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Czech Republic: First steps on the path to health care reform

Lucia Kossarova and Henrieta Maďarová

After some quiet years, the pace of post-1989 health care reform in the Czech Republic seems to have picked up. In addition to the common challenges faced by health systems across Europe (ageing populations, rising expectations of citizens and technological advances), the health care system in the Czech Republic is struggling with an inefficient use of health care resources, the implications of the global financial crisis and overconsumption of health care by the population. Together these factors may threaten the system's performance and sustainability.

Proposed reforms to address these issues are intended to increase efficiency and stabilise the system; while improving both access to and the quality of health care services; and strengthening the role and responsibilities of the patient.¹ A key first step in achieving these goals is to modernise health care legislation that dates back to 1966,² so that it better reflects the needs of the population. This snapshot will briefly describe proposed legislative change and the ensuing political debate.

Reforms will bolster patient rights

A number of health care reform bills have now been prepared as part of a package of interrelated laws (See Table). The five new bills being considered by the legislature would reorganise the regulatory framework into more logical groupings, i.e. the general rights of patients would be separately stated, while the specific rights of insurees would be placed within

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proposed new laws for public health insurance (PHI).

Following an extensive and rather emotional discussion on background policy documents³ prepared for the new bills*, the Ministry of Health decided to proceed in two stages. First, to begin the discussion and legislative process related to the rights of patients, patient-provider relationships and the obligations of service providers set out in Bills 1, 2 and 3 and then subsequently to move to Bills 4 and 5 that propose changes to the regulation of the public health insurance system.

Currently, relevant legislation is not to be found in one place, but rather is fragmented across numerous regulations, where the patient is still viewed as a passive participant. The new *Bill on Health Services and Requirements for Their Provision* can thus be considered as an umbrella bill directly linked to the subsequent bills on special health and emergency services. Primarily the emphasis of this umbrella Bill is on the safety and rights of the patient, making him or her for the first time a 'consumer' of services across

the entire system. For example, it benefits patients by giving them the right to refuse health care services and obtain clear information about health services and their prices. It also specifies how complaints should be dealt with and when providers can be sanctioned. Interestingly, the Bill also sets out obligations and responsibilities for patients, in particular in respect of actions which may positively impact on their health; for example, the obligation to make preventive health care visits and/or to adhere to treatment. The Bill also clearly specifies the conditions under which providers can obtain or indeed lose a permit to deliver services, as well as those situations in which they can legitimately deny care to patients.

Other elements of the Bill include new definitions of the types and level of health services, thus delineating the frontiers of the health system. For example, general transportation services from or to a health care facility are no longer considered as health services and can be provided by non-health care employees. These new definitions will be directly relevant when specifying services to be covered by PHI. Finally, the Bill should help improve quality and safety in the system. For example, 'care standards' for service providers that reflect the most up to date knowledge in clinical medicine are recommended. These standards will refer to clinically effective guidelines specified by the Ministry of Health, health insurance companies and service providers.

Special services which require more stringent regulation and ethical considerations are to be covered in a *Bill on Specific Health Services*. The proposed Bill focuses on safeguarding patient rights in respect of sensitive services such as assisted fertilisation, sterilisation, cloning, blood

Table. Overview of proposed health care legislation⁴

1. Bill on Health Services and Requirements for their Provision
2. Bill on Special Health Services
3. Bill on Emergency Services
4. Bill on Public Health Insurance
5. Bill on Health Insurance Companies and the Health Insurance Companies Surveillance Authority

* Before any new legislation is drafted the government must first approve policy documents setting out the issue, current legislation and a description and arguments for proposed reform.

donation and pregnancy terminations. Attempting to harmonise this Bill with EU legislation has led to vigorous debate. For example, allowing any EU female citizen to obtain a termination in the country under the same conditions that apply to Czech women has raised a myriad of ethical and ideological issues which continue to be discussed in Parliament.

