

# MEETING POINT

## 2006 Trade/Study Mission of the Academy for International Health Studies

### CZECH REPUBLIC

The 2006 Trade/Study Mission of the Academy for International Health Studies (AIHS) visited Prague—a vibrant old-world city and capital of the Czech Republic. Prague was freed of its decades-long repression under Soviet influence in 1989 to find that it must adapt to Western economic and health care philosophies. It joined the European Union (EU) in 2004 and pressured its centralized, socialistic health system to attain EU and Western standards. In many ways, it has been successful. In other ways, it faces tests similar to those challenging other EU members and the United States. At the time of the AIHS delegation's late April visit, the leaders of the Czech Republic were preparing for its June elections, which promised to further complicate the transition of its health system.

#### THE STARTING POINT

Like many European countries, and in particular, Soviet satellite states, the former Czechoslovakia had a socialist health system, under which all health care expenditures and decisions were centrally controlled. After the "Velvet Revolution" and liberation from Communism in 1989, Czechoslovakia split into two countries, the Czech Republic and Slovakia. The Czech Republic has approximately 10.2 million inhabitants spread over 14 regions, with Prague (or *Praha* in Czech) as its capital. More than 10% of the total population lives in Prague, and it is the country's most developed region; a large portion of the country is rural, strewn with small cities, such as Brno, Ostrava, and Pilsen (home of the unofficial national drink).

Like many Western countries, the Czech Republic faces problems in health care financing and demographics. Public spending for health care is greater than 90% (and 96.5% of the country's health care expenditures go to provider payments; administrative costs account for only 3.5%), but the country's health care

expenditure is relatively low and stable, at 7.3% to 7.5% of the gross domestic product (GDP) (about \$1,200 per capita).

In 2003, the life expectancy for Czech men was 72.0 years and 78.5 years for Czech women, but mortalities differ significantly by region. The country's age demographics are trending toward older groups, which represents strong remaining ties to the Republic's Communist era, and possibly the sense of entitlement that it engendered.

In 2004, the Czech death rate per 1,000 inhabitants was 10.5 per 1,000, and the birth rate was 9.6 per 1,000. Michal Pohanka, MD, Deputy Minister of Health, explained that the Czech Republic has "90 residents who are older than 65 years for every 100 children." Relatively few workers are available to pay for the health care of a growing pensioner population. However, vital signs like infant mortality, at approximately four per 1,000 live births, is "dropping all the time, as care for neonatals improves," he noted.

The population is a homogenous one, with 94% of

the residents of Czech origin; 2% of Slovak ancestry; and the remainder a mix of Polish, German, and Romanian stock.

Acute care is a key focus of the Czech government's cost-containment efforts. Hospital utilization is responsible for the lion's share of health payments. "We are trying to reduce the number of acute care bed—sit has decreased from 80 beds per 10,000 in 1993 to 60 beds per 10,000 in 2005," according to Dr. Pohanka. "Average length of stay is down from 11 days in 1993 to seven days in 2004."

## A HEALTH SYSTEM IN RAPID TRANSITION

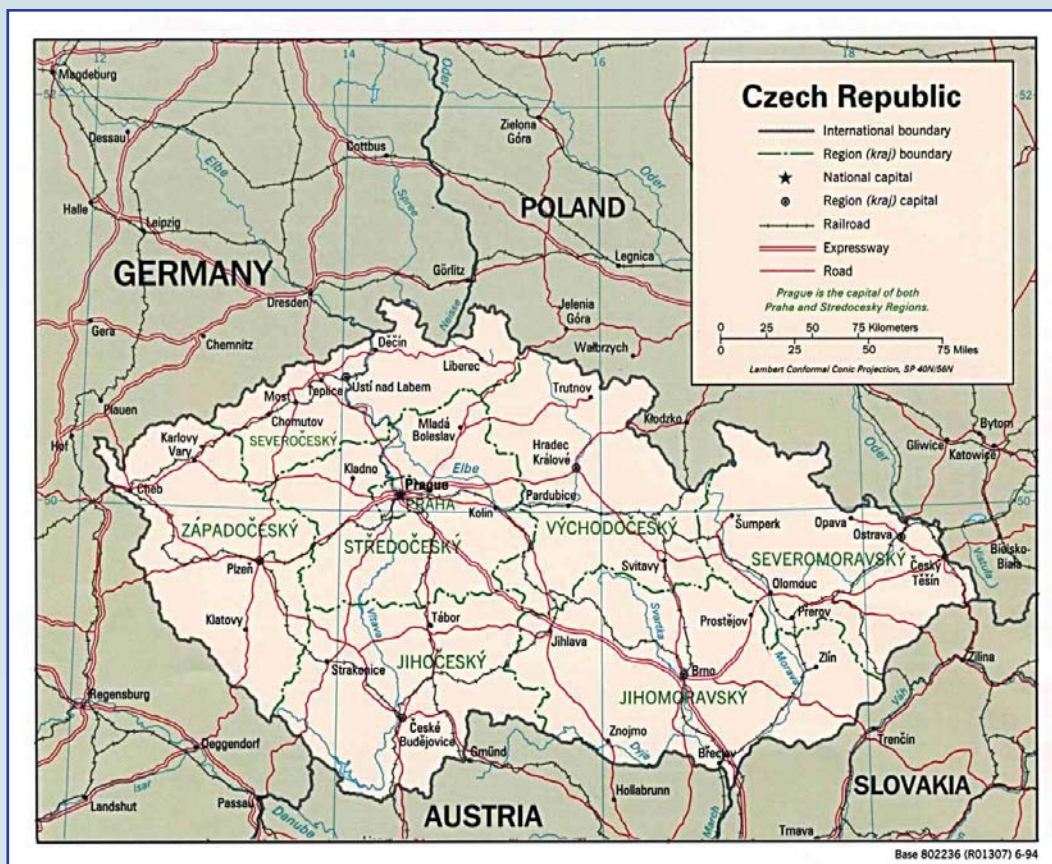
As part of a socialist system from 1948, all health care funds were obtained through general taxes. Health care was transformed in December 1989, soon after the country turned to a parliamentary democratic system. The health care system, unlike the economic system, struggled to throw off the reins of socialism. Citizens were accustomed to the centrally-run and -financed system, and initial attempts to better serve the patient (rather than the government's bureaucracy) were slow to be accepted, explained the physician who was given the task of changing the system. "The transformation occurred under an idealistic concept—'the patient comes first,'" said Martin Bojar, MD, the first Minister of Health of the new Czech Republic. "It was supposed to be based on a free and informed patient. Not all of the patients are informed though. The result was that the reforms were criticized from outside the government ('the system was being transformed too fast') and from within the government ('the pace of reform

