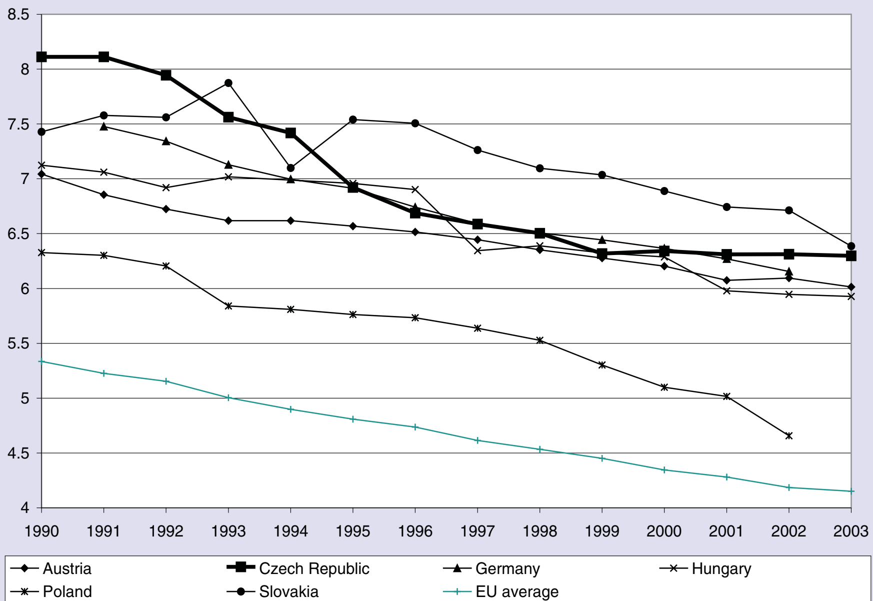
Secondary and tertiary care

The Czech network of health care facilities for secondary and tertiary care consists of specialized outpatient physicians' offices, hospitals and specialized bed facilities. In 2002, there was a total of 26 270 health care facilities registered, with 13 198 (50.2%) of them being in 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. Around 75% of the outpatient facilities have been privatized. Patient access is not restricted by a gatekeeping system.

There are three kinds of hospitals, which are owned according to a public–private mix: regional and university hospitals, district hospitals, and local hospitals. While the national government owns only 19 facilities (9.5% of the total number of hospitals), these constitute 26.9% of the total number of beds, owing to their size. There are 82 district hospitals that are administered by the regions, cities or municipalities. Private hospitals constitute 31% of the total number of hospitals (64) and have 10.6% of the total number of beds.

The Czech Republic has a cautious programme for a long-term decrease in the number of hospital beds, specifically with an aim to reduce acute-care beds and increase long-term beds. In 2002, the number of inpatient beds had been reduced to 8.6 per thousand (a 20% reduction from 1990). The average length of stay for inpatient facilities decreased even more sharply over this period, from 16.0 (1990) to 11.3 days (2001), 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 densities of acute-care hospital beds. The decline has been steeper than that of its direct neighbours, but bed density is now average for this group. The occupancy rate, on the other hand, has remained comparably low.

Fig. 2. 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.

There is a move towards substituting hospital care with less expensive alternatives, and provision of home care and day surgery are both increasing. The effect of this move is to shift demand for care towards primary health care settings.

Social care

Social care provision is insufficient and there are problems surrounding the provision of a comprehensive package of social care, mainly because of a lack of communication among the different providers (private, nongovernmental, etc.). In addition, health and social care services are financed differently, as social care is financed by the state budget and administered from the districts' or municipalities' social budget. 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 by the state budget, have long waiting lists and quality varies considerably.

At the end of 2002, the legal competence of the state district offices was transferred to the municipalities. The process of decentralizing the social services was thus completed, albeit without proper legislation or a definition of the quality of the services or planning system.

A positive development in social care has been comprehensive home care, 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

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2003 or latest available year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Austria	6.0	28.8	6.4	76.2
Czech Republic	6.3	20.4	8.4	74.1
EU average	4.1	18.0[a]	6.8[a]	76.9[b]
Germany	6.2[a]	20.7[a]	8.6[a]	79.4[a]
Hungary	5.9	23.2	6.7	77.2
Poland	4.7[a]	–	–	–
Slovakia	6.4	17.7	8.5	64.8

Source: WHO Regional Office for Europe health for all database, June 2005.
Notes: [a] 2002; [b] 2001.

of his/her social environment. There are currently (2002) 483 home care agencies in the Czech Republic, up from 27 in 1991.