A third *Bill on Emergency Services* aims to improve access to emergency services (ES) for the entire population, adjusting the way these services are provided and financed, while improving coordination between different health care entities. For example, while current legislation states that all individuals should have access to ES within fifteen minutes, as much as 12% of the population have to wait up to thirty minutes. The new bill would take into account demographic, geographical and other risk factors and set a more realistic limit of between fifteen and twenty minutes. By re-designing the ES network and creating forty-four new ambulance stations, almost the entire population could be reached within fifteen minutes, with a mere 2% of the population having to wait twenty minutes. Furthermore, the ES network will be financed by health insurance companies and the state budget rather than in the current system, where it is funded by regional governments, often leading to differences in per capita spending and access to services.

The three proposed Bills, if enacted, would enshrine the role of patients as decision makers and the patient-provider relationship within legislation, unlike the outdated 1966 law. Repealing the 1966 Act would also require the repeal and amendment of a number of other health laws and regulations, including, most importantly, amendment to *Law 48/1997 on Public Health Insurance*.

The revised terminology in all three proposed bills would enable much needed improvements and clarifications in the definition of the basic benefits package (BBP) covered by PHI. In general, the scope of services covered by PHI would stay the same but the proposed definition is more precise. It states that health services covered by PHI should be responsive to the health needs of patients, based on the latest medical knowledge and provided in compliance with the cost effective utilisation of health system resources. The new definition of BBP will be supported by two lower level instruments: a bylaw on the catalogue of health services, as well as

clinical guidelines that should ensure the provision of the most clinically effective care, taking into account individual circumstances.

At present, only standard treatment is covered by PHI and all alternative treatment options are usually paid in full by the patient. The new definition would mean that patients would only have to cover the differences in cost between alternative and standard PHI reimbursed options. These rules are similar to those already in use for drug reimbursement policies that have led to improvements in efficiency. The proposed definition of BBP, coupled with new clinical guidelines, will help to standardise the quality of care, something which at present is left entirely to the discretion of service providers. Not least, patients will know what services they are entitled to under PHI and thus avoid unnecessary co-payments for these services. The amendment bill to Law 48/1997 includes new exemptions from user fees for the most vulnerable groups (primarily children, dependent older people and others living in long term care facilities) and reductions in the limits on user fees and out of pocket spending for selected co-payments for drugs.

The first three bills and the amendment to Law 48/1997 have already been presented to the Parliament and are expected to be approved in the first quarter of 2009. Both within the governing coalition and the opposition, the most controversial discussions at present gravitate around the new definition of the BBP and the list of exemptions from user fees. Most of the concerns with this new definition relate to the provision that full reimbursement applies only to the most cost effective treatments for the individual, depending on their needs. On the one hand, it is generally accepted that resources in the health system are limited and should be used more efficiently. On the other, a minimum level of quality and standards of health services, as well as access to information on alternative treatment options, is expected to be guaranteed and defined through bylaws. This should avoid excessive and fraudulent co-payments for treatments that have been viewed as being 'above' standard but which in fact are standard treatments.

The discussion on user fees is focused on the identification and exemption of those groups that are perceived as being most vulnerable. The definition of this group may however change in light of the high

inflation in food and fuel prices during 2008 and the impact of the global financial crisis on the economy, employment and wages. However, due to the disputes within the coalition and loss of their majority, all user fees were repealed in the lower chamber of Parliament at the end of December 2008. It is hoped that the upper chamber will be able to reach a consensus on the list of exemptions from user fees and revoke the lower chamber decision. A meeting is planned for the end of January 2009.

Reform of private health insurance

Despite the benefits of these three proposed laws, current legislation governing PHI is still not deemed to be sufficient and will require further improvement. That will only be possible when discussions on Bills 4 and 5 – the *Bill on Public Health Insurance* and the *Bill on Health Insurance Companies and Health Insurance Companies Surveillance Authority* commence. These bills together would provide for systematic changes in the organisation and operation of the PHI scheme, with the primary goal of empowering insurees and increasing efficiency in PHI spending.

