CZECH REPUBLIC

	1985	1990	1996
Total Population - Persons thousands	10337	10363	10316
Life expectancy, Females at birth - Years	74,7	76,0	77,2
Life expectancy, Males at birth - Years	67,5	67,5	70,5
Total Expenditures on Health - PPP - mln. ecus			
Total Expenditures on Health - % GDP	4,5	5,4	7,2
Public Exp. on Health - % Total Exp. on Health	92,2	96,2	92,4

OECD Health Data 1998

I. COMPULSORY PROTECTION

Introduction

Until 1948, Czechoslovakia had a Bismarckian health protection system. After that date a system based on the Soviet model of total state control was established. Following the fall of the Communist regime in 1992, a new Bismarckian (social security) system was introduced.

The current trend within the Czech Republic is to reconsider the whole health insurance system. The debate focuses on competition in the compulsory health insurance system.

1. Organisation

The legal basis of the compulsory protection system in the Czech Republic consists of four laws, which cover the health insurance system, health insurance premiums, the General Insurance Company and employees' insurance companies. These laws were passed by Parliament in 1991 and 1992.

The compulsory protection system is the responsibility of both the Ministers of Finance and Health. However, they have no direct power of control. Except in a few specific cases, their responsibility is limited to the obligation to introduce a system of regulations governing the financing of health care institutions and the way in which insurance companies operate.

The bodies in charge of managing and implementing this system, and their responsibilities, are as follows:

- Parliament : laws relating to health insurance and health care institutions ;
- Government : regulation of rights and obligations of all parties involved (patients, healthcare institutions and insurance companies) ;
- Department of Finance : regulation of insurance companies' internal budgets ;
- Department of Health : the scale of services and the official list of medicines which are reimbursed (in full or in part) by insurance companies ;
- Insurance companies : implementation and administration of the compulsory insurance system on behalf of their members ;
- The General Insurance Company : control and redistribution of funds between insurance companies and management of the central register for those insured ;
- The organisations of providers : negotiations with insurers about the reimbursement of the health care services. In case of disagreement the government takes the final decision.

All those insured are free to choose their insurance company. The General Insurance Company covers those who do not make a choice. At the end of 1998 this institution covered 7,776,390 people, this is 74,8 % of the total insured population.

2. Financing

The financing system is of the contributory type, based on health insurance contributions. Insurance companies have to balance their income and expenditure. In case of a deficit, they can alter the « point value » (key letter), on the basis of which they reimburse healthcare services to providers.

The sources of financing for the healthcare sector are distributed as follows:

a) 85% through health insurance funds (contributions from those insured represent 75% of the budget of these funds; the remainder comes from State subsidies for those receiving State assistance : children, pensioners, military personnel, prisoners, etc.) ;
b) 15 % through State subsidies for special healthcare institutions, such as day nurseries and ambulance services.

The level of compulsory social contributions is set as follows:

- 13.5% of gross wages (1/3 employee's contribution, 2/3 employer's contribution) for employees ;
- 13.5% of 35% of the gross profits for self-employed workers ;
- 13.5% of minimum wage (2,900 CZK) for other people (who have no income, but do not receive State benefits) ;
- 13.5 % of 65% of the minimum wage for those who receive State benefits.

There is an upper limit, which only applies to self-employed workers - the annual total for all contributions is limited to 480,000 CZK - and a lower limit for the total of all contributions, corresponding to the minimum wage.

A balancing mechanism between insurance companies is intended to compensate for differences between the social and age structures of those insured. More specifically, the contributions which are charged are redistributed between the different companies according to medical criteria, cost and age.

3. Population covered

Everyone who is permanently resident in the Czech Republic is covered by health insurance. Foreigners working for companies incorporated within the Republic are also covered. In total, the central register of those insured included 10,504,470 people in 1998.

4. Health services covered

Compulsory services include most types of care available in the event of acute or chronic illness. Only certain cosmetic and acupuncture treatments as well as homeopathic products are excluded from coverage.

A system of third party payment is in force. In general, health care services provided by contracted physicians are free of charge.

The patient is free to choose a GP and the care provided by GPs is free of charge.

Hospital stay is free of charge, except when patients stay in a private room.

Patients pay a proportion of the cost for medicines, dental prostheses and dental non-standard procedures and spa treatments. The co-payment for drugs is based on the reference reimbursement of a drug according the content of the active substance.

There are preferential categories of insured that are exempted from any co-payment. The absence of any income can be reason for exemption.

Table : Summary table on the costs paid by patients

	Co-insurance	Co-payment	Excess	Rest of cost	Additional costs	Assumption of total costs
Hospital Treatment	Free of charge (on referral of a GP)	-	-	-	-	Stay in a private room
General Practitioner	Free of charge (if registered)	-	-	-	-	-
Specialist	Free of charge (on referral of a GP)	-	-	-	-	-
Home Nursing Care	-	-	-	-	-	-
Outpatient Medicines	-	-	Amount above the reference reimbursement of a product	-	-	Not reimbursed medicines
Dental Care	yes	yes	-	-	-	-
Physiotherapy	-	-	-	-	-	-

(1) Under certain conditions patients can be exempted from any co-payment.

