Health policy in the Czech Republic: General character and selected interesting aspects

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Abstract: *Transformation of the health care system was a task faced by all formerly socialist Central and Eastern European countries. The years of changes revealed a large number of problems, including those induced by the limited capacity of governments to formulate and implement health care reforms. The goal of this article is to reflect the Czech situation. We start by summarizing the historical development of the Czech health care system in the context of government capacity for implementing health policy. In the core parts of this article, we highlight the main features of Czech health policy making and implementation and present an in-depth analysis of two selected country-specific issues – a low level of patient co-payments and a pluralistic insurance-based financing of health services.*

Keywords: *health policy, health care, reforms, Czech Republic, government, cabinet, failure, implementation*

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INTRODUCTION

All Central and Eastern European (CEE) countries implemented large-scale health care reforms after 1989, trying to convert a "socialist" health care system into a "modern" one (see, for example, Shakarashvili, 2005; Rosenbaum, Nemec & Tolo, 2004; or various WHO and OECD studies). The Czech Republic belongs to this group and its health policy has some very interesting specific features. The goal of this paper is to evaluate selected features of Czech health policy after 1989. To achieve that goal, we first introduce the main theoretical findings concerning the topic. Afterwards, a description of the development of Czech health policy after 1989 is provided. This historical discourse shows that reforming health care in the Czech Republic is connected with many problems (typical for the entire CEE region), and especially with limited capacity for health policy making and implementation, discontinuity and politicization. One factor of such problems, namely the ability of coalition governments to push through legislative changes, is the subject of detailed analysis in the third part of the paper. On a case study example of co-payments, we also demonstrate the extreme politicization of health care developments.

Two specific features are connected with the health care reforms in the Czech Republic – it is one of two countries in the entire region (together with Slovakia) that switched from a "Semashko" model to a pluralistic insurance model of financing health services. The purposes, pros and cons of such a decision will be discussed in the fourth part of our paper. The Czech Republic also has the lowest level of co-payments in the region and one of the lowest in the world. This issue will be discussed in the fifth part.

HEALTH POLICY AND HEALTH FINANCING

Public policy making includes at least four core dimensions: content, context, process and actors (Walt and Gilson, 1994). The processes and actors in health policy do not differ too much from other policy areas; however, the context is really specific. The health sector is an important part of the economy in all countries – for example, in the US, health care expenditures account for about

17% of the GDP (WHO statistics). The nature of decision making in health often involves the matters of life and death. Moreover, health is not only the result of health care quality, but it is affected by many factors and decisions that have nothing to do with health care, including poverty, pollution, contaminated water or poor sanitation, smoking, alcohol consumption, obesity and many others (Altenstetter & Bjorkman, 1997).

In our paper, we focus on finance and access as the core specific issues connected with the health care sector. Concerning access, we have to stress that in the European Union, member states are expected to provide universal access to health services for all citizens (see, for example, the European Charter of Social Rights). Such universality is based on the principle of recognized and not just perceived needs: the different agents of health care (see later) decide if a need perceived by the patient is also real and covered by insurance. Such an approach is fully necessary because no system can assure full and universal access for all perceived needs – cost containment is inevitable (for more, see, for example, Cullis, 1979). Universal access (equity) cannot be guaranteed without state interventions and the involvement of public finance.

Health economics theory (for example, Feldstein, 1993) deals with efficiency issues – "market failures" – connected with health care delivery. Several obstacles prevent the achievement of allocative efficiency in the health care market, primarily the following:

- health care is an impure public good;
- informational asymmetry;
- externalities; and
- uncertainty and complexity.

Many authors argue that (except for social arguments) the problem of information asymmetry (limited information on the part of patients) is the most important obstacle preventing a free market in health care (Stiglitz, 1989). One of the conditions of a free market is that the consumers of health services obtain information about the factors that govern the effectiveness of all available treatments and about the likely future effects of these available treatments on their health. In reality, though, the consumers have little or no information concerning their needs, the level and form of treatment required, or treatment effectiveness. The situations where an information asymmetry exists are studied by the principal-agent theory (see, for example, Arrow, 1985). Because the direct consumer – patient – does not have sufficient information to decide, the principal (government) is expected to appoint an agent to protect the patient and his/her interests (or each role can be played by a different government body).

The social and economic contexts of health care determine the very specific character of health policy making: there is no one uniform, optimal model

to follow. Given the variability of models and configurations of health care systems, one common and uniform health policy – in terms of contents – is impossible (Altenstetter & Bjorkman, 1997). Countries and their policy makers have to decide between many alternatives. As regards financing, the following main models are available (Bjorkman & Altenstetter, 1998):

- a general taxation model (tax revenues are used for the financing of a dominant part of health services; currently exists in the United Kingdom and Nordic countries; used to be the norm in former socialist regimes in CEE);
- a social insurance model (the revenues of compulsory health insurance are used for the financing of a dominant part of health services; frequently called the "Bismarck model" insofar as the state redistributes resources via the insurance market); and
- a program model (the public hand finances health care via specific targeted programmes; the United States, with their Medicare and Medicaid, are a typical example).

