CZECH REPUBLIC: FISCAL STUDY

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1. POLITICAL BACKGROUND

1. We cannot state that ministries of health in any of the countries of Central and Eastern Europe are well stabilized. The actual term in office of any individual minister usually does not exceed 18 to 24 months. In Czech Republic this term is even shorter. Since June 2002 as many as five ministers have held the post at the Czech Ministry of Health. Even though all five were from the same party (ČSSD), their ideas about the functioning of the health care system were largely different.

2. With the benefit of hindsight we can propose that while the ministers Součková and Kubínyi were promoting more fundamental reforms (even though postponed until after the 2006 election) aimed at increasing the financial participation of citizens and introducing a mild shift towards more market-oriented rules of the game, the strategy chosen by ministers Emmerová and Rath placed a bet on a hard etatization of the health care system. The working draft of Emmerová's health care reform strategy attracted stark disapproval of private practitioners and providers who feel existentially threatened by it.

3. In January, the ruling Prime Minister Gross said, that the government is not planning to initiate higher financial participation of the patients. They rather focus on stabilizing the system by searching reserves and stopping the lavish of financial resources in healthcare. The same "spirit" is shared by the new Prime Minister Jiří Paroubek, who was appointed on April 25, 2005 after the scandalization campaing and resignation of Stanislav Gross.

4. In November 2005 David Rath, president of Czech Medical Chamber, was appointed by the government. His first steps as minister of health are very controversial and are discriminating both private insurers and private providers.

5. The opposition ODS party is already working on its own version of health care reform codenamed 'The Blue Chance' which plans a complete change of the health-care system by introducing regulated market in health insurance and competition in health care provision. The reform aims to support greater financial and decision-making participation of the citizen involving their treatment and costs by introducing individual accounts as a complement to mandatory health insurance.

2. CZECH MINISTRY OF HEALTH: CURRENT ISSUES ARE CAUSED BY LACK OF RESOURCES

6. The reform of the Czech health care from a state-run system of the Russian type, which places emphasis on a high degree of availability and suppresses the role of quality and efficiency, to a modern health system of European type began in the 90's by introducing compulsory health insurance. Transition from financing by general taxes to a system of compulsory health insurance was subsequently supplemented by privatization of primary and secondary out-patient care.

7. After 15 years of transforming the Czech health care system the Czech Ministry of Health identified the subsequent negative aspects related to the current public health insurance, in the following order:

1. Deficit-generating finances of the system
2. Unbalanced distribution of the deficit among the 9 insurance companies (the General Health Insurance Company – VZP – is generating deficit while other companies have balanced performance or generate a surplus)
3. Decelerating income growth due to the reform of public finances (the premiums paid by state on behalf of those insured by state)
4. Increasing expenditures driven by population ageing, increasing occurrence of disease, introduction of new technologies, VAT adjustments, payment of claims abroad and increasing salaries in the health care sector.

8. These identified problems can be transcribed into the 'Evans equation' which expresses a balanced state of the health care system. The result is

Diagram 1: Broadest diagram of fiscal stability of the health care system

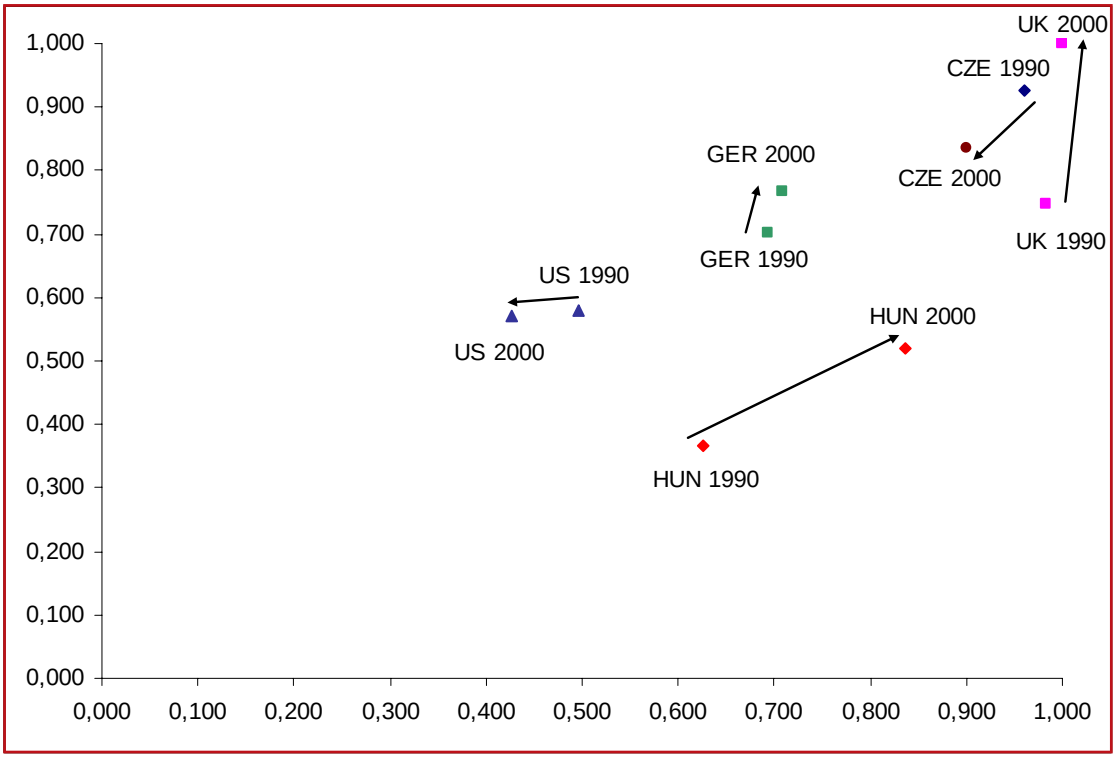
Source: author

an equation specific to the Czech condition, with unequal sides in which both demand and supply exceed available resources. This equation can then be used to derive a broader model of fiscal stability of the Czech health system (Diagram 1).

9. The Ministry also determined that the current financial imbalance of the system was historically caused primarily by a lack of resources due to very low contributions of the state on behalf its statutory insurance holders. In 1993 these payments accounted for 29% of the total resources while today the proportion has shrunk to 23% even though this category of insured amounts to 56% of all inhabitants and its share in the costs amounts to 81% of the total expenditures. The Czech Ministry of Health believes the second reason could be the expansive contract policy of health insurance companies on the side of expenditures, low efficiency of regulatory tools, insufficient supervision activity and increasing costs of drugs and medical aids.

10. This 'historic' explanation of problems is, naturally, always very attractive from the political standpoint. Placing responsibility to the ministry of finance is injudicious and more a testimony to the inability of the previous health ministers to communicate health care as a priority in state budget negotiations. At the same time it was convenient from the viewpoint of public finances and the finance ministry to shift the public finance deficit to the private sector in the form of growing liabilities. Secondly, placing responsibility on health insurance companies is a gross oversimpli-

Figure 1: Efficiency gap of the Czech system using uncorrected figures (for all countries), while there are no data on corrected results by age structure and employment for Czech Republic



Source: Osterkamp, 2004

Table 1: Hold- up of health-care reforms? - Changes of efficiency from 1980 - 2000

	Input variable: health expenditure				Input variable: health employment			
	uncorrected		corrected		uncorrected		corrected	
	change of		change of		change of		change of	
	input eff.	output eff.	input eff.	output eff.	input eff.	output eff.	input eff.	output eff.
Austria	better	better						
Belgium (b)	better	better					better	better
Czech Rep.	worse	worse						
Denmark	better	better						
Finland			worse	better			worse	worse
France (a), (d)			worse	better			worse	better
Germany (d)	better	better					worse	better
Greece	worse	worse						
Hungary	better	better						
Ireland (d)	better	better					worse	better
Italy (b)	better	better					better	better
Netherlands	better	worse					better	worse
Norway (d)	better	worse					worse	better
Poland	worse	worse						
Portugal	worse	worse					better	better
Sweden	better	better					better	better
Switzerland (a)			better	better			better	better
United Kingdom	better	better						

(a) 1990 - 2000 (health expenditure)
(b) 1980 - 1990 (health employment)
(d) 1990 - 2000 (health employment)
Source: Osterkamp, 2004

fication given the unclear goals and aims of the Czech health care policy. In the following we will show that the real problem of the Czech health care system consists of its low efficiency combined with a high level of inherent rigidity which prevents a more functional use of the scarce resources.

11. Efficiency of the Czech health care system has deteriorated in last 10 years (Figure 1) and the efficiency gap towards the most efficient countries (UK, Mexico, Netherlands, Japan) has widened. In 1990 the position of Czech Republic was [0.960, 0.925] and in 2000 only [0.901, 0.835]. In the case of Czech Republic, the input and output efficiency get worse in last ten years (Table 1) as compared with other western countries, where the efficiency has grown in the last decade.

12. We will now take a closer look at how resistant the Czech system is to demographic, efficiency and flexibility challenges in both the short- and long-term, and how the Czech health care policy will respond to the leveling of the imbalances between demand, resources and supply. On the side of demand the government can respond to the worsening demographic indicators and reduce demand by introducing marginal user fees while retaining the availability of health care. On the side of supply the government might respond by a more flexible supply system and a higher degree of competition. As for resources the government will need to take an unambiguous stance on the issue of participation of the patients in the treatment and the possible issue of introducing individual accounts as a decision-making model of using public resources for health care.

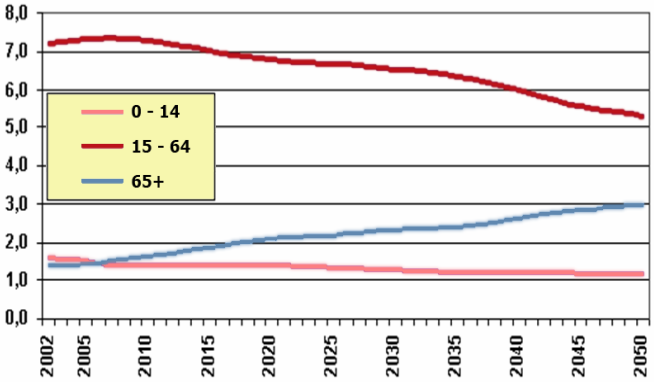
3. Demographics: The Ageing Process is Beginning

13. The current demographic structure in the Czech Republic from the statistical viewpoint is very favorable. The proportion of inhabitants aged 20-59 in the total population has reached a record level of 59.1% (Table 2). According to the Ministry of Finance the Czech Republic, dynamically, is at the onset of its population ageing process. Due to

gradual reduction of natality and lifestyle changes the proportion of young people will decrease and the number of seniors in the population will increase (Figures 2 and 3) as life expectancy continues to rise.

