In the Czech Republic, austerity has provided a window of opportunity for healthcare reform

Austerity policies adopted all over Europe have provided momentum for painful reforms of healthcare sectors. **Tomas Roubal** *explains which policies the Czech Republic has adopted since the beginning of the crisis, and argues that the country's health care system has started the process of fundamental modernization.*

The Czech Republic has had one of the most stable and prosperous economies in Central and Eastern Europe. Having learnt lessons from a smaller-scale financial crisis in the late 1990s, the country was careful in liberalizing its financial sector. Hence, its banking system has not been very exposed to the effects of the global economic crisis. Nevertheless, the country's export-driven economy was hit severely by a rapid decline in demand from its main trading partners, most notably the German economy.

The healthcare sector is very high on the political agenda of many governments in the European Union, though reforms and the introduction of cost-saving measures that would also modernize the governance of the healthcare system remain difficult in many countries. The current reforms in the Czech Republic have been rooted in the planned "big bang" reforms of the previous right-wing government, where the introduction of user fees had been the only success. With user fees implemented for health care services, Czechs suddenly understood that healthcare is not free – a realization which caused the previous government's defeat in regional elections. The current government learnt from the failures of its predecessor and started with less controversial topics that did not touch much the financial structure of the system. It is only now slowly moving towards deeper reforms of health insurance funds and reimbursement schemes.

Longer term strategies are targeting the scope of the benefits package. From 2012, the basic benefit package and the list of reimbursed services will undergo Health Technology Assessments (also incorporating evidence from abroad) which may lead to a better definition of the basic benefit package. In parallel, steps of rationing the basic benefit package include the legal possibility to the providers to create a list of services that are above the standard care reimbursed by the social health insurance funds. The providers are reluctant to introduce formal price lists as it is closely observed by the media and negatively judged by the general public.

There has been a bundle of policies geared towards reducing costs and introducing greater efficiencies in health care now: Firstly, as part of a wider public sector savings drive, 2009 saw a 10 per cent cut in expenditure on the salaries of public administration employees, including those working in the health sector (except health professionals such physicians and nurses). Physicians were threatened with salary cuts resulting from proposed payment reductions to hospitals but they resisted (20 per cent of them handed in their notice).

As a result, the insurance funds did not reduce payments and salaries did not decrease. On the contrary, a memorandum of understanding was signed with the hospital labour unions stating that physicians' wages will rise over the next two years. However, part of the negotiation was that physicians accepted other health sector reforms which were implemented in 2011, including a freeze on hospital expenditures and the introduction of a Diagnostic-Related Groups (DRG) payment system.

Another measure that had an indirect impact on patients was the decision to cut the insurance funds' reimbursement rate for medications by 7 per cent between 2009 and 2011. Patient co-payments for such medicines increased in cases where the importer/producer did not reduce its wholesale prices accordingly, or where pharmacies did not decrease their margins. In 2012 when the decrease was abolished the reimbursements went up again which might cause further financial instability in the system.

Another cost-saving measure introduced in 2011 focused on the mandatory use of positive lists for reimbursable drugs for providers (for example university hospitals which have a 50 per cent market share). Previously, the use of such lists was voluntary – and further positive lists are planned for other medical

materials in 2012; these will be applied more broadly to other inpatient facilities.

One of the most recent laws decreased the number of personnel and technical requirements that are necessary to provide care. It has taken into account technological developments of the last 20 years in medicine which make it possible to have a lower physicians/bed-ratio and which allows for the transfer of more competences to non-physicians. In the longer term, these developments could have a positive financial effect on providers, although quality concerns may arise and should be closely monitored.

The most controversial steps in the Czech healthcare system are yet to be undertaken: The insurance funds resist in overtaking more governance functions because it would force them to face competition and push them into more active role of a buyer of healthcare services. The providers are reluctant to innovate the models of provision and resist becoming patient-friendly and to accept changing competencies and responsibilities. The politicians do not want to reveal the imbedded instability of the current system of financing of the healthcare sector because any change is highly unpopular. Fortunately, the change has already started and it will be hard to stop. The country's health care system is now fundamentally modernized. The current times of austerity are a good excuse for all to face the truth and start doing what needs to be done.

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