Effective health policy making should mean especially following one trajectory without too many zigzag changes (while respecting the rules of the policy process like the involvement of all actors). However, in many countries the reform trajectories are rather a zigzag sequence of problems/solutions/new problems/new solutions/etc., where former 'solutions' turn into new 'problems'. This happens when solutions are offered and implemented before clear problem definitions emerge, or before there is a clear order of priority in which problems are to be tackled. Such 'solutions' may not respond to the system's reform needs and provide an answer to a shared problem. Re-organization, as an act of reshuffling the different organizational boxes and modules, is a common type of 'solution' which does not always match the reform needs. However, it is convenient because it is visible and convincing at first sight. Moreover, sometimes a 'solution' is the right answer to the right problem, and still new problems are created, possibly in the course of its implementation which is not optimal (Dunn, Staronova & Pushkarev, 2006). The right solution is not well implemented for a range of reasons like timing, resources, target groups, and ownership (for more, see Vries & Nemec, 2013).

With respect to process (as analysed bellow), for example, Mazmanian and Sabatier (1989) discuss the question of limitations that affect the cabinet in formulation and implementation of health policy. Based on existing top-down approaches to implementation, we suggest a set of conditions for successful implementation of changes in the health sector (for more, see Pavlik, 2010):

- The cabinet holds a majority in all representative bodies (especially the Parliament) or it is able to negotiate support across political parties.

- The cabinet's health policy clearly formulates the policy aims to be evaluated.
- Voters are supportive of or neutral to the cabinet plan, or can be convinced by policy marketing.
- Financial resources are sufficient.
- The cabinet is able to gain support of strong interest groups or to deal with their resistance.

The following economic arguments have been connected with the introduction of a pluralistic health insurance system: a trade-off between the costs of a public monopoly evident in the previous system (whose efficiency might be improved by an internal market) and the excessive administrative costs but low economies of scale if there are many competing insurance companies. Alternatively there would be the general economic welfare problems of oligopolies if the market came to be dominated by a small number of large insurance companies. Changes from "Semashko" to social insurance models in the Czech Republic were supported by arguments that plurality, independence and competition would help to improve the performance of health systems (for more, see Lawson & Nemec, 2003).

Concerning co-payments, as another issue analysed, economic theory argues that some level of individual participation, which does not impact universal access, might be feasible (the core economic arguments used include regulation of demand, increased consumer interest and consumer control, and transaction costs). Another obvious practical argument for individual participation today lies in limited capacities of public finance systems and the necessity to teach people that publicly provided doesn't mean "valueless" (Stiglitz, 1989). Health care is not a pure public good and probably should not be fully publicly financed. Consequently, during any type of transition the level of private co-payments should be discussed. In the present case of transition from 'socialism' to 'capitalism', private co-payments need to be established somehow.

HEALTH POLICY AND HEALTH REFORMS IN THE CZECH REPUBLIC

Before we can start evaluating the developments of Czech health policies and the concrete health care reforms in the country, we need to characterize briefly the old system.

The aim of the old system was to provide comprehensive health care for all members of society. In fact there were several parallel health systems. Alongside the main system were separate institutions for the armed forces, for railway personnel and for Interior Ministry employees. In addition to these four systems that provided equivalent levels of care, there were institutions closed to ordinary citizens that provided a higher level of health care to high-ranking officials. This parallel provision, along with the bribes that were given in the main system to secure prompt and effective treatment, was at the root of health provision inequalities in the past.

All decisions on medical provision were made by the federal government and the Czech and Slovak national ministries of health. They were generally made on political or administrative grounds, and the only accountability was to the communist party. A second aspect of the planned economy that was would later shape the structural aspects of post-revolutionary Czechoslovak health care was the supply-constrained nature of the system. Health services were free at point of use, but only after 1987 did patients have the right to choose their primary care providers, opticians and dentists. At the same time, a small number of hospitals were given experimental economic independence, though there is no evidence that this experiment was ever evaluated to see if it should have been extended. There were no economic incentives to improve systemic performance, and excess demand generally prevailed. Some observers of the system felt that where excess supply existed officials would order unnecessary extra tests so that hospitals could present an impression of working at full capacity. There were no attempts to reduce excess supply or demand either by coordinating treatment scheduling, or by pooling the resources of the different sectors of the health care system.