14. The demographic development can be partially alleviated by migration into the Czech Republic but in the long term we can consider it to be a risk factor for the economic development and for the financial sustainability of the health care system. The government has so far been responding to demographic risks by parametric changes of the system whose effect expires very quickly. The health care system based exclusively on the pay-as-you-go principle needs to be extended to include several stabilizers leading to higher individual responsibility and financial participation of the patient.

Figure 2: Expected structure of population according to main age groups in 2002 - 2050



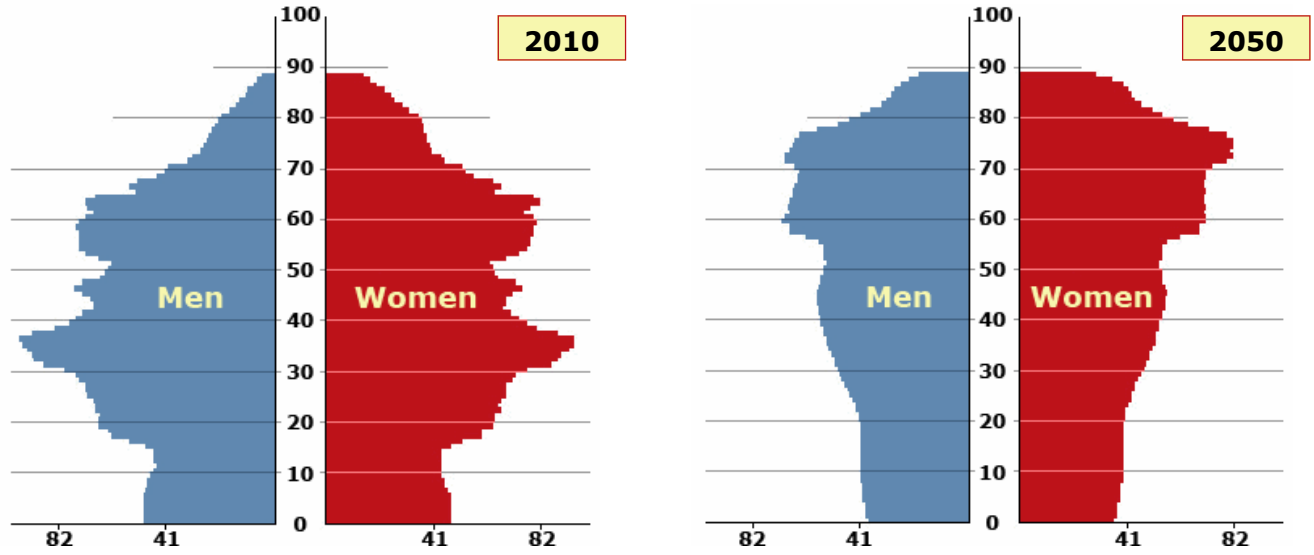
Source: Czech Statistical Office, 2004

Table 2: Demographic Development in the Czech Republic

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Number of inhabitants in thousands of persons										
total	**10,290**	**10,278**	**10,232**	**10,206**	**10,203**	**10,211**	**10,225**	**10,236**	**10,247**	**10,257**
0 – 19	2,485	2,407	2,348	2,296	2,255	2,219	2,176	2,139	2,105	2,073
20 – 59	5,941	5,998	6,003	6,005	6,016	6,022	6,039	6,053	6,035	6,012
60 and above	1,864	1,873	1,882	1,905	1,932	1,971	2,010	2,044	2,106	2,172
Shares of age groups in the whole population (in %)										
0 – 19	24.1	23.4	22.9	22.5	22.1	21.7	21.3	20.9	20.5	20.2
20 – 59	57.7	58.4	58.7	58.8	59.0	59.0	59.1	59.1	58.9	58.6
60 and above	18.1	18.2	18.4	18.7	18.9	19.3	19.7	20.0	20.6	21.2
Mean Life Expectancy in years										
men	71.1	71.4	71.7	72.1	72.1	72.2	72.4	72.5	72.6	72.8
women	78.1	78.1	78.4	78.4	78.5	78.7	78.8	78.9	79.0	79.2

Source: Czech Statistical Office, 2003 and author's calculations

Figure 3: Age tree in 2010 and in 2050



Source: Czech Statistical Office, 2004

4. Health Situation: At the Forefront of the Transforming Economies

15. The health status of Czech population lacks behind the EU countries but is at the forefront of transforming economies. Among European countries Czech Republic shines predominantly in infant and perinatal mortality (Table 3).

16. In comparison with Slovakia the lead of Czech Republic measured by average life expectancy is growing in both genders (Table 4). In 1985 the lead was negligible, in 2002 Czech women live longer by 0,9 years and Czech men even by 2,3 years. Similarly, in infant mortality both countries report massive progresses, the lead of Czech Republic is 3,6 children per thousand newborns (Table 5).

5. Macroeconomic Development, Employment and Wages

5.1 Growth prospects of the economy

17. The growth is likely to be lower in the context of V4, but will pick up later. At the time when this outlook was compiled (December 2004) the Czech economy was the slowest grower in the V4 group. **In the time until 2007 the economy should move along a trajectory of economic growth between 2.8 and 3.5% (gradually accelerating).**

18. According to this scenario the economic level of the Czech Republic (measured as per capita GDP according to purchasing power parity), when compared with EU-15 will increase between 2003 and 2007 by approximately 2 percentage points to 65.5% of the average EU-15 level. The government

Table 3: National health indicators in Europe

Position of the Czech Republic among other European countries	
Excellent	**Poor**
Infant mortality	Natural demographic development
Perinatal mortality	Number of new-borns
New cases of clinically diagnosed AIDS	Cancer mortality between 25 and 64 years of age
New HIV infection cases	Lung cancer mortality between 25 and 64 years of age
	Diabetes prevalence
	Lung cancer – incidence and mortality
	Cervical cancer – incidence and mortality
	Release from hospital for digestive disorders
	Total alcohol consumption

Source: Atlas of Health in Europe, WHO, 2003

Table 4: Average life expectancy

		1985	1990	1995	2000	2002
Men	**Czech Republic**	67.5	67.5	70.0	71.6	72.1
	Slovakia	66.9	66.6	68.4	69.1	69.8
	Lead of Czech Republic	0.6	0.9	1.6	2.5	2.3
Women	**Czech Republic**	74.7	76.1	76.9	78.4	78.5
	Slovakia	74.7	75.1	76.3	77.2	77.6
	Lead of Czech Republic	0.0	1.0	0.6	1.2	0.9

Source: Statistical Office of the SR, Czech Statistical Office, Lawson and Nemec, 2003

Table 5: Infant mortality per 1000 new-borns

	1985	1990	1995	2000	2002
Czech Republic	12.5	10.8	7.7	4.1	4.0
Slovakia	16.3	12.0	11.0	8.6	7.6
Lead of Czech Republic	-3.8	-1.2	-3.3	-4.5	-3.6

Source: Statistical Office of the SR, Czech Statistical Office, Lawson and Nemec, 2003

Table 6: Employment and unemployment in thousands, wages in CZK

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Employment	4937	4866	4764	4732	4750	4765	4733	4685	4671	4674
Employees	4329	4203	4079	4023	4033	4002	3922	3895	3880	3872
Self-employed	607	663	685	708	718	763	811	790	791	802
Unemployment	248	336	454	455	421	374	399	425	421	406
Labor force	5185	5201	5218	5186	5171	5139	5132	5110	5093	5080
Number of inhabitants aged 15 to 64	7091	7114	7139	7166	7192	7183	7214	7255	7290	7313
Proportion of employed aged 15 to 64	69.6	68.4	66.7	66.0	66.0	66.3	65.6	64.6	64.1	63.9
Average monthly wage (salary), nominal	10802	11801	12797	13614	14793	15857	16917	17954	19138	20404

Source: Labor force surveys, 2004 and Czech Statistical Office, 2004

expects that the implementation of the reform of public finance and other reforms can help increase the potential product growth rate (around which the real product growth rate fluctuates) to a level above 3% (the estimate for the first half of 2004 was 2.7%). The risk for an acceleration of potential product growth includes adverse trends on the labor market: the participation rate (i.e. the ratio of total workforce to the number of people of productive age) is falling.

5.2 Employment, income and consumption

19. Decreasing participation rate; stagnating employment. The development of employment and mainly its predominantly structural nature can be considered a possible risk to the future macroeconomic development. The standing rate of creation of new jobs is not sufficient and some rigidity remains on either side of the labor market (low professional, qualification and geographic mobility of the workforce, insufficient creation of new jobs and low motivation to participate in the work process as opposed to relying on social benefits). The outcome is an adverse development of employment and a rising unemployment rate. On the side of demand the stronger economic growth will drive higher employment (but the power of its drive will not be sufficient, judging by the above data, to revert the negative tendencies on the labor market). FDI inflow will only create a limited number of working opportunities because the investments are likely to be directed to activities with a high technological level and labor productivity, but will have indirect positive effects stemming from the possible cooperation with domestic companies. A substantial positive effect could be delivered by the considered reduction of tax burden of labor and the creation of more flexible conditions for concluding employment contracts. On the other hand the continuing process of restructuring will require improvements in labor productivity including further dissolution of inefficient operations. **In the time frame until 2007 some decrease of the participation rate can be expected (but the rate is already quite high at approx. 70%), as well as a decrease of the number of employed. Growth of employment can at best be expected towards the end of this period.**

20. An adverse situation on the labor market contributes to the stability of wage development because any extreme wage demands are eliminated. **Stable growth of average wages at 6.5% (3.5-4.0% in real terms) can be expected.** Compensations of employees (gross wages and deductions) will represent approximately 51.5% of the created added value this year (i.e. 51.5% of the GDP in base prices or 47% of the GDP in market prices – for comparison the EU average is 57% of the GDP in base and 50% of the GDP in market prices). Private consumption, which is one of the decisive indicators of the standard of living, should grow at a rate very close to GDP growth (i.e. between 2.9 and 4.0%). Government spending will stall or decrease slightly in accordance with the consolidation program for public finance.

5.3 Price Level

21. The Czech economy can be described as low-inflation, with the inflation rate remaining predictable and poised for a moderate decrease to 2.5% in 2007. This is the positive effect of the inflation targeting regime which directs inflation expectations of businesses. After a basically inflation-free development in 2003 the inflation rate increased due to administrative measures (adjustment of regulated prices and indirect taxes) but in the following years the contribution of administrative measures to the total inflation should not exceed 1 percentage point. The accelerating economic growth driven, among other elements by the liberalized real currency conditions, could gradually create some demand pres-

sure in the economy which might assume the role of the main factor determining the price development in 2005. Import prices should work against an acceleration of inflation because their upward development will be suppressed by the expected nominal appreciation of the CZK/EUR and CZK/USD exchange rates.