The Bill on Public Health Insurance would further improve the definition of the BBP by specifying a maximum travelling distance to general practitioners, specialists and inpatient facilities, as well as a maximum waiting time for diagnostic and elective health services. In order to make the system more transparent, patients would also be able to access a range of information including data on the quality of health care providers, the performance of health insurance companies and prices of alternative treatment options.

The new Bill on Health Insurance Companies and the Health Insurance Companies Surveillance Authority would require health insurance companies to operate as specialised private companies answerable to their shareholders and adopting standardised accounting and regulation principles. The bill also proposes stricter financial regulation and control of services provided to insurees, for example, monitoring waiting times and ensuring access to a network of providers within a maximum travelling time.

In summary, there is general agreement in the country that the health system needs systematic change after years of small ad hoc adjustments. Given all the challenges that the system is facing, beginning this

process of reform through discussion of these proposed laws is important. While the disagreements within both the governing coalition and opposition threaten the approval of this legislation in its current scope, discussions on these bills should continue so that, in time, a proposal acceptable to all can be agreed upon. The Czech health system requires modernisation and so does its legislation.

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The Finnish welfare state meets the consumer society

Hannu Valtonen

The long tradition of local government in Finland seems to be reaching a turning point: the government is implementing reforms intended to strengthen the municipal structure (i.e., increase the size of the municipalities), to alleviate equity problems and to give clients more freedom of choice. The most frequently evinced reasons for these reforms are similar to those set out in many other European countries - the ageing population, securing sufficient supply and availability in the labour force, securing the financing of services, improving the position of clients/patients and meet the challenge of globalisation. The current reform policy presents itself as a rational reorganisation of service structures and financing. Its success will depend on how well it meets the demands and expectations of health care consumers, health care personnel and provider organisations.

In Finland, local health policy decision-making has been decentralised since the beginning of the 1990s; indeed it is sometimes claimed to be the 'most decentralised health system in the world'. The Finnish

municipalities (431 in 2006 for a population of 5.3 million; but only 348 municipalities from 2009), are responsible for the provision of both health and social services, and in this they use their own local tax revenues and are supported by state subsidies. Hospital services are provided within twenty-one hospital districts. The financial flows to primary health care, hospital services and social services all go through the municipalities. In principle, if maybe not in practice, the municipalities, with their long and strong tradition of local self government, have been important political and managerial decision-makers in health and social policy. Their position was strengthened even further at the beginning of the 1990s with the decentralisation of decision-making on the organisation, extent and content of services that they provide. One of the arguments for this decentralisation process was that of responsiveness: the municipalities would be able to adjust their services to meet local needs and conditions. Compared with this, the present trend in reforms is just the opposite, back to a more centralised organisation.

Challenges to municipal health services

Some observers contended that the municipalities, have not in this period been capable, innovative, willing, courageous or radical enough in their actions. Alterna-

tively, others have argued that they did not have the necessary political power to fulfil the expectations imposed on them – to organise fairly distributed, responsive, efficient and financially sustainable health and social services. The ongoing reform wave includes several health and social care structural and functional programmes and reforms for the whole social security income transfer system. In health care the reforms concentrate on municipal local health and social services, and in particular on how to strengthen their financial basis.

The challenges faced by the municipal health services had culminated in political discussions concerning two key problems: doubts over the capacity of municipalities to finance and to control the rate of growth for all services, and in particular for hospital services; and secondly, the operational difficulties of local health centres (local primary care units), notably in access to health centre doctors and in ensuring a sufficient level of recruitment to the labour force. Furthermore, as a whole, their public image is weakening.

These problems have also been recognised by external commentators: for example, one review by the OECD¹ identified a need to strengthen both the capacity of health centres and improve their efficiency, not only because of financial sustainability requirements, but also to address equity

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