Despite financial constraints (health spending in 1989 stood at roughly 5% of GDP, against an OECD average of about 8%) and management constraints, the Czechoslovak system was relatively effective, and the kind of crises that beset the Soviet system (Davis, 2001) as well as Polish health care (Millard, 1994) were avoided by effective planning. Especially in its early phase, the system functioned well. Some diseases disappeared and the rates of infant mortality declined. Between 1960 and 1964 the Czechoslovak health system ranked 10th among 27 European countries. However, later on, health indices stagnated or declined, indicating that Czechoslovak citizens were sicker and died sooner than the nationals of other European as well as some non-European countries. The country's ranking dropped from 22nd in 1970 to 27th in 1980.

Clearly part of the stock of problems existing in 1989 reflected the absence of direct consumer input into the processes of policy formulation or resource disbursement under communism. There were no pressure groups, and no public discussion about health policy. Policy making and implementation were mainly in the hands of the bureaucracy, with one important exception: communist groups inside and outside the health sector debated policy changes, send-

ing signals to superior party bodies, and so informing the policy formulation and implementation process. Outside of the party there was no formal consultation, but the fact that party members could reflect public concerns means that such concerns were not completely ignored – but they rarely changed central policy.

Post–1989 developments

In the following part, we briefly describe the main phases of the development of the Czech health care system after 1989 in Table 1.

Table 1 Health reforms in the Czech Republic

1990–1991
Preparation of basic changes Launch of these basic changes Abolishment of regional and municipal districts of health administration Establishment of the Czech Medical Chamber, the Dental Chamber and the Pharmaceutical Chamber
1992
Preparation of the health insurance system Preparation of privatization
1993
Introduction of the health insurance system (with multiple payers) Establishment of some sectoral health insurance companies Start of the privatization process (mostly in outpatient care)
1994–1995
First serious problems in health system financing Establishment of the majority of sectoral health insurance companies Legal limitation of competition among health insurance companies The necessity of a fundamental reform begins to be generally recognized
1997–1998
Left-wing government seeks a purely non-profit orientation of health policy Escalation of expenditures contained (lump sum payment) Attempt to re-structure the hospital network
1999–2001
Stagnation
2002–2009
Continued escalation of health expenditures Several reform proposals but only on paper Transfer of hospital ownership to regional governments Controversial transformation of some hospitals operated by regional governments to joint-stock companies Partial amendments in the system Minister Julínek's reform proposal (2006) Stagnation (since 2009)

Source: Vepřek, Vepřek and Janda, 2002, developed by the authors.

Transformation (1989–1991)

In the early 1990s, citizens' initiatives began to appear and to cooperate with the Ministry of Health. Together they formulated the first principles for changes in the health system. It was evident that modifications of the system would not suffice and a completely new system of health care was required. The target was to create a flexible system capable of adjusting to the changing needs of society while ensuring a balance of professional, economic and human aspects. In other words, a complete transformation from the centralized model into a more democratic and liberal system would provide better health services to all citizens and have better control over efficiency and economy.

Even if the government monopoly in providing and managing health care services was to be abolished, the state continued to play an important role in the health system by guaranteeing adequate health care for all citizens. The formulation, implementation and coordination of health policy were decentralized when it was agreed that each community would implement the principles of public health within its own territory. Health services were to be financed from different sources (state budget, local communities, enterprises, citizens), and obligatory health insurance were to become an indispensable part of the new system of health care. Competition was to be introduced into the delivery of health services, along with the principle of free choice of provider and healthcare facility.

Important changes were adopted in financing the health system, in institutionalization of services, and in public administration. Regional and municipal health districts were abolished as health care facilities became independent businesses with their own legal and economical liability. The centralized system of health care financed from state budget was replaced by a system financed by different sources although still based on the principle of solidarity.

Obligatory health insurance was chosen to be the most important source of financing while patients would have the right to choose their physicians and their health care facilities.

The transformations between 1990 and 1993 occurred quickly and were aimed mostly at financial issues. Physicians greatly influenced the direction of these initial changes – even within the citizen initiatives mentioned above in which physicians sought to increase their social prestige and income. Because legal and economical details were not discussed during the planning and implementation of this transformation, there was a long period of instability in the health system. The importance of control over the use of public funds was underestimated, a situation that remains in the current Czech health system.

Privatization (1992–1996)

The year 1992 was characterized by the launch of privatization in the health system. The first idea was to privatize everything except large hospital complexes. Because the legal system prescribed no rules for non-profit organizations, most health facilities took the form of business enterprises. In 1993 a law introducing obligatory health insurance came into force, which increased the level of competition. Initially 27 health insurance companies were established but most of them subsequently merged or collapsed. By 1996 two-thirds had gone bankrupt, becoming a burden for the state budget. Nine health insurance companies remain in the Czech Republic today.