5.4 Public Finance

22. The government is committed to reducing the public finance deficit while simultaneously reducing the share of public revenue and public expenditures in the GDP. At present the Czech Republic runs an excessive deficit of public finance which is a serious obstacle to meeting the convergence criteria. The government adopted a strategy of consolidation of public finance to renew its balance. **In 2006 the deficit should not exceed 4.0% of the GDP and in 2007 the deficit should not be higher than 3.5% of the GDP. This is an ambitious plan given the 2004 deficit, assuming an average annual reduction by 0.7 percentage points.**

23. Consolidation of public finance should progress simultaneously with a reduction of the share of public revenues and public expenditures in GDP (reduction of public expenditures is naturally much more visible). The proportion of social contributions in GDP should increase slightly, from 16.0% to 16.2% of the GDP. The gross government debt in this period will increase from 40.5% to 44.0% of the GDP.

24. The intention of the government is to pursue such rate of public finance consolidation which 'will not slow domestic demand too much and will not threaten the social peace'. Alongside the reduction of the deficit the government proceeded to change the structure of tax revenues and government expenditures with the intention of reinforcing the supply side of the economy and creating a basis for an accelerated potential product growth rate.

25. The two-stage reform of public finance progresses with questionable vigor. In the first stage of the reform emphasis was on halting the deficit tendencies and slowing the growth dynamic of public debt. The measures focused on reinforcing tax revenues and restricting the growth of social transfers and government spending (in the second half of 2003 the parliament was actually passing laws of the first stage of the reform). In 2004 the second stage of the public finance reform was prepared. This stage focuses on promoting economic growth and securing long-term sustainability of public finance development. A 'tax package' was developed in the second stage to drive economic growth. Tax modifications were proposed to promote investment activity, innovations, and to increase motivation to a more active participation in the labor market. These measures will be financed from funds obtained through an adjustment of indirect taxes. A risk factor can be the continuing indecisiveness of the government in implementing the reform of public finance.

Table 7: Overview of estimated basic macroeconomic parameters of the Czech economy

Parameter	2003	2004	2005	2006	*2007*
Growth of real GDP in %	2.9	2.8	3.1	3.3	*3.5*
Growth of real private spending in %	5.4	2.9	3.1	3.4	*3.4*
Growth of the price level in %	0.1	3.1	2.8	2.5	*2.5*
Growth of real wages in %	7.9	3.3	3.7	4.0	*4.0*
Growth of the volume of paid nominal wages in %	5.8	5.6	6.2	6.4	*6.6*
Growth of employment in %	-0.7	-0.8	-0.3	0.0	*0.1*
Employment rate in %	65.6	64.6	64.2	64.0	*63.9*
Participation rate in %	*71.1*	*70.7*	*70.3*	*70.1*	*69.8*
Unemployment rate according labor force surveys in %	7.8	8.5	8.7	8.7	*8.5*
Public sector revenues as % of GDP	41.9	42.4	41.1	40.9	*40.6*
Public expenditures as % of GDP	54.5	47.6	45.8	44.7	*43.9*
Public finance balance as % of GDP	-12.6	-5.2	-4.7	-3.8	*-3.3*
Revenues from social contributions as % of GDP	16.0	16.0	16.1	16.2	*16.2*
Gross government debt as % of GDP	*39.7*	*40.5*	*41.8*	*43.2*	*44.0*

Source: Convergence program of the Czech Republic, EBRD Transition Report 2004.

6. Financing of the System

26. The health care system in the Czech Republic is financed by public health insurance. Health insurance is provided by competing health insurance companies. Their income is derived from contributions by economically active population towards health insurance and by payments of the state for those who are not economically active.

27. Income of the health insurance companies are derived from compulsory contributions whose amount depends on the insurance rate, nominal wages and employment. Health insurance is paid obligatorily by all economically active citizens. The payment of the state on behalf of its insured is deducted from general taxes and its size is set by a political decision every year. Additional income of the system beyond health insurance companies includes capital expenditures of the central government and regional self-government. The financial contribution of patients is one of the lowest in Europe, at 8%.

6.1 Collection and payment of insurance premiums is decentralized to health insurance companies

28. Health insurance is paid by all employees, self-employed, persons without taxable income (PWTI) and the state, on behalf of its insured. The rate of insurance contributions is set at 13.5% of the assessment base. Employers, self-employed and PWTI pay directly to the health insurance company. The state first transfers the amount on behalf of its insured to a special account where the amount is redistributed and the accounts with individual health insurance companies are balanced.

29. For employees with an employment contract the assessment base is the sum of their income from the job. For periods of unpaid leave or unjustified absence from workplace the assessment base is the minimum salary. The general minimum assessment base is the minimum wage, although certain vulnerable groups of persons are exempt from this rule (e.g. the severely disabled and full-time guardians of underage children) and their assessment base is equal to their actual income. This arrangement makes the health insurance linear over the whole range of income. Insurance is paid on behalf of the employee by the employer.

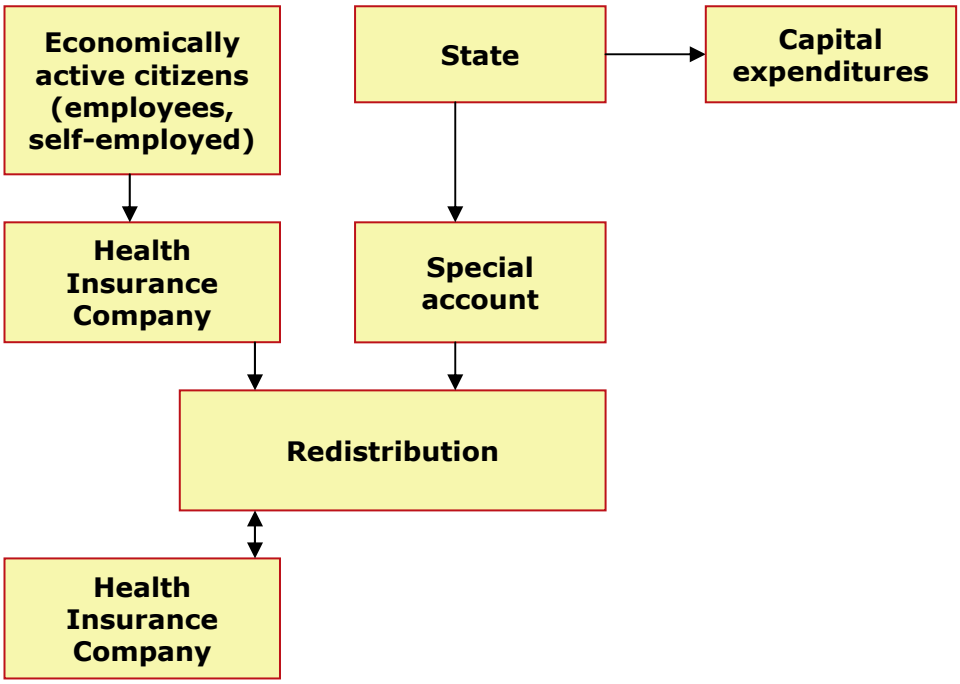
30. The assessment base of self-employed is a percentage of the total income from their business activity. This proportion increases from 35% in 2003 to 50% in 2006. This arrangement was adopted in 2003 and is a parametric response of the government aimed at maintaining economic balance in the system. The minimum assessment base is specified as ½ from 12-times the average monthly salary from a period two years precedent to the current assessment period. Unlike with employees the assessment base of the self-employed is limited by a maximum of CZK 486,000.

Table 8: Economic performance of the health care system in CZK billions

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
RESOURCES	**40.3**	**46.5**	**78.9**	**84.9**	**98.0**	**107.9**	**119.6**	**129.5**	**138.8**	**145.0**	**156.6**	**166.3**
Health insurance corps	**0.0**	**0.0**	**59.0**	**63.5**	**72.2**	**84.4**	**93.6**	**103.5**	**110.8**	**116.2**	**128.5**	**134.4**
Employees			12.6	15.2	17.8	21.0	23.2	25.0	25.9	27.4	30.6	31.8
Employers			25.3	30.4	35.7	42.1	46.5	49.9	50.2	54.9	61.3	63.5
Self-employed			4.1	4.1	4.8	4.4	5.0	5.3	6.5	6.2	7.4	8.3
Unemployed			0.1	0.4	0.6	0.4	0.5	0.5	0.8	0.2	0.2	0.3
State on behalf of ENP			16.9	13.4	13.3	16.4	18.5	22.8	27.4	27.5	29.0	30.6
State budget (except payments for ENP)	**39.0**	**44.4**	**16.1**	**16.0**	**18.4**	**15.2**	**16.1**	**15.4**	**16.8**	**16.8**	**15.4**	**18.7**
Health Ministry chapter	12.9	38.0	6.6	7.7	7.8	6.2	5.6	6.0	5.9	5.6	5.3	6.4
District Offices chapter	0	0	0	0	0	0	0	0	0	0	6.4	7.5
Other budget chapters	0.8	0.8	0.9	1.0	1.4	0.9	0.8	1.5	1.2	1.1	1.2	1.6
General Treasury Management chapter (net of ENP payment)	0.0	0.0	2.2	1.2	1.9	1.6	3.8	2.1	2.5	2.0	0.2	0.5
Subsidy to regional budgets			1.2	1.2	1.5	1.5	2.2	1.7	1.9	1.9	0.1	0.03
Resources of regional budgets	25.3	5.6	5.2	4.9	5.8	5.0	3.7	4.1	5.3	6.2	2.2	2.7
Contribution of citizens	**1.3**	**2.1**	**3.8**	**5.4**	**7.4**	**8.3**	**9.9**	**10.6**	**11.2**	**12.0**	**12.7**	**13.2**
EXPENDITURES	**40.3**	**46.5**	**72.8**	**89.6**	**102.3**	**112.2**	**121.5**	**130.6**	**136.2**	**142.4**	**158.9**	**169.2**
Direct expenditures from the state budget (net)	13.7	38.8	7.5	8.7	9.6	7.2	7.5	7.8	7.7	6.8	13.0	16.0
Expenditures of regional budgets	25.3	5.6	6.4	6.1	7.3	6.5	5.9	5.8	7.2	8.1	2.3	2.7
Expenditures of health insurance companies	0.0	0.0	55.1	69.4	78.0	89.9	97.3	105.8	110.0	115.5	130.9	137.3
Financial coverage to buy claims from ČKA						0.3	0.9	0.6	0.1	0.0	0.0	0.0
Contribution of citizens	1.3	2.1	3.8	5.4	7.4	8.3	9.9	10.6	11.2	12.0	12.7	13.2
SURPLUS/DEFICIT	0.0	0.0	6.1	-4.7	-4.3	-4.3	-1.9	-1.1	2.6	2.6	-2.3	-2.9

Source: Author's calculations based on data from the Czech Finance Ministry, Health Ministry and Institute for Health Information and Statistics
ENP … Economically Non-active Population

Diagram 2: System of collection and redistribution of resources



Source: author

Recommendation 1: *Introduce an upper limit of the monthly assessment base for employees of 5-times the average monthly salary (60 times annually). This will remove the discrimination of the employees to self-employed who have an upper limit (here we can think about the slight increase – 36 times average monthly wage annually - or even equalization of assessment bases with the employed – to 60 times annually). Financially, this will only have a microscopic negative effect on the income of health insurance companies which can easily be compensated by the increased motivation to pay insurance premiums.*

31. The assessment base of persons without taxable income is the minimum wage. These are persons who do not have an income from employment or self-employment and who are also not state-insured.

