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Current Problems in the Financing of the Czech Public Health System

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The reform of the Czech public health system started in 1991. The main goals were the liquidation of the state's monopoly on health services, the creation of non-state health care that would include private facilities, and the introduction of multi-resource financing for health care that respected the principle of social solidarity.

Since 1992, when the law on non-state health facilities was passed, the transition and decentralization of state facilities has gone extremely quickly. By the end of 1994, the share of non-state facilities out of the whole system reached 93.5 per cent. Out of the remainder, facilities managed by local authorities were only about 2 per cent. (Graph 1, Table 1) The number of health facilities increased during the same period by a multiple of more than 2.5. This was offset by the decrease in the total number of beds and physicians (by 6 and 2 per cent respectively). Of total employment, about 4.4 per cent are involved in the health care system.

Graph 1: Relative share of state and non-state health facilities

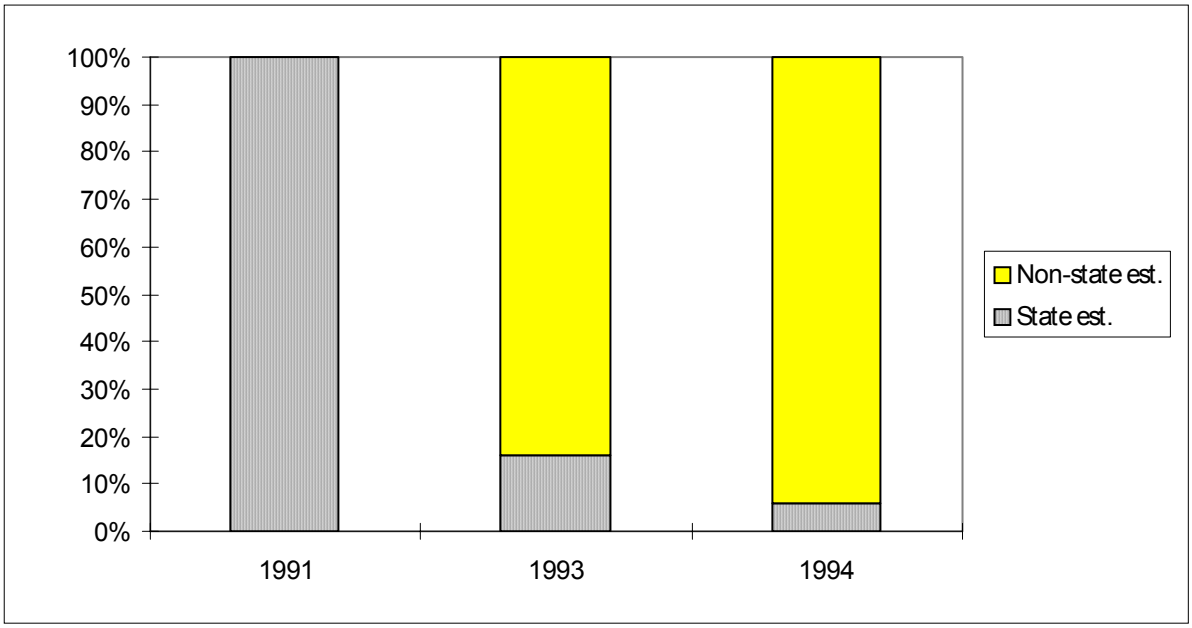


Table 1: Health care facilities (at year-end)

	1991	1993		1994	
	State	State	Non-state	State	Non-state
Health care facilities	6982	2862	14451	1161	16785
of which:					
Hospitals and maternity homes	169	158	34	143	56
Out-patient care facilities	5203	1352	11824	205	15562

Source: Statistical Yearbook of the Czech Republic 1995, Ministry of Health

The transformation of the health care system and the reform of its financing is shown in the development of expenditure proportions (see Table 2). In 1992, the relationship between the central and local budgets was changed. This was connected with the transition of health facility financing, health schools, and training institutions from local authorities to the central government (Ministry of Health). The growth in expenditure from the central budget was partly influenced by the preparations for introducing the new financing scheme - the health insurance funds. It was necessary to support the establishment of the General Health Insurance Fund and to finance other processes attached to the reform.