Among the effects of privatization were better quality of services, better technical equipment and the introduction of economic principles in the health care system. Health care management became a shared responsibility of public administration, professional chambers and insurance companies. Unfortunately, rationalization of the hospital network, expected as one of the outcomes of the privatization, did not occur.

Rationalization of the hospital network (1997–1999)

In the mid–1990s the health system found itself in financial crisis. Many hospitals fell into serious debt and insurance companies were affected by financial imbalances. Consequently government began to regulate the supply side of the health economy. The policy goals were to reduce the number of acute hospital beds, to increase the number of specialized acute hospital beds, to reduce the number of physicians and to control drugs and investment expenditure. These goals continue to be discussed in the Czech Republic till present day; the problem is not the number of hospital beds per se but their geographic mix.

Public administration reform (2000–2003)

Within the framework of public administration reform, 82 state hospitals of the total of 203 hospitals in the Czech Republic became the property of regional governments. These hospitals were in debt, with total indebtedness of about €20 million. Central government committed to compensate the regions for approximately 60% of the debts. Consequently, some regions changed the legal form of these hospitals to joint-stock companies in order to stabilize their economic situation by increasing the motivation and personal responsibility of management boards and making their assets and commitments more transparent. Nevertheless, this measure was controversial. Even if a hospital is owned by the region, it should be managed just like any other private company. Some politicians presented this situation as defiance of the principles of equity and solidarity. This issue continues to exist in the Czech Republic.

2005 and 2006 developments

The necessity of change was amplified by the accumulated debt of the General Health Insurance Company (the biggest insurer in the Czech Republic) and of several large hospitals. Lawmakers sought to centralize decision making on all financial flows in the sector as much as possible in order to take control of the development and help manage the debt. Another policy target was to increase the reimbursement of the work of doctors and other medical personnel (whose pay was very low compared to other EU members) and to exert pressure on quality.

Changes in the reimbursement procedure meant increasing in the prices of medical services (due to higher rates of fee-for-service reimbursement for some concrete services) and setting an upper limit on income per provider. The result was not only discontent among providers, including protests and walkouts, but also a real threat to the accessibility of health care for patients. Therefore, a subsequent regulation softened the original reimbursement limits.

In a proclaimed apprehension of financial fraud in hospitals operated by regional governments, the social-democratic government blocked further 'privatization' and passed a law on the establishment of a non-profit hospitals network with the goal of having 'one hospital in every district'. This law obliged health insurance companies to conclude a contract with every non-profit hospital. It also provided for several issues to be ordained by the Ministry of Health – for instance, the scope and structure of health care provided, equipment, number of beds, personnel capacities, salaries and the remuneration of doctors.

The "Julínek reform" and subsequent stagnation

The original reform programme of Minister Julínek was ambitious and detailed, and expected to take two parliamentary terms to implement. The initial phase had four objectives. The first objective was to expand the room for individual choice and responsibility by creating a health care account for every patient. By recording individual details on health-related revenue and expenditure, the programme would also generate data on individual, geographical and inter-temporal access to health care. Furthermore, to discourage excessive access, individuals were to be charged for prescriptions, emergency calls, visits of medical specialists and hospital stays. Theoretically, such co-payments were expected to improve efficiency, but also conflicted with the aim to make services free at point of use. To maintain consistency with the key value of Czech social policy, solidarity, total charges per individual were to be capped and allowances provided under specific personal circumstances. Co-payments were expected to increase the health care system's revenue, and perhaps also decrease incentives for informal payments. Any decline of informal payments would be consistent with the social policy principle of equity, for such payments allow the wealthier to access better care.

The second objective was to give health insurance companies more powers to make independent decisions, and at the same time to make the insurance market more competitive. The hitherto relatively weak health insurance companies were to be empowered at the expense of other actors on the supply side: specifically medical staff, and especially doctors' unions. This objective was to be achieved by privatising the insurance companies and allowing them to act as the purchaser of health services for their clients, patients, who in turn would be allowed to buy higher than basic (supplemental) access policies. Thus the companies were to be given the opportunity and the incentive to increase profits, while pressuring health providers to control costs. As a result, access would be partly dependent on willingness to pay, and services would no longer be entirely free at point of use: two clear changes to the previously guiding principles of social policy in this area. This was intended to be the key change to the system of health care, a clear shift away from its pre–1989 étatist origins and towards a mixed-type system with state and societal regulation, societal financing and mixed state-societal-private provision (Wendt, Frisina & Rothgang, 2009).