Recommendation 2: *Introduce a system of annual settlement for every payer of the health insurance. This must be supported by a specification of an advance payments system with introduction of annual settlement of health insurance premiums paid on the basis of tax settlement. This would lead to lower number of non-payers and to very transparent system of contributions and their settlements.*

32. At present the state is paying insurance on behalf of 5.8 million persons, 56% of the population of the Czech Republic. Payment of insurance is not linked to specific individual but has the form of a collective transfer at the same level of the public finances for the number of people according to the reports of the health insurance companies. In 2004 the assessment base of those insured by state was set to CZK 3,250. From January 1, 2004 the assessment base is stipulated by a government resolution. According to the law its valorization will need to take into account inflation and the performance of the public health insurance. The assessment base for the next calendar year will be published by the government by June 30 while observing the rule that the assessment base may not be lower than the base valid for the previous year. The payment of the state on behalf of one insured will therefore reach 13.5% of CZK 3,250, hence CZK 439 per month in 2004, and will increase by CPI inflation (1%) in 2005 to CZK 445.

33. Stipulating the assessment base by a sub-law legal standard is an unacceptable risk for financial sustainability of the system. Firstly, it is easy to manipulate, cannot be easily predicted and does not permit the health insurance companies to set up health insurance plans. Secondly, it is a purely political decision with no link to the real economy.

Recommendation 3: *Introduce representative payment. Representative payment individualizes financial resources paid by the state on behalf of its insured persons. The purpose of its introduction is to reduce political impact on the resources contributed*

Table 9: Summary of the payment of contributions in the Czech Republic

Insured	Payer	Insurance rate, %	Assessment base	Minimum assessment base	Maximum assessment base
Employee	Employer	13.5	Wage	Minimum wage	Not existing
Self-employed	Self-employed	13.5	Until December 31, 2003 this was 35% from the business income less deductible costs. In 2004 – 40 % In 2005 – 45 % From 2006 – 50 %	50 % of 12-times the average monthly wage	CZK 486,000 (approx. 27-times the average monthly wage)
Persons without taxable income - PWTI	PWTI	13.5	Minimum wage		
15 groups of citizens (pensioners, children, ...)	State	13.5	Amount specified in a decree		

Source: Author based on current legislation

from the state budget into the health care system and to increase the predictability of resources for health insurance companies as a basis for their insurance plans.

The second reason in addition to the stability of the health care system in the public finance area is the accession of the Czech Republic to the EU and the corresponding mobility of patients and changes in health insurance which require a new system of insurance holder registration. Council Regulation (EEC) No. 1408/71 specifies that dependent family members of a Czech worker or a Czech pensioner residing in a different member state will be covered by the health insurance of their guardian, i.e. by the foreign healthcare system. In contrary, dependent family members of a foreign worker or a foreign pensioner (other member states) with residence in Czech Republic will be covered by the health insurance of their guardian, i.e. by the Czech healthcare system. Due to this reason it is necessary to design a system of identification of these persons and the corresponding financial coverage.

While respecting the rule of fiscal neutrality (i.e. no negative impact on the deficit of the public finance) we suggest the following procedure for the introduction of the representative payment in the conditions of the Czech Republic:

1. *Specify a neutral parameter to which the representative payment could be linked. We recommend the average wage in the national economy two years prior to the current calendar year.*
2. *Specify the group of persons on behalf of whom the state would be paying the premiums. This is a clear definition of the representative payment of the state as opposed to the current method of state payments. While now the state is paying for all persons specified by the law, when the representative payment is introduced, it will only pay insurance on behalf of three groups of persons (pensioners, unemployed, women on maternity leave). Other groups will continue to be insured but the state will not be paying on their behalf to the system directly.*
3. *Specify the percentage rate linked to average wage. This is related to the reduction of the number of persons paid for by the state.*

After the introduction of the representative payment three effects can be foreseen:

1. *At the time of introduction there is no fiscal impact. In the short term the representative payment does not increase the volume of resources, but lays a foundation for different 'rules of the game' in the future, banning arbitrary allocation of resources earmarked for public health insurance.*
2. *Simpler administration. The principle of representative payment would, according to the Czech Ministry of Finance, substantially simplify the application of European law with respect to collection of insurance premiums and determination of the responsible Czech health insurance company for the purposes of the EU directive.*
3. *Transparency. Representative payment is suitable as a new form of the relationship between the state budget and the public health insurance system within public finances.*

The transition to the representative payment system is not entirely risk-free. It demands a substantial modification of the legal regulations governing public health insurance which are within the field of responsibility of the Czech Ministry of Health. It is this ministry which actually has not made up its mind yet on the issue of representative payment and its inclusion in the new health care reform is still an open issue.

6.2 The new redistribution system of insurance premiums reinforces the financial stability of the General health insurance company

34. The special account of general health insurance is established according to law by the General health insurance company (Všeobecní zdravotní pojišťovna). Supervision is executed by a supervisory body which includes representatives of the Czech Ministry of Finance, Ministry of Health, Ministry of Labor and Social Affairs, General Health Insurance Company and other health insurance companies. Until now the premiums have been redistributed as follows:

1. The respective health insurance companies reported to the account administrator the numbers of their insured aged up to 60 and those aged above 60 on whose behalf the insurance is paid by the state
2. Health insurance companies reported to the account administrator 60% of the collected premiums
3. The account administrator announced the total amount for all companies
4. The total amount for one health insurance company is obtained by adding up the shares for each of its insurance holders paid for by the state, with one share for insured up to 60 years of age and three shares for those aged above 60.
5. One share was calculated as a share in the sum of the 60% of premiums collected by all insurance companies, the total payment by the state for all state insured and the number of all state insured, so that every insured aged more than 60 was counted three times.
6. The balances (surpluses and deficits) were cleared by the health insurance companies as the difference between the sum after redistribution and 60% of collected premiums to the special account, and not among themselves.

35. The past redistribution system was not optimal and contained several risks. Firstly, the cost risk index for persons aged above 60 was substantially higher than 3-times the cost risk index for persons aged below 60. Secondly, the claims and liabilities are anonymous to the special account and not particular to an insurance company. Additionally, the special redistribution account is not a legal entity and hence the claims and liabilities are practically unenforceable. This would mean a potential risk in case of insolvency or bankruptcy of any health insurance company to the other companies which would need to pay for the liabilities of the defunct insurance company. Thirdly, the redistribution of 60% of collected premiums does not sufficiently cover the distribution of risk in the population. Fourthly, the definition of collected premiums is difficult because only collected, not prescribed insurance premiums entered the redistribution.

36. The government responded to these shortcomings by changing the parameters of redistribution according to the following rules. All of collected premiums enter the redistribution, as do 100% of the state's payments. To redistribute, the risk index is used based on 5-year age groups divided by gender and combined with partial compensation for costly health care, which is defined as annual costs per insured higher than 30 times the average costs per insured in last closed calendar year (approx CZK 450,000 per insured). Approximately 5% of all resources are allocated for this compensation (CZK 7.5 billion). The insurance companies obtain 80% of the amount exceeding the limit for costly health care.

37. This new redistribution system may not be motivating because it redistributes the whole amount of collected premiums – this can have a negative impact on the success-rate of premiums collection. It also provides additional strength to the financial stability of the General Health Insurance Company (VZP) by 2.3 % of total health care resources (Table 10), which allows VZP to achieve

Table 10: Parameters of representative payment introduction

	Current System	Recommendations
On behalf of who?	A total of 15 groups defined by law (the most numerous group being pensioners, dependent children aged up to 26 years, beneficiaries of welfare benefits). Approx. 5.7 million inhabitants	Pensioners Unemployed Women on maternity leave Approx. 3.5 million inhabitants
How much?	13.5 % of the assessment base determined by the government in a decree	Linking a defined percentage to a real economy parameter free of political interference (e.g. 8% of average wage)
How?	To the redistribution account	Directly to health insurance companies

Source: author

Table 11: Redistribution model for income of health insurance companies with 60% and 100% redistribution (calculations based on 2002 data)

Health insurance company	Income after 60%-redistribution	Income after 100%-redistribution	Difference	Difference as % of income
VZP	94 912 877	97 082 854	2 169 977	2,29 %
VoZP	6 998 411	6 673 893	-324 518	-4,64 %
HZP	3 922 835	3 842 654	-80 181	-2,04 %
OZP	6 071 495	5 065 488	-1 006 007	-16,57 %
ZP ŠKODA	1 560 068	1 469 115	-90 953	-5,83 %
ZPMV	10 959 814	10 503 458	-456 356	-4,16 %
RBP	3 264 468	3 138 002	-126 466	-3,87 %
M-A	3 037 287	2 980 337	-56 950	-1,88 %
ČNZP.	3 593 785	3 565 239	-28 546	-0,79 %
Total	134 321 040	134 321 040	0	0,00 %

Source: Health Insurance Year-book, 2004

a balanced performance. Due to the fact that the modification of redistribution parameters does not increase the volume of resources, only their structure, the performance of the system would not change. The new redistribution will not have any impact on the volume of resources, only their distribution towards greater risks.