5. Medical professions

Patients have free choice of GP and hospital.

Private doctors must obtain a licence issued by the Medical Association and they must also be registered with their regional government authority.

GPs are considered as the point of entry into the healthcare system. The patient therefore registers with the GP of his choice. He is free to change his GP. In this case the previous doctor sends the patient's medical file to his new GP.

The GP's functions as a gatekeeper : he recommends the treatment a patient should receive from a hospital specialist. Referral from the GP to specialist care is recommended once a three month.

6. Role of the mutual health funds

The compulsory health insurance system consists of 10 not-for-profit health insurance funds. Those insured are free to choose their health insurance fund and can change once a year. The largest health insurance fund, the General Insurance Company of the Czech Republic, covers three quarters of the population.

There is a fund reinsuring the health insurance funds (except for the General Health Insurance Company) in case of bankruptcy. These funds have to contribute 0,5 % of their annual income for this.

II. VOLUNTARY PROTECTION

1. Private Mutual Health Insurance and Private Health Insurance

Private health insurance is only of very minor importance in the Czech Republic. Travel insurance is the only significant sub-sector. The total income of the private insurance sector represents only 1/1000 compared to the funding of the compulsory system.

Private insurers have to obtain a licence from the Ministry of Finance. The insurance companies under the compulsory system can also provide private insurance on a for-profit basis. For this they need a license from the Ministry of Finance under the same conditions as the private insurers.

The most widespread types of insurance coverage are:

- Travel insurance : This is a complementary insurance to cover for the cost of healthcare services provided abroad. Under the compulsory system, the costs for treatment abroad in the case of acute illness are only reimbursed at the rates which apply in the Czech Republic (usually 1/10 of the costs incurred abroad) ;
- Substitutive insurance for those who do not have access to the compulsory protection scheme (usually foreigners) ;
- Complementary insurance to cover for not covered services under the compulsory system : private room when staying in hospital. Recently commercial insurers started to offer insurance covering dental services not covered by the compulsory system.

There is no legal prohibition to cover patient's charges under the compulsory health insurance scheme by voluntary insurance.

III. SETTING PRICES AND CHARGES FOR HEALTH INSURANCE

1. Medical fees

1.1. Guiding principles

General practitioners are paid per capita (approx. 80 % of the reimbursement) in combination with fee-for-service for certain procedures (preventive services, visits at the patient's home, etc.). Specialists practising outside hospitals are reimbursed on a fee-for-service basis. However, the volume of claimed services is strongly limited. The limitation is based on the limitation of the total « normative » time claimed by a doctor for the specified period (usually a quarter of a year).

The hospitals (including outpatient care provided by hospitals) are for the time being financed by prospective budgets. These budgets are derived from the amount of money hospitals claimed in the last period of fee-for-service financing. A small number of hospitals are financed on an experimental basis by a DRG-based remuneration system.

1.2. Procedure for setting prices

The reimbursement rates are settled by the negotiations between the insurance companies and the providers. In case of disagreement the government takes the final decision. The Ministry of Health determines the reimbursement level of drugs.

The care provider must sign an agreement with an insurance company in order to be entitled to submit care requests for non-acute illness. A care provider can sign agreements with several insurance companies. Due to the surplus of care providers, health insurance companies select contracts. However, the signing of any new contracts is made subject to a tender. Tenders are issued by the district state authorities in case of outpatient care or by the Ministry of Health in case of in-patient care. The insurers are not obliged to follow the results of the tenders, but they usually do.

The contracts usually contain penalty clauses in case of delayed payment or attempts to abuse the system. Disputes are regulated through special schemes on the basis of an agreement between the health insurance companies and associations of care providers.

2 Synthetic material (prostheses and implants)

2.1. Comparison of the prices of certain implants and prostheses

Device	Types	Average price by type in Czech crowns (1998)	Reimbursement (fully/partially)
Pacemaker	• SSI programmable • SSI multiprogrammable • SSI-R-1 sensor • SSI-R-2 sensor • DDD-non-rate responsive • DDD-R-1 sensor • DDD-R-2 sensor • VDD • VDD-R-1 sensor • VDD-R-2 sensor	45.400 52.050 71.650 73.200 89.090 132.190 136.240 122.800 124.650 130.970	100%
Cardiac valve	Mechanical valves: • Ball and cage • Monoleaflet • Bileaflet • Valves with transplant Biological valves: • porcine valves • pericardium • stentless • Biological Valved Conduits • Annuloplasty	 41.475 42.200 44.100 60.000 49.000 47.000 50.000 82.000 18.000	
Hip prosthesis (Stem)	• UNCEMENT • CEMENT	37.200 18.350	
Intra-ocular contact lenses	• PMMA non-coated • PMMA coated • Poldable • Multifocal lenses	3.000 3.000 3.000 no	