The third objective was to introduce or strengthen competition between health care providers, to lower the costs for insurers and their clients and to make service provision more uniform. This was to be achieved by allowing insurers to contract suppliers on a similar basis, whether they were private doctors, or public or privately owned hospitals. Since that would give insurers considerable influence over the pattern of provision, the changes were met with vigorous protest by doctors and their professional chambers. But the government did not reverse the change because its objective was clearly to reduce the ability of such chambers to determine the amount of reimbursement or to block initiatives. The doctors counteracted by emphasizing the need for more reform: in the run-up to passing the 2011 legislation, 30% of the country's doctors organized and threatened to resign their jobs unless they received substantial pay increases—which they did.

The fourth objective of the initial phase of the reform was to establish an efficient and transparent procedure for determining maximum prices and reimbursements paid from public health insurance. The procedure would be supervised by the Ministry of Health of the Czech Republic. The objective was also to harmonise Czech law with the EU's Transparency Directive (Darmopilová & Špalek, 2008) by reimbursing the cost of new drugs on the basis of their effectiveness and, where appropriate, setting additional co-payments for individuals. To recognise variations in individual circumstances, such co-payments were to be subject to individual ceilings.

A limited policy of co-payments was implemented, but privatisation and competition between insurance companies proved too controversial, and little changed when the centre-right Topolánek government fell in March 2009. After a caretaker government interregnum, the election brought in a new centre-right coalition with a different prime minister, but the same leading party. The new government proclaimed the same programme of public service reform, and it finally managed to pass a series of health care bills in the summer of 2011. These bills introduced into health insurance the distinction between basic and supplemental coverage, increased the powers of insurance companies, and confirmed the shift from citizens as patients of the state to citizens as clients of insurance companies. In the context of an aging population, rising health costs and general pressures to limit expenditure, the following motivations for the changes were declared: to raise health care productivity, to improve health outcomes, to provide more choice, to shift resources from acute care towards preventive care, and to make patients more aware of and so more responsible for their own health.

A new government coalition lead by the Social Democrats (in power since 2014, after resignation of previous government in June 2013) has not introduced any major changes yet.

EVALUATING HEALTH POLICY MAKING AND IMPLEMENTATION IN THE CZECH REPUBLIC

The history of Czech health reforms provides considerable evidence that reforms were needed but very little of substance changed after the initial transformation. It indicates several policy making and policy implementation problems, including limited capacity for health policy making and implementation, discontinuity and politicization. In the following text we try to develop on these aspects.

Health policy discontinuity has several sources – for example, different opinions of different parties about the health care system and its instability. Not only did Czech governments change more frequently than expected by the political cycle, but health ministers came and went even more often – their average tenure since 1990 lasted less than eighteen months. Nearly one half of the ministers were dismissed after physicians' protests (Pavlik, 2010).

To demonstrate the extent of the problems in health policy making, we briefly analyse one specific issue – the "power" of coalition governments to push through changes. The better one's ability to pass legislative changes against the will of the opposition, the better the chance to implement a health policy reform. Obviously a reform may as well be promoted by a wider coalition of cabinet and non-cabinet parties, but this situation is unusual across most public policy agendas in the Czech Republic.

Graph 1 below summarizes the situation of Czech cabinets. We used the following methodology: the cabinet's position in a given representative body is determined by the percentage of seats held by the leader party and its coalition parties. The letters "a" and "b" express the situation before and after election in a given year. For the Chamber of Deputies we used the following formula:

$$PV_{rs}^{PS} = V_r^P + 10 \times \sum_{i=1}^{n} V_r^P$$

where

PV^{PS} – means the Chamber's support for the cabinet;

V – means the percentage of seats in the Chamber gained by a given political party;

and the indexes mean:

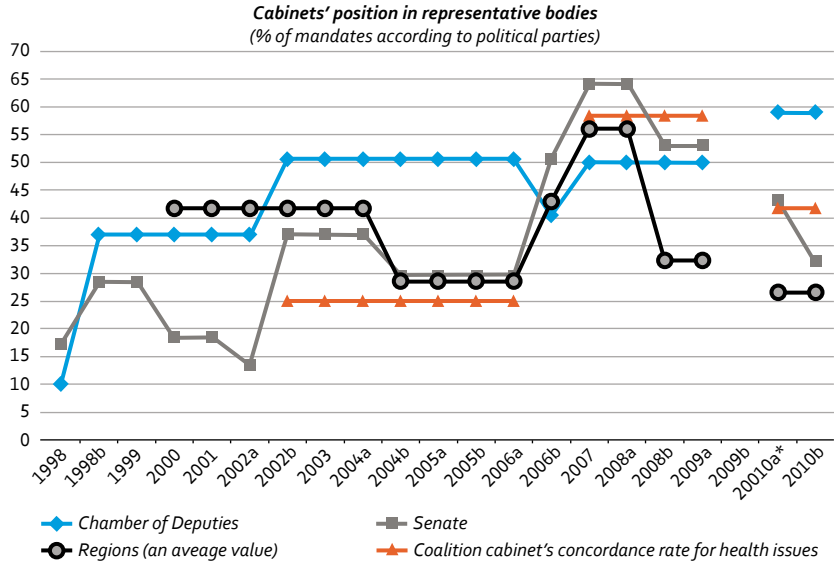
P – leader party

K – coalition parties

r – year

The same methodology is applied also for the senate and regions.