Recommendation 4: *Modify the system of financial flows. We recommend changing the current system of financial flows of state funds to the special account to a system of direct payments to health insurance companies. Subsequently, the special redistribution account needs to be abolished and a balancing matrix with clearly defined redistribution criteria needs to be introduced, defining unambiguous claim-liability relations directly between the competing Health Insurance Companies.*

Recommendation 5: *Introduce redistribution of prescribed premiums instead of collected premiums and significantly reinforce claim management.*

Recommendation 6: *Introduce supervision of redistribution without the redistribution account been present, because the redistribution account administered by the General HIC is not an independent legal entity. This step requires that a new and independent health insurance regulator is established.*

Table 12: Structure of private health care expenditures between 1998 and 2002 in CZK millions

Type of expenditure/year	1998	1999[1)]	2000[1)]	2001[1)]	2002[1)]
Drugs and medical aids	**7 392**	**8 452**	**9 337**	**10 740**	**11 251**
- drugs prescribed by a practitioner	1 205	1 686	2 137	2 788	2 917
- non-prescription drugs and other medications	4 839	4 679	4 808	5 308	5 702
- medical and prosthetic aids	1 338	1 810	2 126	2 356	2 356
- other medical products		278	277	278	275
Out-patient health care	**2 800**	**2 447**	**2 435**	**2 531**	**2 560**
- out-patient practitioner care		648	616	597	612
- out-patient dental care	1 060	1 563	1 520	1 615	1 724
- other out-patient care		237	298	319	224
In-patient health care	**422**	**617**	**473**	**442**	**632**
Total:	**10 604**	**11 516**	**12 245**	**13 711**	**14 443**

1) In 1999-2000 there were methodical changes and changes to the content of the items, or some of the items were broken down into more detail and are hence not comparable in time. The only fully comparable items are those printed in ***bold.***
Source: Economic information in health care in 2000, 2001 and 2002, ÚZIS of the Czech Republic, Czech Statistical Office.

6.3 Out of pocket payments of the patients

38. Direct financial contribution is one of the lowest among OECD countries. OECD countries spend on average 8.4% of their GDPs (OECD, 2003a) on health care, of which 72% constitute public expenditures. In 2002, Czech health care expenditure reached 7.0% of the GDP with out-of pocket payments below CZK 15 billion (Table 11) which counts for 8% of total health expenditures.

Recommendation 7: *Introduce user fees similar to the Slovak (SKK 20 for doctor's visit, SKK 20 for prescription, SKK 50 for hospitalization day) and Croatian (HRK 10 for doctor's visit, HRK 10 for prescription, HRK 5 for transport) example to reduce redundant demand and educate people that health care is a good with certain value and should not be misused. In Slovakia and Croatia the implementation of user fees had positive effects in three ways:*

1. *the redundant demand decreased,*
2. *the perception of corruption decreased,*
3. *the access to care was not harmed,*
4. *people attribute value to health services.*

6.4 Capital Expenditures

39. The Capital expenditures in amount of CZK 20 billion flow through two main channels. First, directly form the state budget (approx CZK 10 billion) to state owned and run institutions and facilities. Second, from the municipal budgets to their hospitals (approx CZK 10 billion), which are mainly fuelled by the state budget.

Recommendation 8: *The abolition of capital expenditures on the level of the Czech Health Ministry and transfer of all those funds from the Health Ministry chapter to the budget of health insurance companies. This will require the inclusion of amortization in the price of health care (value of the points and performances), which can have some leverage effect and will reduce the price of acquired assets. The capital expenditures (approximately CZK 20 billion) will be transferred to the health insurance companies through the increase of the representative payment defined as a percentage of the average wage.*

6.5 Response to Demographics – Individual Accounts

40. The Czech Republic needs to respond to the negative demographic forecasts by changing the paradigm of the health care system, not just by making parametric modifications. One of innovative possibilities is the introduction of individual accounts.

Recommendation 9: *Introduce individual accounts. The introduction of individual accounts is of long-term and fundamental importance as it responds to demographic trends and increasing costs of health care. Its introduction can have the form of either of the following alternatives:*

1. ***The saving alternative.*** *Introduction of the saving element in order to spread the contribution over time. The individual account would only receive funds set aside voluntarily by the patient/insured. These savings would be used when necessary.*
2. ***The decision-making model.*** *In this alternative the individual account is used to accumulate funds from personal deposits and savings of the patient, but also a bonus from public resources based on the risk index-derived redistribution. In this case the individual account becomes a decision-supporting tool when purchasing health care, with the insured deciding about the purchase of his/her health care plan.*

The proposal to individualize public resources in connection with the extent of compulsory insurance and costs born by the personal medical account was made by Macháček, Hroboň and Julínek. Their proposal is a decision-making model which attempts to make a paradigmatic response to the adverse demographic forecast in the Czech Republic. The M-H-J draft is based on the following basic principles:

1. *public resources collected in accordance with the tax obligations and used to finance medical services are individualized and used to subsidy individual participants of the system on the market of health insurance companies and medical services;*
2. *the system is a combination of compulsory health insurance and supplementary health insurance or health savings, or direct payments from personal medical accounts of individuals, according to the decisions of the participants;*
3. *there is only one market for health insurance and one market for medical services, managed by the preferences of individuals.*

7. Payment Mechanisms

41. In the Czech health care system the price does not fulfill its allocation role, and is not a measure of relative scarcity. The whole price-setting process is delegated to non-functional "negotiation process" (dohodovacie konanie) which governs in-patient care (acute and long-term), primary and secondary out-patient care, diagnostics, standard transport, emergency transport, home care, spas and dental care. One-day medicine is not governed specifically. On the other hand, the passivity of

the Czech Health Ministry and the negotiation process led to the formation of a platform for the use of the DRG system.

42. The negotiation process was initially intended to set only the basic value of a point in the catalogue of treatments but in its present form it provides for (1) prices, (2) the payment mechanism and (3) regulation. The negotiation process includes health insurance companies and associations of providers (e.g. the association of small hospitals, the association of large hospitals). Observers may include representatives of patients and the Ministry of Health. While health insurance companies may, in some cases, take a united stance, the providers are usually non-uniform. Moreover, each of the participating parties has a veto right and any agreements are therefore reached with great difficulty.

43. The last successful and complete agreement in the negotiation process was achieved in 1999. The negotiations usually result in partial agreements only: by segments or bilateral agreements. The negotiation process ties up administrative capacities of both sides, is exhausting and fails to move things forward. In case of a failure to reach agreement there are two possible outcomes. Either the parties continue to apply the terms agreed on the previous occasion or the ministry intervenes by a regulation or government decree whereby it assumes the role of an arbiter.

Recommendation 10: *Abolish the negotiation process. It is desirable that the Ministry of Health stops intervening in the negotiation process and that the process itself is discontinued. This can be achieved in two ways: by immediate cancellation or gradual reduction of the scope and depth of the current negotiation process. If the process is to have any sense, it should only be used to agree the BASE RATE of the point price and the BASE RATE for DRG. The process must also contain a clause making it the universal solution in case that there is no individual agreement among the parties.*

7.1 Out-patient Care

44. The primary sector includes the general practitioners for children and the general practitioners for adults. They are remunerated by capitation payments. The minimum value of capitation is agreed in the negotiation process. For 2004 it was determined to be at least CZK 33 per patient, with further standardization according to the patient's age. The practitioners have a prescribed maximum number of 2400 patients. The capitation forms approximately 70% of the practitioner's income while the rest is obtained for services from the catalog and payments for preventive services.

45. Specialists in the Czech Republic include dentists and gynecologists. These are remunerated by a catalog-based performance system with an upper limit. Limits for specialists have two forms – the volume of historic UTPs (the practitioner works against his/her own limit); or the performance of other practitioners of the same specialization, as per UTP (the practitioner works against a competitive limit). Primary and secondary care both have drugs limits which, per UTP and per year, may not grow by more than 5 to 7% above the historic limit. Dentists are limited by maximum prices specified by the health insurance companies. UTP is a uniquely treated patient, e.g. a patient insured that visits a provider at least once in the given calendar half year.

46. The catalog is a separate story – it has two functions. Firstly, it is a catalog of all medical services and secondly it sets the relative weight of the services by assigning point values to them. The formation and adjustment of the catalog led to many distortions against reality. As clear from few cost studies, the unit cost of one point (the expend costs used for gaining one point) among specifications varies between CZK 0.50 – 2.00, while the actual price of the point reimbursed by the insurance companies varies between CZK 0.89 – 1.04. Many providers keep their equipment at old prices, while the real prices of equipment sunk in that period by 50 – 70%. The General health insurance company proposes that the catalog should be a purely technical standard where the points as relative weights are not subject to the negotiation process. According to this proposal the negotiation process should only determine the price of the one point which is to be published later by the ministry.

Recommendation 11: *The catalog should be removed from the negotiation process and retained as a technical standard stipulating the relative scarcity (weight) of services.*

47. One-day surgery is included in out-patient care but is probably insufficiently defined and regulated.

48. Emergency service Ambulance operation is paid on a performance basis.

49. Laboratories. Laboratories are paid by a mixture of fixed amounts for UTPs and payments per service. The price is agreed jointly but there are individual exceptions.

Recommendation 12: *We recommend to remove laboratory services from the negotiation process with health insurance companies and to gradually transfer them to real fund holding (with hospitals) and virtual fund holding (with doctors).*

7.2. In-patient care and the story of DRG in the Czech Republic

50. Along with the introduction of health insurance new payment mechanisms began to evolve in the Czech Republic. Between 1993 and 1996 in-patient facilities were compensated on a fee-for-service basis. Until 1995 the value of the point was floating and set retroactively while after 1996 it was determined progressively. In 1997 budget-based payment was introduced on the basis of historical revenues, which was not reduced, if the hospital produced at least 80% of the historically set budget. This administrative mechanism caused a temporary stabilization of the system but was not accompanied by further development impulses. In the mid-90's the General health insurance company launched a pilot experiment for testing the DRG system in 40 hospitals. Due to lacking support of the health policy makers, however, the project was halted.

51. After that, until 2000, the hospitals were budget-paid. In 2000 a new system of payments based on the 'Uniquely Treated Patient' (UTP) was introduced. This system is based on the 'birth certificate numbers' and tests the presence of a patient in an in-patient facility according to these unique birth certificate numbers once every 6 months, irrespective of the length and cause of hospitalization. The payment system also incorporates the standard point based catalogue used in the out-patient sector. The result is a flat-rate payment for UTP per type of hospital. Due to these reasons it is possible that even hospitals of a similar type receive a different flat rate for UTP. The district hospitals receive CZK 10,000 to 15,000 per UTP while university hospitals receive between CZK 25,000 and 30,000.

