Health care 2016 – a part of broader "Country Report"

Summary

In 2016, the development of the health policy showed a steady effort of the government to move the system towards slightly higher transparency, through measures such as publishing contracts between health insurance agencies and providers, and conducting audits of hospitals' purchases made under the public procurement scheme and funded mostly from EU structural funds. Recently, equity and access issues have been addressed too. The Ministry announced an intention to lower the annual ceiling on the maximum drug co-payment expenditure for the elderly and children. This reduced limit for out-of-pocket expenditures is to significantly diminish the financial burden for these groups.

Long-term care traditionally suffers from a lack of coordination, efficiency, and sufficient capacities of services. No progress has been observed.

1.1.1 Healthcare

The Czech health care system is based on a compulsory public health insurance with a multi-payer system. The space for competition among insurers is limited as the insurance law uniquely determines the contribution rates, as well as the benefit package. All permanent residents are mandatorily insured. Insurance contributions are paid by employers, employees, and self-employed persons. The state covers the premiums for, roughly, 60% of the insured. These specific groups of persons encompass pensioners, children until they finish their education, registered unemployed persons, women on maternity leave, disabled persons, parents caring for small children, prisoners etc.

The contribution rate for active payers is determined by law and has remained fixed for already 20 years (13.5%, i.e. 9.0% paid by the employer and 4.5% by the employee, now with no ceiling). The contribution rate for state-insured persons is determined by the government and serves, in effect, as a tool to regulate the volume of funding in the public health insurance scheme. The revenue generated from contributions paid for state-insured persons has ranged between 20-27% of the total revenue in the public health insurance scheme since 1992.[1] The government increased the contribution to CZK 870/€32.2 from January 2016, and to CZK 920/€34.0 from January 2017. Such an increase would still leave the contribution far below the level paid by insured persons without earnings, (CZK 1485/€57 per month, representing 13.5% of the minimum wage).

The cabinet has recently proposed an amendment redesigning the way in which the contribution rate for state-insured persons would be set until 2020. The proposed change should ensure an increase in the total amount of contributions by CZK 3.5 billion/€134 million annually. The proposal is currently being discussed in the House of Representatives.

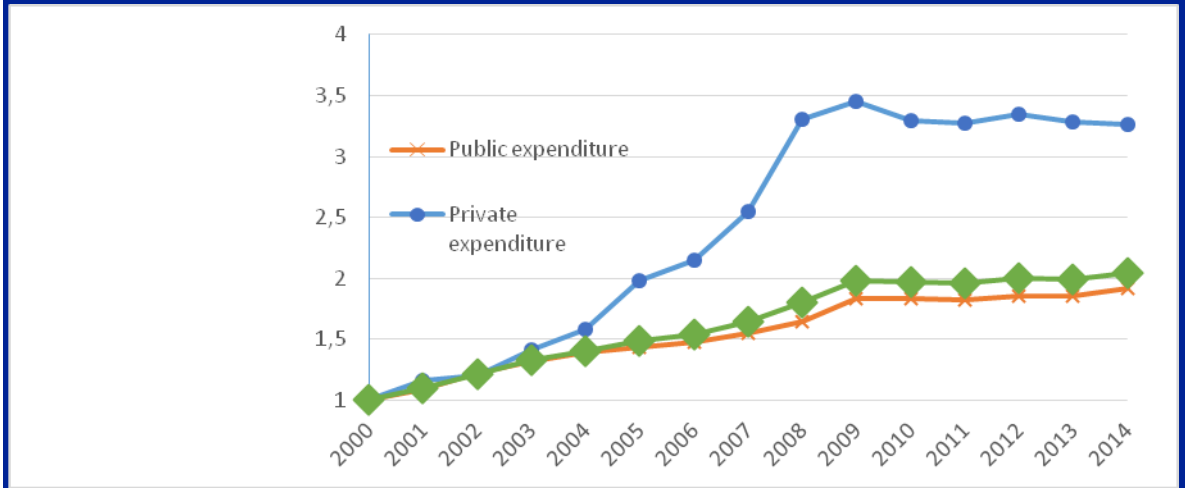
The public health insurance scheme is administrated by seven health insurance agencies. One of them – the General Health Insurance Agency of the Czech Republic (VZP) - has a dominant position. This is due to historic reasons as it had a monopoly position at the outset of the reform. It currently insures 57% of the population. All health insurance agencies are open for any applicant for insurance. All of them are non-profit and their activities are governed by the same, or very similar, rules (Holub, et al., 2014). Health insurance agencies collect contributions from their policyholders. The collected contributions are fully redistributed among the health insurance agencies according to the age and gender structure of the portfolios of policyholders in order to reflect expected costs of treatment. There is also another redistribution measure that

[1] In 2013 it represented CZK 54 billion/€ 2 billion in total.

takes into account the number of policyholders who have to be covered for particularly expensive health services. The health insurance agencies are supposed to sign contracts with selected health care providers, according to their own health plans, in order to ensure complex and accessible medical care for their clients. Health care prices are largely uniformly determined by the Ministry of Health, although the Ministry's resolution on the price levels is formally preceded by negotiation between health insurers and representatives of health care providers (Holub, et al., 2014) (ibid).