Graph 1 Cabinets' position in representative bodies, the Czech Republic, 1998–2010



Source: Pavlík, 2009, updated by the author

What is important is that only the short period of 2007–2008 opened a window for significant system changes – and indeed the reform started with increasing patient co-payments. However, the first step of the reform was consequently boycotted and the reform process was stopped (see previous part). The health policy reform was one of the reasons why the cabinet was finally forced to resign and a snap election was held.

The possession of a majority of seats may at least partly explain that most Czech governments offered only discontinuous and incremental changes (e.g., in the legal form of hospitals, reimbursement amounts, and the level of government intervention in the health insurance system) and only one systemic reform attempt (Julínek) occurred in the entire post–1993 history.

The "fight" over co-payments: an example of typical problems of Czech health policy

The following part presents a case study documenting the extent to which Czech health policy is politicized. As already explained, the political position of the cabinet in 2007 was extraordinarily strong – coalition parties held a major-

ity in all regions as well as in the Senate and the Chamber of Deputies. Despite this, the implementation of regulatory co-payments/fees became controversial and generated public frustration. The government failed to explain the change as part of a sophisticated and beneficial broader reform. It failed to win support of major interest groups and instead, the coalition's unity weakened. Opposition parties used the regulatory fees in their campaign before the 2008 regional elections and achieved an overwhelming success. Consequently coalition deputies did not pass the other reform bills tabled in the Chamber of Deputies.

At the beginning of 2009, the cabinet lost its majority and Prime Minister Topolánek resigned. A 'non-political' caretaker cabinet was formed without the authority to introduce any changes, with the only duty to bring the country to an early election. The opposition's victory in regional elections strongly affected the impact of the regulatory fees policy when all regional governments except Prague boycotted the policy in different ways. Most decided to compensate patients for the regulatory fees incurred, but only in hospitals they themselves operated. There were differences in the compensation method as well as in the spectrum of regulatory fees covered. Table 2 shows the key differences region by region.

As regional governments began to compensate for the regulatory fees, the following problems became evident:

- conflict between the cabinet's policy and policies in the regions,
- discrimination against patients outside the hospitals operated by regional governments,
- a fragmented array of compensation methods and confusing information for patients.

The cabinet 'struck back' when the Ministry of the Interior ruled that the regions had acted beyond their authority. The only approved way to compensate for the fees would be through a deed of gift retrospectively: patients had to pay the fee and then apply for a refund. Consequently, one by one, the regions stopped compensating for the regulatory fees during 2010, and only one region, Central Bohemia, insisted on the refunds. The following years of debate led (in 2015) to abolition of all fees excluding that for visiting an emergency unit in cases when general practitioner is not available.

Table 2 Regional governments' policies to counteract regulatory fees

Region	Policies to counteract regulatory fee				Compensation method	Percentage of covered persons
	30 CZK per visit	60 CZK per day in hospital	90 CZK per emergency visit	Per prescription		
South Bohemian	Yes	Yes	Yes	Yes	Deed of gift	70
South Moravian	Yes	Yes	Yes	Yes	Deed of gift	65
Karlovy Vary	Yes	Yes	Yes, excluding dental care	Yes	Deed of gift or verbal gift	63
Hradec Králové	Yes	Yes	Yes	Yes	Deed of gift or verbal gift	65
Liberec	Yes	Yes	Yes	Yes	Written release of liability	51
Moravian-Silesian	Yes	No	No	Yes	Deed of gift	45
Olomouc	Yes	Yes	Yes	Yes	Deed of gift	65
Pardubice	Yes	Yes	Yes	Yes	Deed of gift	46
Central Bohemian	Yes	Yes	Yes	Yes	Gift upon application	25
Central Bohemian	Yes	Yes	Yes	Yes	Verbal gift	95
Ústí nad Labem	Yes	Yes	Yes	Yes	Written acceptance of reward	40
Vysočina	Yes	Yes	Yes	Yes	Deed of gift	60
Zlín	Yes	Yes (youth, pensioners)	No	No	Gift upon application	25
Prague	No	No	No	No		

Source: Malý, Pavlík and Darmopilová, 2013, p. 85.

PLURALISTIC HEALTH INSURANCE AS A WAY OF FINANCING HEALTH CARE IN THE CZECH REPUBLIC

As shown in the first part, a law introducing obligatory health insurance and increased the level of competition came into force in 1993. Initially 27 health insurance companies were established to manage the system's funds. The decision by the Czech Republic to introduce a pluralistic health insurance model to finance health care (the structure of health finance is shown in Table 3) was rather unique in the region (only Slovakia – being part of the common state till January 1st, 1993 – did the same) and deserves discussion.