52. In the meantime the institute of the negotiation process is being used more frequently and at a higher level of contractual freedom it permits the creation of other forms of reimbursements to hospitals. If the health insurance company and the hospital agree beyond the framework of the negotiation process, they may bilaterally specify a different manner of reimbursement than the flat-rate payment for UTP. And so, between 2000 and 2003 some hospitals were paid by the regulated point-based system (catalog) while some had a prospective budget and some others, after agreement with the health insurance companies, adopted an innovated DRG system.

53. The next draft of an updated DRG system (weights, grouper, coding rules and base price) was eventually developed by the National Reference Center (NRC) at the Institute for Postgraduate Medical Studies (IPVZ) with close cooperation with health insurance companies. Their proposal which would have been instituted by a payment regulation in 2003 was, however, stopped by the legislative council of the government. The DRG system was only introduced as an option for bilateral agreement between health insurance companies and hospitals.

54. Due to the argument of the university hospitals that they would be financially discriminated by the introduction of the DRG system, DRG only operates on the basis of the negotiation process between the health insurance companies and small hospitals, or, in exceptional cases, some larger hospitals.

Recommendation 13: *Finance tuition using a specific financial channel. We understand the argument of the university hospitals, since they would need to include in the DRG price their costs related to training. We therefore propose that the tuition costs are paid by a different channel, e.g. from the budget chapter of the Ministry of Education by ordering tuition at hospitals so that the health care system would not bear the costs of teaching. This will enable easier acceptance of the DRG system by the university hospitals. The system of negotiation using vouchers per single medicine student will also support competition in pre-gradual medical training.*

55. The DRG system is currently used by 70 hospitals out of 200 while in the first half-year of 2004 approx 95% of the resources were distributed in the form of budgets and only 5% in the DRG system. In the second half-year this ratio changed to 90:10.

Recommendation 14: *Introduce fully-functioning DRG by 2007. Nowadays, the General health insurance company (VZP) is using four different payment mechanisms for reimbursing in-patient health care providers. We strongly recommend VZP and the other health insurance companies to deploy the DRG system jointly and with the following schedule. In 2005 the proportion of payments using DRG should be increased to 15%, with a target of 25% in 2006. This proportion would be a critical mass of funds transferred through DRG. From January 1, 2007 we recommend a gradual transition to full payments via DRG, which can be organized via regulated payments per case or via budget set on real production of hospital quantified by DRG with respect to volume and price adjustment negotiated between the given hospital and the given health insurance company.*

56. The passive attitude of the Czech Health Ministry means that health insurance companies and the Ministry of Finance become the real developers of the health care policy.

8. Regulation

8.1 According to the Ministry of Health the structure of the network is stabilized. We believe it is rigid.

57. The out-patient sector is characterized by a high proportion of private ownership. It includes 28,500 practitioners and 55,000 paramedical staff.

58. The network of in-patient facilities includes 201 hospitals, 169 specialist treatment institutes and 68 spa facilities. Per thousand inhabitants there are 6.53 hospital beds, 2.29 beds in specialist treatment institutes and 2.26 beds in spa facilities. The excess of capacity is a result of the high number of facilities and over-employment.

59. The number of pharmacies and medical dispensing stations is increasing. In 2002 there were 2,188 registered pharmacies and 229 medical dispensing stations. There is one pharmacy per 4,660 inhabitants. Every citizen uses 9 prescriptions per year, on average.

8.2 The sector suffers from over-employment

60. There are a total of 236,978 persons employed in the sector and this figure has remained largely unchanged for several years. Doctors of medicine account for 21.2%, pharmacists for 2.7%, paramedical staff with secondary education for 59.4%, lower medical personnel for 3.8% and general medical staff for 9.5%.

8.3 Drugs and medical aids

61. Before being introduced to the market drugs need to obtain registration (SUKL). Subsequently the Ministry of Finance specifies their maximum price. The producer and distributor may not exceed this price. Usually the maximum price is substantially higher than the actual price. The pricing policy of producers and distributors is based on the specification of health insurance coverage of the price. The Ministry of Finance only has a symbolic impact on the maximum prices because it has no tools to verify the justifiability of the costs specified in the applications of pharmaceutical producers and distributors. Paradoxically, the Ministry of Finance can exert the greatest pressure on domestic drug producers, who, however, are not the most expensive.

62. The amount paid from the health insurance is specified by the Ministry of Health after a deliberation in the classification committee. The classification committee consists of representatives of health insurance companies, professional medical associations, the Ministry of Health, patient organizations and the medical chamber. Doctors of medicine form a majority on the committee. The conclusion of the committee is not definitive and can be overruled by the minister – this is an obstacle to transparency.

63. Specification of health insurance coverage must respect the law (Act 48/1997) which lists all anatomical, therapeutic and chemical (ATC) groups. In each ATC group at least one medicament must be fully covered by health insurance. The principle of determining the payments is based on reference payments for a cluster of drugs but this rule is not applied without exceptions. The rules for specifying a reference payment are not determined. The payments are set in relation to the maximum approved prices. Producers/ distributors are therefore not exposed to competitive pressures lowering the prices which would otherwise ensure that the payments from health insurance could be lowered. Their main concern is to have a sufficiently high maximum price approved and even if the determined insurance coverage payment does not cover the full maximum price, the market price of the product is usually fully covered.

Table 13: Bed capacities of the Czech health care system in 2002

Type of in-patient facility	Number of beds	Number of beds per 1000 inhabitants
Hospitals	66,668	6,5
Long-term treatment centers	7,458	0,7
Hospices	171	0,0
Spas	22,972	2,2
Other	15,743	1,5
Total	**113,012**	**11,0**

Source: Czech Ministry of Health

Recommendation 15: *Abolish maximum prices for drugs which undergo the classification process. This is a self-sustaining and administratively burdensome procedure.*

Recommendation 16: *Institutionalize the market response of producers – link the determination of payments to real prices of drugs. Enable competition when specifying reference payments by a public tender. In case of a greater reduction of price enable faster access to market (pertains mainly to generics). The amount of payment should be specified as a relative proportion in the price of the drug, not an absolute amount. Set transparent and clear criteria for determining size of insurance coverage.*

64. Pharmacies operate on contracts so health insurance companies have access to them under their supervision activities. The pharmacies also maintain a register of quantities of drugs, reducing the risk of mishandling and fraud. The burden of margins (distributor + pharmacy = 29%) on the drug chain is high and, especially in case of the more expensive drugs, unjustified.

Recommendation 17: *Introduce some form of degressive margin.*

65. Medical aids are of two types – aids provided to the patient on prescription and separately billed material (SBM) used in hospital treatment. The VZP insurance company manages a list of medical aids and specifies the maximum insurance coverage which is either 100% or 75% of the 'materially regulated price' set by the Ministry of Finance. This payment needs to be increased by a margin of 8 to 12%. In case of SBM these aids are purchased by the hospital and the health insurance company has no information on the actual purchase price. The hospital claims the maximum price from the insurance company and keeps the difference (20 to 30%).

Recommendation 18: *Introduce a classification of medical aids on prescription similar to the classification of drugs. The price of the basic functional type of a medical aid would be a reference price, forming the basis for insurance coverage of extended functional types of the aid. The best way of procuring SBM is in bulk, by the health insurance company in a tender – this will tighten control over the price and quality of the aids provided to the insured.*

9. Organization

9.1 Providers

66. Entry to the market of providers is only possible with a license issued by the appropriate chamber. The license is fully claimable when all conditions are met. There are no proofs of abuse of this authority, although with pharmacies there is a suspicion that the chamber restricts access to the market and is reluctant to issue licenses to chains, preferring owners-pharmacists. The license lays requirements on the professional level and education. The second step needed before entering the market is a license from the regional authority. This license assesses the structural and technical conditions for operating a medical facility.

9.2 Selection procedures

67. Entry to the market does not automatically guarantee that a contract with a health insurance company can be concluded. Such contract must be requested by the applicant provider in an administrative selection procedure. Although the tender is not legally required, health insurance companies would not risk concluding a contract with any entity without selection. The tenders are announced by the administrative selection committee consisting of four members. One is a representative of the health insurance companies, the second a representative of the chamber; third a representative of a professional association and the fourth represents the regional authority. The decision to conclude a contract with requires at least a 3:1 majority. The criteria for selection include the saturation and quality of the network. The process itself is not managed or supervised.

68. The result of this set-up of the system and process of the administrative selection procedure is the fact that a health insurance company may not be permitted to conclude a contract with someone it chooses (e.g. because that entity has not passed the administrative selection), but on the other hand might be under a strong pressure to sing a contract with an entity it may not want (because in the selection committee it would be overruled by the other three members). Selective procurement of health care by the health insurance companies on the basis of clearly defined criteria is not possible in the current situation in the Czech Republic. Moreover, all providers in the network have contracts for 5 years, with little risk of premature termination.

Table 14: Hospitals have a very unusual structure and ownership

Hospital type	Owner / Founder	Legal Form	Note
University hospitals	Ministry of Health	budget-contribution organizations	
Former district and regional hospitals	Most owned by regions	2/3 budget-contribution 1/3 commercial corporations (joint stock companies, limited companies)	The region "emptied" the budget-contribution organization The state covered debt liability (CZK 4 billion) Ownership transferred to region Region established commercial company Real estate owned by region Hospitals operated by newly established Commercial Corporations owned by region. There is no evidence that the regions would sell these corporations
Private, municipal and church hospitals	Private owner	Commercial corporations (joint stock companies, limited companies)	

Source: author

Recommendation 19: *Immediately abolish the system of administrative selection procedures. Introduce selective procurement of health care by health insurance companies on the basis of clearly defined criteria (structure – process – result) with a tendency towards creating a normative minimum network as a notion of a minimum segment for actual availability of health care.*

In primary care, ensure free access to market and free selection of practitioners by patients. With the system of capitation as a dominant payment mechanism this does not mean an additional financial risk for health insurance companies.

In secondary care, ensure selective choice of providers by health insurance company on the basis of criteria and while respecting the regulatory function of the minimal network. If the patient selected a different provider than the one chosen by the health insurance company then he/she would receive such financial coverage which the health insurance company would be obliged to pay to its contractual provider.

69. The principle of passive district is applied when selecting the practitioner. The patient may actively choose any practitioner, but is not automatically accepted. This does not apply if the patient visits a practitioner in his/her own district.

