Health Care Reform

Current Problems and Possible Future

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The Model Before 1990

- hierarchically organized centralized services paid for through government budgets
- no linkage between the performance and budget assets
- state monopoly in providing, financing and managing the health services
- private practice prohibited
- health care managerial structures were a part of the state administration.

Capacity of the past HCS

- relatively high
  - 110.8 beds per 10,000 popul. (1989) U.S. 48.5
  - 27.2 physicians per 10,000 U.S. 22.5
- seemingly not high enough - excessive demand
  - waiting lists
- relatively low costs - 4.8 of GDP in 1988

Problems

- low level of remuneration of the health workers, especially qualified nurses, but physicians too
- obsolete medical and non-medical equipment
- almost critical lack of some drugs.

Health Status

- significantly lower than other European nation at that time
- shortening of the mean life span
- an increase of morbidity and partial and total disability
- SMR for diseases of the circulatory system was significantly higher than the European average

Reform Principles 1

- an obligatory health insurance system
- free choice of a provider
- increased responsibility for own health
- an income for physician and/or the health service facility should depend on their performance in terms of quantity and quality

Reform Principles 2

- decentralization, privatization, competition
- equal access to „adequate“ levels of services
- plurality (the prevailing form of health care should remain the public health service, but there will be plurality within the health service - state, municipal, church, and private sectors)

Reform Steps - insurance

- Comprehensive Health Insurance Act was passed in 1992
- first insurance company General IC (VZP) was established at the same time
- other smaller insurance companies have been founded (up to 27)
- insurance premium is paid by employees, employers, and the government, and its amount is based on a gross income.

Reform Steps - reimbursement

- fee-for-services relative scale system with a cap on the total health care expenses
- it was applied to all kinds of services
- a massive increase in services produced was an immediate reaction („inflation of a point“)
- the cap was replaced lately and a deficit development was started

Some Outcomes

- the volume of provided care increased significantly
- dtto for the amount of hi-tech equipment
- the quality of care rose too (?!)
- a rapid increase in the life expectancy could be observed between 1990 and 2001 (male 67.63 in 1990 ⇒ 72.14 in 2001).

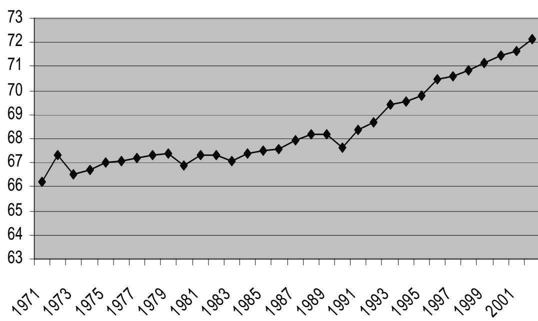
Number of transplantations and cardiac operations

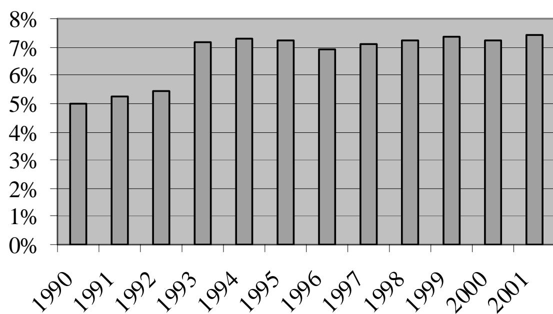
Year	Transplantations					cardiac operations
	heart	kidney	liver	pancreas	lungs	
1991	9	178	2	-	-	1 657
1992	19	190	2	-	-	1 825
1993	34	313	2	2	-	2 471
1994	50	406	11	8	-	3 330
1995	60	389	31	13	-	4 008
1996	75	393	42	19	-	5 043
1997	96	445	49	21	1	5 943
1998	55	366	66	21	8	6 463
1999	64	316	67	24	14	6 868
2000	58	353	61	23	7	7 640
2001	49	330	58	25	10	8 277

Zdroj: Institut klinické a experimentální medicíny

medical equipment

Year / Equipment	1992	1993	1994	1995	1996	2001
CT	48	59	64	69	73	117
Mammograph	44	56	68	87	106	125
Lithotriptor	11	22	25	25	29	30
MRI	4	6	7	10	11	19
Lasers	86	111	156	515	1,02	1,4
Lung ventilators	843	988	980	983	1,188	1,683





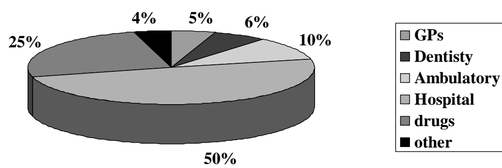
current situation

- 7,4 % of GDP
- 1+8 HICs,
  - same premiums, same benefit package, practically no copayments, slightly different reimbursement level to providers (has no real meaning for providers' behavior)
- General Insurance Company
  - 69,50% of the population
  - + some services for the whole system (central register, redistribution account, center for capitation, DRG experiment….)
- other HICs also open, some national wide, some regional

reimbursement methods

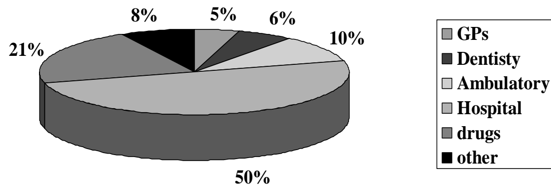
- GPs - capitation plus limited services extra
- Ambulatory specialists - fee-for-service with time limitation
- Hospitals - mostly lump sum payment following their output in the previous year, (originally was introduced as an temporary and provisional tool to save critical financial imbalance…)

cost structure 1998 (VZP)



Source: VZP's Yearbook 1998

cost structure 2001 (VZP)



major issues 1

- risk selection (or at least some indications)
  - dialysis, transplantation, pacemakers… more than 90% for VZP
- drug expenditures escalation (increase from 1990 to 2001: 130% measured in daily doses per 1 000 inhabitants; and 711% in consumption per inhabitant in CZK)

major issues 2

Hospitals:

- **70% fixed costs**
- **18% growth of wages**

  ⇒ **Debt (9 billion CZK, 30.6.2002)**
- **2003 ⇒ income from local (municipal) budgets (previously from state budgets) ⇒ debt transferred to municipals!!!**

major issues 3

- physicians' complains
  - salary in hospitals
  - heavy income regulation for ambulatory specialists
  - administrative complications (overall)
- lack of vision, clear strategies

perspective 1

- several possible strategies depending on political circumstances

I. stronger government regulation, reducing the number of HIC, standards of care, centralization of the system, DRG

II. no radical changes, a splitting VZP in order to create more flexible institutions, introduction of managed care principles...

III. no changes at all

perspective 2 (in any case?)

- to put together health and sickness insurance
- *some* reduced definition of guaranteed care (it is still not clear who and how will do it)
- a private insurance market development (extra services or quality of care…)
- an improvement in ability to negotiate for a volume and price of provided care, selective contracting, ⇒ (further) reduction of supply