Table 3 Health expenditures in the Czech Republic (USD million, current prices)

	1990	1995	2000	2005	2010
Central government	x	294	216	515	698
Regional & local governments	x	274	229	373	583
Total government expenditures	1,031	568	445	888	1,281
Public insurance	x	2,916	3,001	7,103	11,193
Total public expenditures	1,031	3,484,,	3,446	7,991	12,474
Private out-of-pocket	x	277	359	965	2,191
Total health expenditures (public + private)	1,031	3,793	3,805	9,136	17,868
Total health expenditures as a GDP %	4.7	7.0	6.5	7.2	7.5

Source: Malý, Pavlík and Darmopilová, 2013, p. 71.

Since economic and health theories do not provide one best model of health care financing, the question is: Why did the Czech Republic decide for a pluralistic option? And what really happened?

Most authors argue that in the Czech Republic the demand for plurality was a reaction to the long-term state monopoly on health services. Indeed, political considerations the main rationale behind the systemic switch for all post-communist countries (for more, see, for example, Lawson and Nemec, 2003). The demand for plurality and trust in the market's regulatory capacity is reflected in many elements of the Czech health system such as freedom of choice for patients, a public-private mix of providers, multi-source financing, and especially competition for enrolees by several, mainly private, health insurance companies. Proponents argued that the systemic switch to earmarking taxes for health and sub-contracting their administration to independent insurance funds would have the advantages of distancing government from a contentious area of public policy, reducing pressure on general budgets, and improving efficiency and quality.

Today, it is well visible that most of these expectations did not become reality. Let us focus on the issue of competition. First, nine health insurance companies remain in the Czech Republic today, with a dominant position of the public General Health Insurance Company covering more than 60% of insured. Such a system with one dominant player cannot be fully competitive. Second, there is the issue of improper government interventions in health insurance; despite formal delegation of authority, the state is not willing to give up control. Strict regulation of insurance premiums and benefits stifles competition and insurance companies become mere redistributors, rather than the intended regulators.

The "costs and benefits of transition" are another specific issue. Problems with the implementation of pluralistic health insurance can be expected if undertaken too early in the transformation period when financial markets do not yet perform in a standard way. This was the case of the Czech Republic –where two-thirds of established health insurance companies had become bankrupt by 1996 and their liquidation became a problem for the state budget.

We feel that (compared to expectations) the core problem of the Czech health insurance system lies in imbalanced combination of pluralist health insurance with tight state control over the system. The government determines the level of insurance premiums (voluntary bonuses and maluses are not allowed). For employees and self-employed persons, the law determines the percentage of earnings to be deducted. However, 58% of all those insured in the system comprise of individuals who lack income and are 'state-insured' – like students, pensioners, or prisoners. The amount the government decides to pay for each 'state-insured' is always lower than the minimum amount that employees or self-employed persons must pay. Hence any government decision about the amount for state-insured has a major impact on health care resources. In such conditions, the pluralistic health insurance is more a way of "outsourcing" the financial management of the health system (functioning relatively well) than an independent regulatory tool.

As we already showed, all Czech cabinets, with one exception, had an unstable position in representative bodies. That may be one of the explanations why the pluralistic system of health insurance companies is kept alive. Many parties and experts argue that the current system is not a competitive market – differences between the health insurance companies are illusory and one of them holds the majority of insured. And from the point of view of a social policy based on the principles of solidarity and universal access, there is no

reason to have more than one health insurance company. The endless debate about whether the number of health insurance companies is responsible for the system's financial and other problems continues.

THE LEVEL OF CO-PAYMENTS IN THE CZECH REPUBLIC

The Czech Republic has (together with Croatia) the lowest level of private health care funding in the CEE region and one of the lowest in the word (see Annex). Co-payment is required for selected drugs, dental services and medical aids. Since January 2008, subject to a maximum annual limit, Czechs have been paying regulatory fees per prescription, hospitalization day, emergency visits, and visits of medical specialists. The solidarity principle is retained due to the limit of CZK 2500 (approximately €100) on total individual expenditure for direct co-payments per year. In such a situation, two questions might be topical:

(a) Does the private co-payment negatively influence universality of access?
(b) Are there sufficient public resources to maintain universal access given the low levels of direct private participation?

According to recent studies (especially Malý et al., 2013a), existing co-payments in the Czech Republic do not impact universality of access in any significant way. Even in Slovakia, where the official level of private payments is much higher, social impacts are still not too visible (however, there is effectively no research evidence about the impact of co-payments on the most vulnerable groups). Existing data from more economically developed countries show that, with effective social systems, even a 30–40% share of private co-payments may not become a crucial social problem in terms of universality of access.