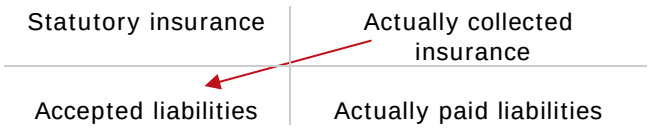
9.3 Ownership, legal form and providers

70. More than 95% of all providers in out-patient care are private, in primary as well as in secondary health care.

Recommendation 20: *Change the legal form of hospitals to joint-stock companies owned by the state. The change of legal form will guarantee equalization of chances between state and private providers, the hospitals will have standard accounting, transparent governing bodies, will operate under hard budgetary constraints and will be forced to higher economic efficiency. They will have to act more as customer-oriented organizations with increased quality of services. Critically important is the implementation of principles of the corporate governance.*

9.4 Ownership and legal form of health insurance companies

71. Health insurance companies are public corporations. Their operation makes use of a special mix of cash and accrual principles. The health insurance company either books statutory premiums against accepted liabilities to providers or collected premiums against actually paid liabilities in terms of cash flow. The realistic view on the financial soundness of the company is afforded by a comparison of collected insurance premiums against accepted liabilities to providers – this indicates the real balance of the system. Using this calculation the deficit of VZP would be CZK 2.5 to 3.0 billion per year.



72. The cumulative debt of health insurance companies reached approximately CZK 10 billion, and the government uses the sale of receivables of health insurance companies to the Czech Consolidation Agency (ČKA) as a hidden form of bailing out. The latest such transaction was worth CZK 5 billion. Statutory insurance premium (reported premiums to be collected) is a virtual notion because failure to collect it does not lead to any penalization of the health insurance companies. Receivables on health insurance premiums (the difference between the reported and collected premiums) are not classified. They are not transferred between years. Their quality is not assessed.

73. Poor Corporate Governance in health insurance companies.

Recommendation 21: *Transform health insurance companies from public funds into joint stock companies. Health insurance companies as joint stock companies must operate under legal rules of business environment (business code), which are much more detailed and standard than current legislation on public funds. As joint stock companies they will have transparent ownership relations, standard governing bodies, standard accounting, mandatory external audit and they will have to meet strict solvency criteria. Over them there will be regulatory body monitoring and supervising all their activities.*

9.5 Supervision of health insurance

74. The health insurance plans of all health insurance companies are approved by the parliament. The deputies of the parliament may review and comment on the plans or reject them. The importance and application of the plans is, however, inconsistent because the health insurance plans of insurance companies for 2004 were only approved by the parliament in December 2004. Their performance is not realistic because legally, they need to be balanced, although in reality they seldom are. The annual reports of health insurance companies are again formally approved by the parliament.

75. The health insurance companies report their quarterly results to the Ministry of Health and the Ministry of Finance using prescribed tables, but without a clearly defined methodology. The supervision of health insurance companies is the responsibility of no less than three institutions: the Ministry of Finance (controlling department); the Ministry of Health (controlling department) and the Supreme Audit Authority. The MoH and MoF have the authority to pass decisions concerning receivership. There is no solvency control as a basis of an early warning system.

76. Entering the insurance market. The General health insurance company (VZP) is established "sui generic" – by the law. A condition of entry for another insurance company is the acquisition of a license and 100,000 policyholders. The license is not claimable.

77. Exiting the insurance market. After bankruptcy and liquidation it is not specified who accepts the receivables and the liabilities. Another way of exiting the market is a merger with another health insurance company. The third possibility is voluntary exit. The transfer of the insurance portfolio is not specifically provided for.

78. Health insurance companies have accounts in commercial banks. Their management is fund-based:

1. Basic fund – expenditures for health care
2. Prevention fund – up to 0.3% of the basic fund for VZP, for all others this includes all income from penalties and income from supplementary insurance
3. Administration fund – 3.5 % for VZP, administration fund size increases up to 4.0% with a declining number of insured. For 2005, these limits are set as 3.3% and 3.8% respectively.

Recommendation 22: *Improve the quality of supervision of health insurance companies – stricter financial control, especially due to the changes in the redistribution system. We recommend to establish a special institution which will supervise the health insurance companies and in case of law-evasion the authority may impose fines, obligation to prepare recovery plan or may impose forced administration.*

10. Conclusion

79. In "wait and see" scenario the health system will produce a deficit approx CZK 3.4 and 3.9 billions annually. Calculating also the bailing out, it increases to CZK 10.4 – 10.9 billions (Table 14). According to ESA 95 methodology, the health care system will add approx 0.35% GDP deficit to the estimated public finances deficit calculated in the Convergence program.

80. The prognosis of the revenues of Health Insurance Companies in 2003 – 2006 are modeled by a multiple linear regression model, which describes the relationship between the sources of the HIC from insurance premiums (CZK) and 2 independent variables of the real economy - average wage and employment (Table 15). The equation of the fitted model is:

Sources (in CZK) = -73257.1 + 6.45977*wage + 15.7295*employment

Table 15: The fiscal position of the health system in CZK billions

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004p	2005p	2006p
SOURCES	**40,3**	**46,5**	**78,9**	**84,9**	**98,0**	**107,9**	**119,6**	**129,5**	**138,8**	**145,0**	**156,6**	**166,3**	**190,4**	**188,7**	**198,8**	**210,5**
Health Insurance Companies	**0,0**	**0,0**	**59,0**	**63,5**	**72,2**	**84,4**	**93,6**	**103,5**	**110,8**	**116,2**	**128,5**	**134,4**	**145,8**	**150,1**	**158,1**	**167,4**
Employees			12,6	15,2	17,8	21,0	23,2	25,0	25,9	27,4	30,6	31,8	34,2	36,1	38,4	40,9
Employers			25,3	30,4	35,7	42,1	46,5	49,9	50,2	54,9	61,3	63,5	67,4	71,0	75,5	80,6
Self-employed			4,1	4,1	4,8	4,4	5,0	5,3	6,5	6,2	7,4	8,3	8,8	9,3	9,9	10,6
Unemployed			0,1	0,4	0,6	0,4	0,5	0,5	0,8	0,2	0,2	0,3	0,3	0,3	0,3	0,3
State for econom. non active			16,9	13,4	13,3	16,4	18,5	22,8	27,4	27,5	29,0	30,6	32,3	33,4	34,0	35,0
State budget (without state transfer to HIC)	**39,0**	**44,4**	**16,1**	**16,0**	**18,4**	**15,2**	**16,1**	**15,4**	**16,8**	**16,8**	**15,4**	**18,7**	**30,9**	**24,6**	**25,7**	**27,1**
MOH Chapter	12,9	38,0	6,6	7,7	7,8	6,2	5,6	6,0	5,9	5,6	5,3	6,4	10,3	9,1	10,0	11,0
District offices Chapter	0	0	0	0	0	0	0	0	0	0	6,4	7,5	0,0	0,0	0,0	0,0
Other Chapters	0,8	0,8	0,9	1,0	1,4	0,9	0,8	1,5	1,2	1,1	1,2	1,6	1,6	1,7	1,7	1,8
Chapter general treasury (without transfer to HIC)	0,0	0,0	2,2	1,2	1,9	1,6	3,8	2,1	2,5	2,0	0,2	0,5	5,5	3,4	3,5	3,5
Subsidy to municipal budgets			1,2	1,2	1,5	1,5	2,2	1,7	1,9	1,9	0,1	0,03	5,3	3,3	3,5	3,8
Own resources of municipal budgets	25,3	5,6	5,2	4,9	5,8	5,0	3,7	4,1	5,3	6,2	2,2	2,7	7,1	7,1	7,0	7,0
Payments of guarantees FN Motol													1,1	0,0		
Out of pocket payments of the patients	**1,3**	**2,1**	**3,8**	**5,4**	**7,4**	**8,3**	**9,9**	**10,6**	**11,2**	**12,0**	**12,7**	**13,2**	**13,7**	**14,0**	**15,0**	**16,0**
EXPENDITURES	**40,3**	**46,5**	**72,8**	**89,6**	**102,3**	**112,2**	**121,5**	**130,6**	**136,2**	**142,4**	**158,9**	**169,2**	**188,9**	**188,6**	**202,2**	**214,3**
Direct state budget expenditures (consolidated)	13,7	38,8	7,5	8,7	9,6	7,2	7,5	7,8	7,7	6,8	13,0	16,0	13,2	10,9	15,2	16,3
Municipal budget expenditures	25,3	5,6	6,4	6,1	7,3	6,5	5,9	5,8	7,2	8,1	2,3	2,7	12,4	10,4	10,5	10,8
Expenditures of HIC	0,0	0,0	55,1	69,4	78,0	89,9	97,3	105,8	110,0	115,5	130,9	137,3	147,5	152,4	161,5	171,2
Out-patient care								23,2	24,4	25,6	27,6	31,0	34,5	35,6	37,7	40,0
In-patient care (1)								47,8	51,1	52,9	59,2	66,1	41,3	42,7	45,3	48,0
Spas								2,5	2,6	2,6	2,8	3,1	2,9	3,0	3,2	3,4
Prescription of drugs								22,7	24,2	24,3	26,7	29,4	32,5	33,5	35,6	37,7
Rehabilitation facilities								0,1	0,1	0,1	0,0	0,1	0,1	0,1	0,1	0,1
Transport								0,9	1,1	1,1	1,2	1,2	1,3	1,3	1,4	1,5
Emergency ambulance service								0,6	0,7	0,6	0,7	0,8	0,1	0,1	0,1	0,1
Medical aids on prescription								2,4	2,8	3,0	3,3	3,7	4,0	4,1	4,4	4,6
Treatment abroad								0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0
Other expenditures for health care								0,5	0,0	0,7	0,8	1,0	1,0	1,1	1,1	1,2
Errors between statistics								5,0	3,0	4,5	8,5	0,9	0,0	0,0	0,0	0,0
Financial coverage to purchase receivables by CKA						0,3	0,9	0,6	0,1	0,0	0,0	0,0	2,1	0,9	0,0	0,0
Out of pocket expenditures	1,3	2,1	3,8	5,4	7,4	8,3	9,9	10,6	11,2	12,0	12,7	13,2	13,7	14,0	15,0	16,0
BALANCE	**0,0**	**0,0**	**6,1**	**-4,7**	**-4,3**	**-4,3**	**-1,9**	**-1,1**	**2,6**	**2,6**	**-2,3**	**-2,9**	**1,5**	**0,1**	**-3,4**	**-3,9**
Financial need for bailing out															-7,0	-7,0
TOTAL DEFICIT															-10,4	-10,9
GDP								**1962,5**	**2041,4**	**2150,1**	**2315,3**	**2414,7**	**2532,4**	**2735,0**	**2920,0**	**3118,0**
Sources (% GDP)								6,60	6,80	6,74	6,77	6,89	7,52	6,90	6,81	6,75
Expenditures (% GDP)								6,65	6,67	6,62	6,86	7,01	7,46	6,90	6,93	6,87
Balance (% z HDP)								-0,06	0,13	0,12	-0,10	-0,12	0,06	0,01	-0,12	-0,12
Bailing out (% GDP)															-0,24	-0,22
Healthcare system deficit as % of GDP (ESA95 methodology)															**-0,36**	**-0,35**

p … prognosis (Author)
(1) Inclusive out-patient services provided by hospitals
Note: Between years 1998-2003 no spending area is grew significantly faster than the others (the growths are proportional to the growth of the total costs). For years 2004 – 2006 we stayed with this structure
Source: Calculations of the Author based on MOF data, MOH data and Statistical office data