Human resources and training

The number of health care workers is relatively high compared to most other CEE countries, but roughly equivalent to the EU average (3.5 per thousand physicians and 9.7 per thousand nurses in 2002). However, there are shortages of nurses and excesses of doctors, mainly in urban areas. Physicians on average are young, and almost two thirds are specialists. The existing surplus of specialists is intended to be reduced by retraining in other specialties, such as public health or general practice, although this has not yet been implemented.

Doctors' salaries 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 throughout their undergraduate 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 EU. There is also a shift towards implementing more education programmes for non-physicians. For example, a "Health Care Assistant" programme will be offered by more highly specialized schools and as a Bachelor programme, and the category "midwife" will only be offered at universities.

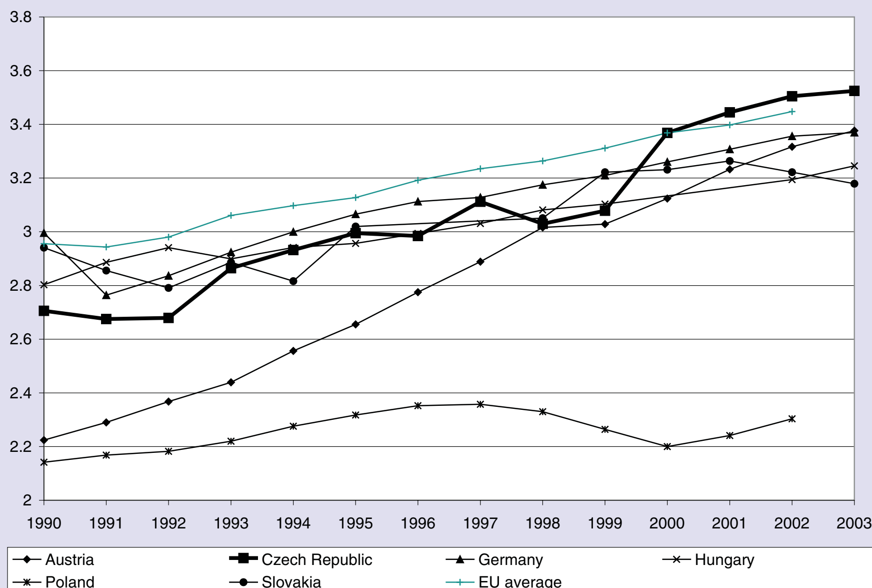
Pharmaceuticals

The licensing of pharmaceuticals and allocation of drugs or medical aids for reimbursement are carried out by the Ministry of Health, in consultation with the Ministry of Finance and the GHIF.

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; and the second and third are partially or fully paid for 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. Pharmacists are also predominantly private, as is the distribution network for pharmaceuticals. The main difficulty now with pharmaceuticals is cost escalation and,

Fig. 3. 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.

since 1995, pharmaceutical costs have represented around 25% of health care expenditure. Measures have been implemented to control costs, such as only allowing specialists to prescribe certain drugs. However, since 2001, costs have been rising significantly.

In addition, a reference pricing system, introduced in 1995, has helped to slow growth in expenditure. Growth on per capita spending on drugs was 10% in 2001. The reimbursement level is calculated on the basis of the amount of each substance contained in each pharmaceutical product.

There is a law defining specific conditions for reimbursement, and the 1997 "drug decree" defines the level of reimbursement. The decree is updated every six months, based on recommendations from an external Ministry of Health advisory body (the Categorization Commission). 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 GHIF issues a drug list in which every reimbursable product is enumerated.

In 2001, a new statute set up the commission's Coordination Committee, which assigns tasks to the Categorization Commission in line with the goals of the state drug policy. However, there is a lack of transparency in the process of devising recommendations and there have not been any results in the form of clear political guidelines with respect to drug policy, which is contrary to expectations at this committee's creation.

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

Challenges 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 using more cost-effective 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 no body has as yet been set up to evaluate new medical techniques.

Financial resource allocation

The size of the overall health care budget is determined by the level of income of the (insured) population. Any remaining costs are covered by the state and regional budgets. The insurance funds collect and spend around 90% of the public financial resources, making them by far the most important actors in resource allocation.