In other words, proper increase of co-payments might still be possible in the Czech conditions, although there are strong political barriers to their effective implementation. Regardless of their pro/against market orientation, almost every minister of health thus far supported the idea of keeping universal access to health services. Even the pro-market "Julínek" reform sought to implement individual health insurance plans only for "extra" services, while the basic coverage of "free" care remained part of the system. The importance of universal access as the key principle is shared across the majority of political parties and thus it can be considered as an issue with a high coalition potential. In such conditions, any proposals for private co-payment lead to major political fights – see also earlier parts of this article.

Concerning the second question, evidence shows that the Czech Republic, with fewer resources compared to other developed countries (in 2010, EU member states spent a non-weighted average of 9.0% of their GDP on health), somehow manages to finance its health care needs and maintain truly universal access for all citizens. The only valid explanation for this should be the relatively effective cost containment measures; the question is how long the current structure of health funding is going to be sustainable.

CONCLUSIONS

The goal of our paper has been to evaluate selected features of the Czech health policy after 1989. In this concluding section we intend to compare the results with relevant theories discussed in the first part of the paper.

With regard to the content, context, process and actors of health policy, we focused mainly on the dimension of process. The information presented clearly shows that discontinuity, politicization and interest groups limit the long-term chances for evidence-based policy making in the Czech Republic and in its health sector. Not only the frequent changing of governments (and especially health ministers), but furthermore, the chance for real changes has been significantly limited by the "division of powers" as demonstrated by our analysis.

The second question discussed concerned the switch from a health system based on general taxation to a pluralistic health insurance system with a quasi-market after 1989. The (declared) idea behind the switch in the Czech Republic was the promise of improving most aspects of health care provision and delivery. For example, health care was to be less dependent on the state, health funds were to be distributed more transparently, and competition between insurance companies would boost efficiency, effectiveness, economy and quality of health care delivery. However, such expectations do not have much support in the theory, and also practical experience shows that there is no optimal model of health financing. Real policy outcomes proved to be much more complicated than expected. With the high "transition costs" generated especially by the bankruptcies of newly established health insurance companies, only recently did the system of health insurance in the Czech Republic achieve some level of stability. The Czech example confirms the limited potential of competition in health care generally, and that distortions of competition are much more important in the specific conditions of early transformation (as well as in an overregulated environment).

The last issue investigated was the level of private co-payments in the Czech health care system (with an almost 84% share of public spending, the

Czech Republic is on top of the list of all developed countries). The relatively very low level of co-payments cannot be supported by standard economic arguments and is rather visibly caused by political factors. As shown by our analysis, the contested marginal increase of co-payments under the "Julínek" reform did not cause any significant access problems. Because of its limited economic performance compared to most developed countries, the Czech Republic cannot avoid the issue of how to finance growing health care costs predominantly from public resources, and will have to reflect it sooner or later (for example, by introducing a real scheme of supplemental private insurance for the extra services that are now delivered mainly through the shadow economy).

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Annex Public expenditures as a percentage of total health care expenditures, the CEE region and selected top developed countries

Country	2009	2010	2011
Albania	44.9	42.2	44.8
Armenia	43.5	40.5	35.8
Azerbaijan	22.9	21.9	21.5
Belarus	64.0	77.7	70.7
Bosnia and Herzegovina	68.1	68.1	68.0
Bulgaria	55.4	55.7	55.3
Croatia	84.9	84.8	84.7
Czech Republic	84.0	83.8	83.5
Estonia	75.3	78.9	78.9
Georgia	22.3	23.6	22.1
Hungary	65.7	64.8	64.8
Kazakhstan	59.2	59.1	57.9
Kyrgyz Republic	55.7	55.7	59.7
Latvia	59.5	60.9	58.5
Lithuania	72.8	72.9	71.3
Macedonia, FYR	64.8	61.8	61.4
Moldova	48.5	45.8	45.6
Mongolia	56.0	57.0	57.3
Montenegro	71.3	66.5	67.0
Poland	71.6	71.7	71.2
Romania	78.9	80.3	80.2
Russian Federation	67.0	58.7	59.7
Slovak Republic	65.7	64.5	63.8
Slovenia	73.2	72.8	72.8
Tajikistan	24.9	26.7	29.6
Turkmenistan	55.9	60.4	60.8
Ukraine	55.0	56.6	51.7
Uzbekistan	46.8	49.0	51.4

Denmark	85.1	85.3	85.5
United Kingdom	83.5	82.8	82.5
France	76.9	76.8	76.9
USA	47.6	47.8	46.4

Source: http://data.worldbank.org/indicator/SH.XPD.PUBL/countries.