is too slow')." The system was stressed by the public's need for wide access and the government's ability to guarantee it. "In retrospect," he noted, "expectations were probably too high."

The pace of change did not abate, however. In reaction to these stressors, a bill was introduced in 1991 to introduce multiple sources of financing to health care, according to Dr. Bojar. Each year hence, however, the health system was run with a deficit.

Today, the Czech Republic maintains universal coverage, with 13.5% of income used to pay for health care insurance; two-thirds of the total is derived from employer taxes, one-third from employee taxes. For visitors from non-European Union (EU) countries (and which do not have separate agreements with the Czech Republic) who need health care services, they must bear all of the cost.

What was introduced as 26 publicly-administered insurance funds during the initial transformation has been whittled down to a choice of nine funds, among which any citizen can choose. None of the funds differ appreciably from the other, "except," said Dr. Pavel Vepřek, in size and "in how quickly they pay providers."



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(Speed of payment by the insurance funds is a common complaint throughout the country, regardless of whether the provider is a hospital or physician.) Dr. Vepřek, President of the Citizens Health Care Action Group, Prague, pointed out that by mandate, the benefits offered cannot differ and neither can the fees

they pay out. Furthermore, new insurance funds are not allowed to enter the market.

“The party in power dictates how all insurance fund monies are spent,” according to Dr. Vepřek. Complicating the situation is that the four main parties controlling the Czech government have differing visions of what the health care system should look like.

Although politicians spoke of using elementary tactics to introduce market forces to the health system as early as 1992, no further action was taken. Only recently has there been talk of using market forces, in a radical manner.

Czech citizens today have little “skin in the game.” Copayments under the current financing structure are very low, and health care access is not widely recognized by residents as problematic. In fact, the per-capita number of outpatient visits in the Czech Republic is twice as high as in other Western EU members, “and 98% of those visits result in a drug prescription,” stated Dr. Vepřek.

Even if choice of health care provider was placed in the hands of the Czech people, little information is available on which to base their decisions: Quality of care is virtually unmonitored here, as in most countries; Dr. Vepřek’s organization is seeking to sue the insurance funds to obtain data obtained from the hospitals’ claims systems (hospital care payments are based on a diagnosis-related group and outpatient care on a fee-for-service system based on *International Classification of Disease* coding).

The Czech government has identified financing (not necessarily overall health care utilization or quality) as a serious problem and recently took some dramatic steps to address it.

Manipulation of provider’s fee schedules supplied a temporary solution to stabilize the debt incurred by the health insurance funds. In 2005, that debt was

equivalent to 10% of the total expenditure of the health care system (approximately 14 billion Czech crowns [Kč] or \$609 million). To compound matters, health care budgets are generally issued only two weeks before the beginning of the applicable fiscal period, according to Miraslav Palat, MD, MBA, Czech Director for Johnson & Johnson, Prague. “That means that hospitals cannot get a handle on their utilization until six months into the fiscal period.”