The figure 2 nicely illustrates that the system has been relatively reasonable cost-wise in recent years, compared to other developed countries - for more details see e.g. (OECD, 2014). Total expenditure, i.e., expenditure from the public health insurance system, the state budget, territorial budgets, and private expenditure, reached the value of approx. CZK 300 billion/€ 11.1 billion in 2014 - an estimate from (ÚZIS/IHIS, 2016). In comparison with the 2013 level this represents an increase of 3.1%. Total expenditure on health represented 7.0% of GDP in 2014 (the EU average was 9.56% in 2011). The decisive part of health services funding comes through public health insurance, and public budgets. Expenditures from public insurance reached 252 billion/€ 9.3 billion in 2015, compared to 239 billion/€ 8.8 billion in 2014. Unfortunately, the size of private expenditures in 2015 is not available.

Figure 2 Growth of health care expenditure (year 2000 = 1) (authors, data from (ÚZIS/IHIS, 2016))



According to the Institute for Health Information and Statistics (ÚZIS/IHIS, 2016), there were 254 inhabitants per 1 physician in 2015 (271 in 2013). The network of inpatient care providers consisted of 187 hospitals, 161 specialized medical facilities (including convalescence homes and hospices), and 88 spa treatment facilities. Hospital bed capacity was 56,960 beds.

The Country Specific Recommendations from July 2014 state (Council of the European Union, 2014 pp. 4-5): "The inpatient sector shows excess capacity pointing to room for possible improvements in cost-effectiveness and governance." Partly in response, the Ministry declared an intention to improve its managerial responsibility towards its directly controlled facilities (mostly hospitals) in 2014 (MZd/MH, 2014). The existing outsourcing practice was indeed reconsidered and a new purchasing mechanism was introduced in 2015. In so doing, the Ministry achieved total savings of almost CZK 100 million/€3.7 million for the year 2015 (MZd/MH, 2015). On the other hand, the most radical reform planned in the cabinet's legislative plan (Vláda/Cabinet, 2015) was not performed. The idea of a backbone public hospital network was abandoned in December 2016 and replaced by a bill introducing a transformation of current "faculty hospitals" into "university hospitals". The proposal tries to strengthen the position of hospitals' directors and to overcome the limitations and rigidity stemming from the current legal status of these hospitals. The bill was passed in the first readings in the

House of Representatives. However, its chances of being adopted are often questioned.

The 2014 Country Specific Recommendations (Council of the European Union, 2014 pp. 4-5) also noted that "no progress has been made in improving the cost-effectiveness of public spending on health care". In its 2014 Statement, the Czech government declared its intention to create "a predictable and stable reimbursement system, reflecting average costs, for all types of care", applying the principle "same volume and comparable quality means same reimbursement" (Vláda/Cabinet, 2014b). The Ministry's announcement of a new project called "DRG Restart" on December 3, 2014, represents a key development in implementing the policy of optimising inpatient care reimbursement. The project is supposed to allow fair and transparent reimbursement of acute inpatient care. The project is in its second year now. A new methodology for data collection was prepared, published, and reviewed. An important amendment of the Act No. 372/2011 Coll. was proposed. It introduces a National Health Information System - an important step for the assessment of accessibility and quality of healthcare. The national register of the provided health services allows the MoH to review data from Health Insurance Companies – really a fundamental step in the short history of the Czech health system. Current development of the DRG restart project raises cautious optimism[2]. However, it has to be noted that any real outcomes of the project can only be expected in 2 years at the earliest.

Despite all political battles between the supporters of the idea of health care as a pure, carefully planned, and strictly non-for-profit public service, and the liberal, pro-market advocates of the healing power of competition, plurality, and choice, the Czech health care system has managed to secure a wide access to good quality services. The benefit package is rather generous and encompasses services in primary, secondary and tertiary health care. There are some exclusions of coverage such as e.g. cosmetic surgery, dental prostheses, etc.

In comparison with other EU member states, the Czech Republic emerges relatively well from the Eurostat statistics on self-reported unmet needs for medical examination, although there could be a bias due to cultural differences, as Eurostat does not recommend using the indicator for cross-country comparisons. The level of 95.7% of "no unmet needs to declare" in the total population represented a higher value than the EU average (93.1%) in 2013. The difference is even bigger when we look at the first quintile of equalized income (94.1% to 89.6%). Unfortunately, Eurostat considers recent data for the Czech Republic to have "low reliability", which makes any detailed analysis rather pointless.