Reimbursements for GPs, specialists and hospitals have changed in the past few years, and have altered incentives, reducing the tendency for unnecessary costly care. However, it should be noted that the total amount of funds has not changed and for several groups of doctors it has even increased.

Payment was originally on a purely fee-for-service basis, with a maximum point value per reimbursement point, set out 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 the volume of services delivered. 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 the approval of the Ministry of Finance. In 2003 there were approximately 3800 different services specified for reimbursement.

Payment of hospitals

Since mid-1997, hospitals have been 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. Since 2001, in addition to the budget, a flat fee is paid on the basis of the number of cases treated in each hospital. However, regulations change quite often. Currently, if a hospital treats more than 101% of cases, but fewer than 105% compared to the same period of the previous year, the flat fee per insured person treated (in the given segment over the 101% limit) is reduced to one half. This is also true if the hospital treats more than 105% of the cases. In this situation, exceeding the 105% limit will reduce reimbursements in the segment over that limit to one fifth. However, the flat fee will be paid in full if the hospital treats fewer than 101% of the cases.

Preparations are currently being made for the introduction of DRG payments. This will be a big change for hospitals, since they gain more than 83% (2002) of their resources from payments by the health insurance funds.

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 GHIF introduced measures to break the vicious circle that had developed as a result of the previous fee-for-service reimbursement system, which had created an upward spiral of increased services.

For GPs, capitation fees per patient were introduced (70% of income), along with fee-for-

service (30%) for preventive services and services related to health-promotion.

For ambulatory specialists, starting in 1997, a system of lump sum payments was introduced. Receipt of the total 100% 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. Introducing this system revealed the unnecessary level of 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 again, and fee-for-service was re-instated, but with volume limits and with a monetary point value dependent on the number of hours worked. However, since 2001, there have been limits on the volume of services so that specialists are not reimbursed without limit.

Hospitals are reimbursed for outpatient care services through 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 causes in the late 1980s and early 1990s, such as democratization, effectiveness, and increasing the status of physicians. These interests led to fee-for-service reimbursement and privatization (both expected to increase efficiency). There is evidence of widespread support for changing the previous health care system, with 70% of the population endorsing the 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 have gone bankrupt in recent years, a situation triggered by fee-for-service reimbursement on the one hand and granting benefits above the mandatory benefits package on the other); the perceived oversupply of ambulatory specialists; persisting dissatisfaction with salaries on the part of 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 necessary legislation. Quality assurance, accreditation procedures, the development of a strengthened public health system, technology assessment, and harmonization of health care legislation with EU requirements also need attention.

Two statutes enacted in 2004 deal with the harmonization of Czech legislation with respect to the country's accession to the EU. This included rules for the acquisition and recognition of professional qualifications in health care occupations (physician, dentist, pharmacist, and nonmedical professionals). There is also a proposal for a new risk structure compensation scheme to include more criteria than just age, providing the basis for fair competition between sickness funds.

Conclusions

The Czech health care system has evolved rapidly and it is still evolving. Resulting problems with reform decisions – such as the fact that fee-for-service encouraged overuse of services by physicians trying to increase their income, and that questionable financial incentives and inadequate regulation led to financial difficulties and the bankruptcy of many health insurance funds – point to new challenges facing the system today. Some of these problems have already been addressed, such as changing the reimbursement system, decreasing the number of acute-care hospital beds, and the retraining of specialists. However, thus far, the Ministry of Finance and central-level politicians have 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.

HiT summary

Czech Republic

Problems persist, and a number of 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, particularly specialists. However, the most important issue for the coming period is to solve problems systematically, contrary to the single-problem orientated approach that has prevailed in the past. There needs to be more economic pressure on hospital management in order to increase productivity and ensure its financial health, and there needs to be a more advanced and equitable risk structure compensation scheme. The benefit catalogue of the statutory health insurance system must be reviewed thoroughly, as there are too many luxury and unnecessary benefits covered.

Overall, the achievements to date 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.

The Health Care Systems in Transition (HiT) profile on the Czech Republic for 2005 was written by Martina Rokosová, Petr Háva (Institute of Health Policy and Economics, Prague) and edited by Jonas Schreyögg. The associate research director responsible for the HiT was Reinhard Busse (from the European Observatory on Health Care Systems and Policies, Berlin University of Technology).

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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 Systems and Policies.

The Observatory is a unique undertaking that brings together 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, CRP-Santé Luxembourg, 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.