Table 2: Public health expenditure (in bln CZK)

	1991	1992	1993	1994	1995	1996 estimate
1. Ministry of Health	12.9	37.9	6.6	7.7	7.8	7.4
2. Payment of pensions granted by the state			16.0	14.3	13.3	15.3
3. Local budget expenditure	25.5	4.9	6.4	6.1	7.3	6.9
4. Total budget expenditure (=1+2+3)	**38.4**	**42.8**	**29.0**	**28.1**	**28.4**	**29.6**
5. Expenditure by health insurance companies			**57.0**	**64.8**	**72.3**	**84.7**
of which:						
6 Health insurance revenue for physical and legal persons (=5-2)			41.0	50.5	59.0	69.4
Index (last year = 100)				123.2	116.8	117.6
7. Total public health expenditure (=4+6)	**38.4**	**42.8**	**70.0**	**78.6**	**87.4**	**99.0**
Index (last year = 100)		111.5	163.6	112.3	111.2	113.3
8 Budget share of public health expenditure (in %) (=7/4)	100	100	41,5	35,7	32.5	29,9

Source: Ministry of Finance

At the beginning of the 1993, a new tax system with mandatory social and health insurance system was introduced. The current rate for contributing to health insurance is

13.5 per cent of individual income. With the exception of health insurance contributions, the authorities participate by financing through the public budgets.[1] As shown in Scheme 1, the current system of health services is financed by the individuals, employers and by the state. The contribution rate for employee is divided between employee and employer (4.5 and 9.0 per cent respectively). The state pays the health insurance contributions for specific groups in the population (pensioners, children up to 15, students, unemployed, those receiving benefits from the state social support and the social care systems, persons in mandatory military service, etc.).

Scheme 1: Payers of health insurance

Policy-holder	Payer	Rate (in %)	Contribution base		Accounting period
			Minimum	Maximum	
Employee	Employee	4.5	Wage and taxable income		Month
	Employer	9.0			
Self-employed	Self-employed	13.5	35 % of *income*: (multiple of 12 of the monthly minimum wage)	(486000)	Year
Individual without taxable income	Individual	13.5		minimum wage	Month
Individual benefits from the state*	State	13.5		65 % of the minimum wage	Month

* If that individual has the taxable income she/he pays 13.5 per cent of the sum which is above 77 per cent of the minimum wage. The payment is paid by the state and individual commonly.

[1] The development in the structure of expenditure (see Table 2) during 1993 - 1995 shows the decreasing ratio of expenditure from the central budget. The budget expenditures include, with the exception of the contributions for health insurance, expenditures which are not covered by health insurance companies - sanitation services, emergency services, preventive health programs, research projects, training health personnel, etc. The decrease is caused only by the reductions in health insurance contributions. This is influenced by two factors: the reduction of the contribution base from the 77 per cent of the minimum wage in 1993 to 65 per cent in 1994 and the gradual fall of the number of state insurants (demographic influence).

As a result of introducing mandatory health insurance, the volume of financing transferred to the health system increased by about 64 per cent in 1993 in comparison with 1992. The share of public expenditure on health care in GDP increased by 2.3 percentage points. In comparison to the shares of European OECD members, the Czech Republic has reached the average level which these countries had at the beginning of 1990's (see Table 3). However, the structure of the Czech health care expenditure is different.

Table 3: Total health expenditure share of GDP (in %)

	1985	1990	1991	1993	1994	1995
OECD - Europe	7.3	7.6				
Austria	8.1	8.3	8.4			
Belgium	7.4	7.6	7.9			
Czech Republic*	4.1	5.1	5.4	7.7	7.6	7.2

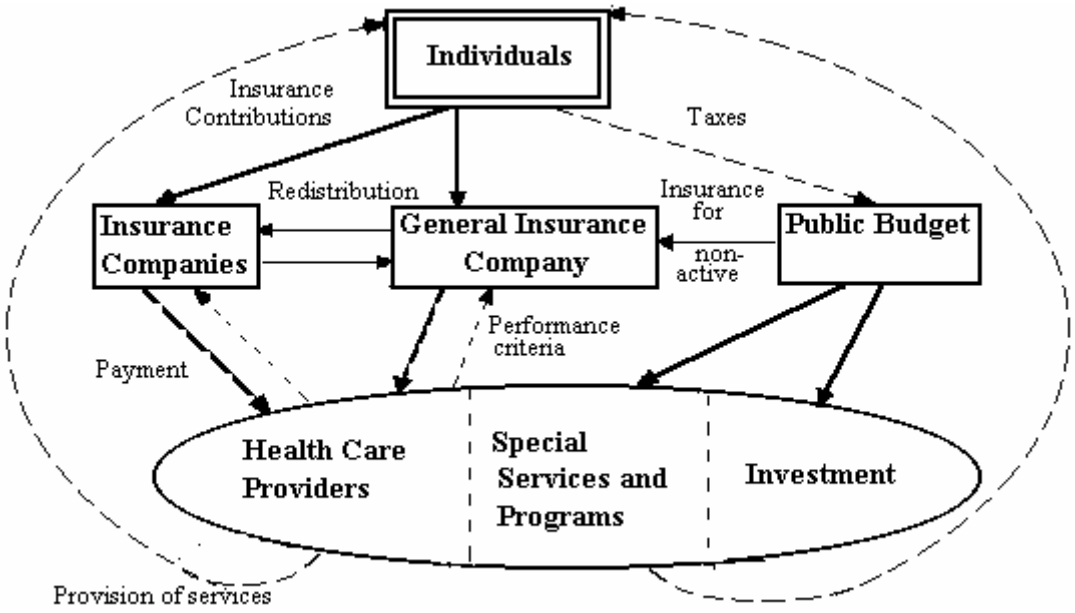
* For Czech Republic - share of public health expenditure in GDP
Source: National Accounts (1960-1991), Volume I, OECD 1993
Health Policy Studies, (OECD Health Systems, Volume I), No 3/1993
Ministry of Finance, Czech Republic