In 2016, the development of the health policy showed a steady effort of the government to move the system towards slightly higher transparency, through measures such as publishing contracts between health insurance agencies and providers, and conducting audits of hospitals' purchases made under the public procurement scheme and funded mostly from EU structural funds. Recently, equity and access issues have been addressed too. The Ministry announced an intention to lower the annual ceiling on the maximum drug co-payment expenditure for the elderly and children in September 2016. This reduced limit for out-of-pocket expenditures should significantly diminish the financial burden for these groups. The current level of the protective cap on annual drug co-payments for the elderly (65+) and children is CZK 2,500/€ 93. It means that the health insurance agency pays back the sum of drug co-payments that exceeds this limit. The Ministry has prepared a proposal to decrease that limit considerably and to enlarge the number of entitled groups. For details see Table 3 and (Vláda/Cabinet, 2017). The proposal is currently being discussed in the House of Representatives.

Table 3: Suggested changes of drug co-payment caps and consequent savings

Category	Current cap	Proposed caps	Savings per

[2] For details see http://www.drg-cz.cz/index.php?pg=aktuality&aid=37

	CZK/€	CZK/€	person CZK/€
Elderly 65–70	2,500/93	1,000/37	1500/56
Elderly 70+	2,500/93	500/18.5	2000/74
Children till 18	2,500/93	**1,000/37**	1500/56

Source: authors

1.1.2 Long-term care

The development of long-term care (LTC) has been carried out in a fragmented fashion, with responsibility split between the health care sector and the social care sector in the Czech Republic. This is combined with vertical fragmentation, with competencies split between different institutional tiers: the state, regions and municipalities. The governance of LTC, as well as palliative, health and social care, remains an issue, mainly in terms of integrating the health and social aspects. Despite prior expectations, the announced draft bill addressing cross-cutting issues in social and health services, mainly "integrated long-term care", was not released until May 2017.[3] There are still great differences in the costs of care for clients. While the clients pay a major part of social care, the care in health care facilities is covered from public health insurance. This discrepancy often leads to hospitalisation of people who rather need social care.

Multi-source funding is a key concept of the current social services funding scheme. Clients' fees represent the main resource. Other sources consist of the MLSA's subsidies and grants flowing into regional governments' budgets. Health insurance funds are another important resource – they partly cover the costs of health services linked with social services

The introduction of personal care allowance (cash benefits) for people in need of long-term care, accomplished in 2006, represents a major reform step in the area of social services. The criteria for granting a specific allowance level are specified in the law on social services[4]. The allowance is scaled into four levels, according to the recipient's degree of dependency on support. The highest level of dependency entitles the recipient to a care allowance of around half the average salary and slightly above-average pension in the country. The number of recipients of the care allowance increased from 260,000 in 2007 to almost 350,000 in 2015. In total, it reached CZK 21.1 billion/€780 million in 2015 (comparing to 20.4 billion/€750 million in 2014 (MPSV/MLSA, 2016c). Since August 1st 2016, this major resource for funding **long-term care** has been raised by 10% (see Table 5).

Table 4: Personal care allowance, from August 1st 2016

Category	Monthly benefit 2014–15 CZK/EUR	
	Age	
	<18	18+
Level 1 (mild dependence)	3,300/122	880/33
Level 2 (medium dependence)	6,600/244	4,400/163
Level 3 (heavy dependence)	9,900/366	8,800/326

[3] According to the vice-minister Jentsche Stocklová, the draft bill has been ready and awaiting both ministers' (MoH and MLSA) approval prior to the public release since April 2016. (Zdravotnický deník, 2016).

[4] Act No 108/2006 Coll., see at http://www.mpsv.cz/files/clanky/7372/108_2006_Sb.pdf. The Act also recognized a broader scope of types of social care services.

Level 4 (full dependence)	13,200/488	13,200/488

Source: (MPSV/MLSA, 2016k)

Personal care allowance should be the essential source of funding. However, almost 50% of the recipients entitled to these allowances do not use them for purchases of services from any registered provider. As we mentioned in the ESPN Country Profile, Stage 1 – 2014-2015, a large part of the care allowance is retained by the recipients and not used for purchasing the services. A large part of the care allowance is retained by the recipients and is not used for purchasing formal services. This means that it at least partially serves to reimburse the costs of informal care provided by the relatives and/or friends, and represents some sort of income/benefit for the carers. Right now, it is rather difficult to foresee which changes are going to be adopted. Different stakeholders declare different preferences and interests. For instance, the Czech National Disability Council (NRZP) strongly opposes the idea to reduce the allowance for those who do not use it for a service purchase and who keep it in the family (that provides necessary care instead of professional services).