Table 16: The prognosis of health resource for 2004-2006 based on regression model

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003e	2004p	2005p	2006p
HEALTH RESOURCES														
EE+ER+SE in CZK	**41 977**	**49 649**	**58 300**	**67 515**	**74 650**	**80 217**	**82 537**	**88 513**	**99 282**	**103 547**	**110 471**	**116 414**	**123 842**	**132 068**
Employees (EE) in CZK	12 626	15 193	17 833	21 035	23 231	24 963	25 852	27 437	30 633	31 759	34 246	36 088	38 391	40 941
Employers (ER) in CZK	25 251	30 387	35 667	42 069	46 463	49 927	50 182	54 875	61 266	63 517	67 387	71 013	75 544	80 561
Self-employed (SE) in CZK	4 100	4 069	4 800	4 411	4 956	5 327	6 503	6 201	7 383	8 271	8 838	9 313	9 907	10 565
REAL ECONOMY														
Employees + Self-employed	4 874	4 927	4 963	4 972	4 936	4 866	4 764	4 731	4 751	4 765	4 733	4 685	4 671	4 674
Employees In thousands	n/a	n/a	n/a	n/a	4 329	4 203	4 079	4 023	4 033	4 002	3 922	3 895	3880	3872
Self-employed In thousands	n/a	n/a	n/a	n/a	607	663	685	708	718	763	811	790	791	802
Average wage in CZK	5 904	7 004	8 307	9 825	10 802	11 801	12 797	13 614	14 793	15 857	16 917	17 954	19 138	20 404

Note: In the long run (10 years in a row), the proportion of EE:ER:SE on the overall revenues from contributions is approx 31:61:8. We will use this share for the years 2003 – 2006 (Table) 13.
Source: Data for health resources 1993 – 2002 – Ministry of Finance
Data for real economy: Ministry of Finance and Convergence Program
e… estimate
p… Prognosis based author's regression model

81. The second channel of finances to HIC is the contribution of the state for specified groups of population. This is strictly a political decision, so the prognosis is based only on expert estimate as a sustainable scenario for the public finances. We expect that the total volume of the transfers from the state budget to HIC will not change dramatically. For 2005 we expect a slight year-on-year increase by 1.8% and for 2006 by approx 2.8%.

82. The third channel is the co-payments of the patients. According to latest Government statements, for the next two years (up to the next elections in June 2006), we calculate a non-reform scenario. Therefore, we do not expect any introduction of user fees and only slight increase in co-payments, mainly in drugs. In spite of this Deputy Prime Minister for the Economy Jahn is favoring the Slovak pattern, to introduce user fees for prescription (CZK 20) and at least CZK 50 for visiting a specialist.

83. Most important issue of the years 2005 and 2006 will be the bailing out of old debts. The stock of debts until 31.12.2003 reached approx CZK 14 billion (CZK 4 billion providers, CZK 10 billion HIC). This debt must be financed form the state budget and according to ESA95 in the time of the bailing out, it is calculated automatically into the deficit of public finances. We expect CZK 7 billion every year.

Table 17: The contribution of the state for specific population groups per capita and total in CZK and as % of total sources of HIC

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Total sources of HIC	**59,0**	**63,5**	**72,2**	**84,4**	**93,6**	**103,5**	**110,8**	**116,2**	**128,5**	**134,4**	**145,8**	**150,1**	**158,1**	**167,4**
State budget for economically non-active population	16,9	13,4	13,3	16,4	18,5	22,8	27,4	27,5	29,0	30,6	32,3	33,4	34,0	35,0
State transfer as % of total sources of HIC	28,7%	21,2%	18,4%	19,5%	19,7%	22,0%	24,8%	23,6%	22,6%	22,7%	22,2%	22,2%	21,5%	20,9%
CZK/month/per capita							392	392	392	439	467			
Number of persons covered – average in thousands										5 805				

Note: In 1998 since 1.7.1998, In 2001 since 1.7.2001
Source: Ministry of Finance, 2004

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- Konvergenční program České republiky (Convergence Program of the Czech Republic) www.mfcr.cz
- EBRD Transition Report 2004. European Bank for Reconstruction and Development, 2004.
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ENDNOTES

1) *Lidové Noviny, January 11, 2005*
2) *At the end of February 2005, the Government presented its long term health care concept (already the third since 2003).*
3) *Health care reform strategy, Ministry of Health of the Czech Republic, January 2004*
4) *From the point of view of health policy theory this does not constitute proper problem identification. At least three of the four identified issues cannot be deemed problems under the modern theory*
5) *Evans: Runnig for Gold, 1996*
6) *The health care system is in a balanced state if the Evans equation is true: Demand = Resources = Supply*
7) *Osterkamp, R.: Is There a Hold-up of Health-care Reforms in Europe?*
8) *The groups insured by the state are defined in the Insurance Act*
9) *If the level of average wages is increased by CZK 1, than the volume of resources is increased by CZK 6.5 million ceteris paribus. If the level of employment is increased by 1000 people, than the volume of resources is increased by CZK 15.7 million ceteris paribus. Since the P-value is less than 0.01, there is a statistically significant relationship between the variables at the 99% confidence level. The model as fitted explains 99.7112% of the variability in CZK (R-squared = 99.7112 percent). Since the Durbin-Watson value (2.45838) is greater than 1.4, there is probably not any serious autocorrelation in the residuals.*

Table 18: Recommendations for the Czech Republic

Area of Intervention	Recommendation and Measures	Nature of Recommendation	To be Introduced	Notes	Estimated Effect
Financing	1. Introduce upper limit for the assessment base of employees	Structural	2006	Remove discrimination of employees to the self-employed	Microscopic shortfall of income of health insurance companies
	2. Introduce the notion of annual settlement of contributions paid to health insurance companies		2006	In relation to the upper limit	Lower health contribution evasion
	3. Introduce representative payment (CZK 33 billion)	Technical	2006	For whom, how much, how	Fiscally neutral in the short-term. In the long-term, at good settings it can stimulate inflow of resources (if real economy parameters improve)
	4. Abolish the special redistribution account	Technical, partly paradigmatic			
	5. Introduce redistribution of statutory (to be collected) insurance premiums	Technical	2006	Increases the efficiency of contributions collections	
	6. Introduce independent supervision of redistribution	Technical	2006		
	7. Introduce user fees. CZK 20 for prescription, CZK 20 for visiting I primary care, CZK 50 for specialist, CZK 100 for one day in hospital, CZK 2 for 1 km in transport	Paradigmatic	2006		Effects are positive when the level of user fees is sensitively stipulated (evidence from Slovakia): excessive demand felt down informally payments lowered access to care was not hurt Financially more robust system
	8. Abolish capital expenditures (CZK 20 billion)	Technical	2006	Transfer these resources to health insurance companies and incorporate price of amortization to payments to providers	Reduced prices of procured investments Sober financial planning
	9. Introduce individual accounts	Paradigmatic	2006	The introduction of individual accounts is of long-term and fundamental importance as it responds to demographic trends and increasing costs of health care.	The system is more resistant to the demographic curve Increases the involvement of the patient on cost awareness and decision making

Table 18: Recommendations for the Czech Republic (cont.)

Area of Intervention	Recommendation and Measures	Nature of Recommendation	To be Introduced	Notes	Estimated Effect
Payment mechanisms	10. Abolish the negotiation process, or change it substantially	Paradigmatic	2006	If the negotiation process is to have any sense, it should only agree the BASE RATE for the price of a point and the BASE RATE for DRG	The negotiation process will have a clear field of reference and will not unnecessarily hamper the health care policy Drop the concept of minimum prices
	11. Remove the point catalog from the negotiation process. Modify its development and updating	Technical	2005	The target is a point catalog as a system of WEIGHTS.	Reduce political and lobbyist impact on weights
	12. Introduce fundholding for ordering laboratory services				
	13. Financing of tuition	Structural	2006	Compensate university hospitals for medical training by a voucher system	Elimination of resistance of the university hospitals to the introduction of DRG which does not include prices for medical training
	14. Continue the DRG project and gradual transition of exclusive DRG	Structural	2006	Gradual implementation	Introduce a non-discriminatory payment mechanism and remove the 4 currently applicable payment methods for in-patient care
Regulation	15. Abolish the system of 'selection procedures' when saturating the network and simplify entry to market	Structural	2005		Liberalization of the provider market
	16. Institutionalize the market response of producers – link the determination of payments to real prices of drugs. Set transparent and clear criteria for determining size of insurance coverage.	Structural	2005	Enable competition when specifying reference payments by a public tender. In case of a greater reduction of price enable faster access to market (pertains mainly to generics). The amount of payment should be specified as a relative proportion in the price of the drug, not an absolute amount.	Reduction of prices Transparent and foreseeable system Lower corruption
	17. Introduce degressive margin for the drug chain				
	18. Introduce a classification of medical aids on prescription similar to the classification of drugs.	Structural	2005		Reduce expenditures on medical aids Release resources for other segments
Organization	19. Immediately abolish the system of administrative selection procedures.	Structural		Introduce selective procurement of health care by health insurance companies on the basis of clearly defined criteria (structure – process – result) with a tendency towards creating a normative minimum network as a notion of a minimum segment for actual availability of health care.	
	20. Change the legal form of hospitals to joint-stock companies owned by the state.	Structural	2006		Surrender actual managerial powers to managers
	21. Transform the legal status of health insurance companies from public funds into joint stock companies.			Introduce hard budgetary constraints	Better corporate governance Financial responsibility
	22. Introduce improved supervision of health insurance provision			Related to changes to the redistribution mechanism (transition to 100% redistribution) which shifts resources towards VZP and may slightly destabilize smaller health insurance companies	Introduce solvency control
Debt Settlement	23. Create a financial reserve for bailing out approx CZK 14 billion for old debts and CZK 7.3 billion for new debts)	Fiscal	2005 and 2006		
	24. Establish a Consolidation Agency	Fiscal	2005		

Source: author