Presently there is no system of private health insurance in the Czech Republic; the ratio of patient participation in health expenditure is low in comparison to the systems in western European countries. In the Czech Republic, it is estimated to be 5 - 7 per cent of the total health expenditure. This is a sharp contrast to the 1990 ratio in European OECD states of 15.8 percentage points.

In contrast to the social security systems (including pension and sick-leave insurance, employment policy, social support, and social care) which are financed through the public budgets, health insurance is financed separately. In 1993, a new financing scheme was introduced and a system of health insurance companies was established. At the present, this includes the central company (General Health Insurance Company - GHIC) and 26

employee health insurance companies.[2] Scheme 2 shows the financing flows between the partners in the system - insured persons, the state, companies, and health care providers.[3]

Scheme 2: Financing flows between Individuals, the State, Companies and Health Care Providers



[2] At the present, there is a trend towards a reduction in the number of employee insurance companies.

[3] All insurants pay the premium into the account of the health insurance company with whom they are registered. The state health premium is redistributed from the special account, administrated by the GHIC, to all insurance companies in accordance to the number of registered state insurants. With respect to the basic principle of social solidarity, 60 per cent of the health premium collected by health insurance companies are redistributed in common with the state contributions.

With respect to this, health insurance companies are obliged to identify 60 per cent of the premium received every month. On the base of this information, the sum belonging to every company is calculated as the aggregate „shares" for every state insurant. One share is given for each state insurant younger than 60; three shares for a person aged 60 and above. The value of the "share" is calculated as the ratio:

$$\frac{0.60\,HP + SP}{n_1 + 3n_2},$$

(HP - health premium collected by the insurance company,
SP - state contribution (premium) into the special account,
n_1 - number of the state insurants younger than 60,
n_2 - number of the state insurants 60 years old and above.)

If 60 per cent of collected health premium is higher than the calculated sum, the insurance company transfers the difference into the special account administered by the GHIC. If it is lower, the difference is covered from this account.

The revenues for health care increased almost by two thirds, thanks to the introduction of mandatory health insurance. However, financial tension has been felt since the starting of the new system. After three years of operation, the system is in crisis.

This crisis has been caused by many reasons. At the beginning of the transformation, the health care system was characterized by a disproportional structure of health facilities and services, limited access to the top services, insufficient drugs, health materials, and equipment, restricted distribution, and a low level of wages and salaries in health sector. It was evident that the necessary changes to this situation will require a substantial growth of expenditure into this branch of the public economy. Included in this growth were the projected "costs" of the economic transformation and the institutional transformation of the health care sector. In the first place, these included the initial effects of price liberalization, expensive credits, costs of health facilities' privatization, costs connected with the starting of the new health care financing system, and more. However, the main cause for the present crisis can be found within the present financing system which stimulates the distorted and non-economical behavior of partners on the supply side and on the demand for health care.

To explain the last point in more detail, it is necessary to say that the state had a key role in the faulty formation of the system. This is confirmed by the multiple amendments of the legal norms concerning health insurance and the providing of health care. For example, between 1991 - 1995, more than 30 legal norms were passed. At the time of introducing the new financing system, those norms included very lenient conditions for the founding of health facilities and insurance companies. The uncontrolled conditions led to an excessive growth in the number of facilities and also to the personal inter-connection between private and non-private facilities (for example, physicians practicing simultaneously in state facilities and in their own private facilities). The foundation of employee's health insurance companies was not regulated. Conditions for their operation were not set sufficiently at the starting of the system while the administrative costs and additional expenditures which were not connected with the health care rose quickly. The original idea - to create institutions for special groups of insurants with specific health care needs - was soon liquidated and employee's insurance companies became open for all insurants without distinction. In

addition, pressure from different special-interest groups during the creation of the legal framework gradually excluded the possibility of competition between subjects.