The Czech Republic belongs to the traditional model where LTC is largely considered a "family affair" and family members and friends provide most care. Internal data of the MLSA estimated this share at between roughly 52% and 75%, depending on the degree of dependence of the service user, in 2010 (MPSV/MLSA, 2013a).

Social care providers have been allowed to provide nursing care covered from the public insurance scheme since 2007. However, no specific regulation has been available for setting the price of these services. It was an implication of the previous strategy to rigorously divide health and social services, mainly in terms of funding. Representatives of social services providers repeatedly requested explicit regulation here, since an absence of a price setting mechanism may cause law suits between them and health insurance companies (HICs). It increases their uncertainty and transaction costs, mainly in situations when the provider and the payer cannot reach an agreement concerning the amount of reimbursement. In this case, there is practically "a legal vacuum", and it is quite difficult to assess the result of a law suit – the only way to overcome a lack of consensus. The Ministry has recently attempted to fix this issue via inclusion of nursing services for clients of residential social services facilities into the Decree no.373/2015 Coll. that sets up reimbursement conditions for health services for the year 2016. However, this attempt failed due to a Decision of the Czech Constitutional Court.

The Czech population gets older. According to the demographic prognosis by the Czech Statistical Office (CZSO), there will be half a million inhabitants older than 85 years living in the country in 2050 (comparing to 100,000 in 2006). Three million inhabitants, representing 31% of population, will be older than 65 years (ČSU/CZSO, 2004).

The need for LTC depends not only on the share of the older population but also on the sustainability of good health in older age. Table 6 shows the relation between years of good health and life expectancy of persons over 65 years in the Czech Republic.

Table 5: Life expectancy and Healthy Life Years in the Czech Republic

	2005	2010	2011	2012	2013	2014	2015
Life expectancy at 65 (males)	14.4	15.5	15.6	15.7	15.7	16.1	15.9
Life expectancy at 65 (females)	17.7	19.0	19.2	19.2	19.3	19.8	19.4
Healthy Life Years at 65 (males)	6.6	8.5	8.4	8.3	8.5	8.5	8.0
Healthy Life Years at 65 (females)	7.0	8.8	8.7	8.9	8.9	9.3	8.6

Source: Eurostat

It is clear there will be growing demand for social services, both formal and informal. Currently, carers face many shortages of the current LTC policy. An integrated LTC system does not exist, neither in terms of legal environment nor financing. There is an insufficient supply of field social and health services targeting dependent persons, and this also applies to public services for carers.

A "round table" organized by the MLSA in December 2015 addressed issues of informal care in the CR (MPSV/MLSA, 2015d). The participants clearly indicated the necessity to increase not only carers' leaves and cash benefits but also in-kind benefits, professional services and support for informal carers. The Czech Republic belongs among countries with a less developed supply of field social services that does not suffice the needs of either carers or dependent people. Most public services often include just food delivery. Respite support (provision of a short break from the caring duties), psychological support, and counselling for carers were explicitly mentioned by representatives of dependent people organizations in this respect (ibid.). Tomášková (Tomášková, 2015) published a survey mapping the utilization of health and social services available for those who care for a dependent person. Her findings suggest a large gap of unmet needs – with the exception of early care. The cost of services and a lack of information represent two main barriers for higher utilization. (For more detailed information about capacities of selected social services see Annex 2.

The Government approved the National Strategy of Social Services Development for 2016-2020 in March 2016. It represents a quite comprehensive document (160 pages). The Strategy contains the goal "to improve the position of informal carers - persons and families who provide the care" (MPSV/MLSA, 2015e). We believe this is essential. The Czech social and health system neither values nor lightens the role of informal care providers. Existing measures of support are not sufficient (MPSV/MLSA, 2015e). Excessive demand for inpatient services clearly suggests that there is an imbalance. Czech families may rather prefer less involvement with LTC. It is not clear whether this is mainly due to a lack of support services, to the low well-being of carers (mostly women), who are often forced to simultaneously deal with care and some kind of parallel economic activity, or purely to low family income, where the household has to make ends meet on just one income (Sirovátka, et al., 2016).

There is no proper carer's leave scheme, direct cash benefits are limited, and the supply of support services varies quite considerably across regions. The quality of informal care is a serious concern, due to a lack of information about good practice, education and training.

It may be worth paying greater attention to the issue of the employment effects of informal care, as well as to the well-being of carers and dependent persons. There is a need for reform to integrate social care and healthcare into one system, and to enable a rather substantial development of professional home care. Lastly, measures that would support part-time work for specified reasons, such as care obligations, should be introduced – e.g. special care leave and special benefits/allowances for carers.