The creation and the level of health care prices are also a significant element influencing the behavior of partners in the system. The prices of health services are regulated by the state and by the health insurance companies.

This is primarily done through the *List of Health Care Services and Prices*. The price of a service is made up of the medicine's material price and an explicit number of points with which the physician's service is accredited. The value of a point is assessed by the health insurance companies at the beginning of the year. At the same time, the state assesses the maximum value of the point. The value of point assessed by companies usually reaches about two thirds of the value assessed by the state. The reason is that the contribution rate for health insurance is fixed for all insured persons; thereby the revenues of health insurance companies are limited and the increasing costs of the health care have to be covered from this.

The conditions and limitations given by the legal framework influence the behavior of the main partners in the health care system.

Patients are indifferent to the volume of extended health care because their share of payments is fixed and limited by the rate of insurance. The only limits to their indifference are their willingness to consume more health services and to participate in paying for drugs and materials which are not covered by insurance.

Health care providers, which have the majority of information resources in the system, are motivated to perform the maximum level of services. This could be defined more precisely as attaining the maximum of points. Their behavior is not only influenced by earning, but also through the payments for services as there is at least a one month gap between providing services and receiving the payment for them. Moreover, the construction of prices which are based on the separation of the crown and the point parts contributes to the more rapid expenditure growth for crown items and to decreasing the

revenues from point evaluated services[4]. The present financing system for health care does not be sustainable given the valorization of the services' value. Incomes of workers in this branch are directly dependent on the amount of performed services, i.e., on the amount of points accredited for each medical service. The regulation of health care prices also influences the structure of the set and the supply of services from health facilities. It leads to higher demand for expensive health equipment. It is also conducive to the high rate of insolvency among health care facilities subsequent to the insolvency of health insurance companies.

The position of the health insurance company is between the insured person and the health care provider. It means the insurance relationship - payment for the insured occurrence - isn't able to be fulfilled. The company plays only a mediating role. It is only able to partly influence the structure of insured persons by the supply of extra-standard services and in this way to influence the revenue volume. But at the present, point inflation and the rapid growth of other expenditure items limits this supply. In addition, most companies are gradually restricting these services. A reduction of point value isn't possible as a more rapid growth in the number of points would result. Companies are able to partially solve these problems by reducing the number of agreements with service provider facilities. But this practice is creating higher pressure from the representatives of health care providers.

A separate problem is the control system. During past three years, the state control of insurance companies' operations was at a low level. Some control instruments were assigned to the central health insurance company (e.g., control of the central register of insured persons). Within companies, there are varying methods of accounting for expenditure. Their internal control systems are also at a low level; a result from the pressure to decrease administrative costs. Current practice shows that companies are reducing the number of

[4] It is necessary to add that the present *List of Health Care Services and Prices* is a result of negotiation between the state and representatives of health care providers. During past three years, there has been no reevaluation of the point value to a physician's services. On the other hand, the value of a point assessed by health insurance companies was adapted to the extreme growth in health care consumption with most employee's insurance companies gradually decreasing its value, (GHIC has held the value of point at the 0.52 crown level since 1993).

physicians they work closely with or cooperative in this field with physicians which manage their own health facilities.

Special problems stem from medical policy and the extensive development of expensive medical equipment.

The massive payment problems of health insurance companies became evident in the second half of 1995. By the end of the year, debts reached 5,184 mln CZK, of which 45 per cent was held by the employee health insurance companies. Almost half of them are indebted to some multiple of their monthly revenue. With this situation, the state is forced to look for a solution with the other partners in the system.

Measures currently being discussed by the authorities aim in part at financial assistance. This includes loans from the state budget (about 1 billion CZK) and increasing the contribution base of payments for state insurants by 15 percentage points. This would enable the debts to be covered and increase point value in a short time. On the other side of the equation, measures are prepared regarding the set of health care facilities (decreasing of bed capacity, the liquidation of some state health facilities, and regulating the purchase of some technologies). Also included in the discussed changes in the health insurance system are means by which an individual insurant's participation could be introduced. This could include establishing individual accounts for insurants to pay for stomatology care and a limited, per patient lump sum for physicians.

All these measures require substantial changes within the legal norms governing health services. These amendments will be priority undertaking of the government following the election in June 1996.