Dr. Vepřek explained that the only copayments Czech citizens must bear are for pharmaceuticals. “Public insurance expenditures are dominated by payments to hospitals (96.2%); drugs are responsible for 2.9% of total expenditures, but spa payments are fully covered, at 2.1% of the total.” Spa entitlement is deeply ingrained in central and western European culture, and the Czech Republic boasts a number of prime spa locations.

## **DESPERATE TO CUT THE DEBT**

Perhaps the greatest perceived problem was the debt incurred by the nation’s largest health fund, Všeobecná Zdravotní Pojišťovna (VZP), or General Health Insurance Company, which has nearly 70% of the citizenry as members. The previous Minister of Health resigned in 2005 and David Rath, MD, took over the office. He began to enforce harsh measures to reform the financing side of the equation. He placed VZP under direct federal administration, blaming the situation on mismanagement and bureaucracy. Under Czech law, health insurers are not allowed to manage their risk. They cannot negotiate fees with providers, establish networks, or manage utilization or quality.

Dr. Rath increased the fees paid to physicians by 30%; however, he did not increase the system’s budget. As a result, once the fund’s budget is expended earlier owing to the higher fees, the physicians are not paid (i.e., they do not work). He cut the pharmaceutical expenditure by 2% for 2006, in reaction to the high prescription rates from office visits. Furthermore, if any insurance fund finds that it does have a surplus, it is mandated “to pay the providers more,” said Dr. Vepřek, “draining any reserves the fund had.” Unfortunately, this surplus cannot, by law, be used to offer additional benefits to their members.

Clearly, these moves were not popular within the health care community and are not expected to have long-lasting positive effects on the financial status of the system. “The control of expenses has focused only on health care providers and insurers, solely through regulatory measures,” remarked Jiří Bek, MD,

President of the Czech Union National Health Insurance Companies, "and they have not had their intended effect." Although Dr. Rath's moves have been effective in reducing the health care budget (from 8% growth in the previous year to 1% decrease currently), some physicians are refusing to see new patients. Elections held in June 2006 brought in another change in leadership and likely new attempts to address the debt issue.

One way to bring more revenues into the system would be to introduce the option for supplementary coverages. According to Dr. Bek, an opinion poll conducted in September 2005 indicated that 81% of those surveyed would welcome supplemental insurance programs. From an American standpoint, though, if a resident had a noncapped benefit, it may be difficult to believe that he or she would welcome the opportunity to pay for additional care!

Another mechanism being considered by Czech leaders to introduce more cost sharing by consumers into the system (through coinsurance and consumer-directed approaches). These are discussed later.

### **OTHER HEALTH CARE CHALLENGES IN THE CZECH REPUBLIC**

Whether they are indicative of the public health situation or the cultural values in the Czech Republic, the country does present some strange challenges. Not only are the number of outpatient visits far higher than that of other EU countries, but the number of sick days per employee is 30 days/yr and rising.

"The Czech Republic is the only country in the EU without a [public health benefit] cap and social tax," said Dr. Palat. He also pointed out "we have large islands of technical excellence (e.g., invasive cardiology); however, in cases of hip or knee transplants, the procedures may be done extremely well, but other ancillary procedures and services (e.g., rehabilitation) may be done less well."

Decisions on coverage of new health care technologies are made by the Minister of Health; no appeals process exists, according to Erik Bossan, Country Manager for Pfizer Inc, Prague. New drug products may only be prescribed by specialists, he added, and since the drug budgets are fixed, physicians who prescribe higher-cost medications will tend to limit their prescriptions in an effort to avoid exceeding their budget. Unsurprisingly, the utilization of generic medications is relatively high. According to Mr. Bossan, this has had the effect of stifling innovation. He added that the research-based pharmaceutical and medical

device companies have filed a joint complaint with the EU against the government of the Czech Republic.

Incentives in the health system can be challenging: not only does little incentive exist for technological innovation by manufacturers, there is also little incentive for prevention on the part of the physicians. The physicians have strict budgets for pharmaceutical expenditures. This can be a positive, as this may deter overutilization. On the other hand, screening for hypercholesterolemia might mean that the patient would have to be treated, costing valuable crowns from the physician's drug budget. In other words, why screen if you do not want to treat? asked Mr. Bossan.

Why not simply add more money to the system? The country could do this, raising the GDP share of health care another percentage point or two, but the health system does little in the way of basic management tools to affect the latter (and it would simply increase the debt). First, it does not explicitly limit the health benefit. Second, it has only begun to perform retrospective utilization management in an effort to eliminate extraneous care services and billing. Third, it does not utilize a drug formulary. Fourth, it does not incorporate consumer copayments or coinsurance in their care (except for drugs), which might restrict outpatient visits. Fifth, few private health care providers exist to help bring efficiencies into the system. "Private health care is sometimes available in corporate environments," said Vladimir Finsterle, PharmD, MBA, President of a new Internet pharmacy, trying to pioneer competition with Czech-government run pharmacies. Private physician practices do exist, but technically, Dr. Finsterle said, the doctor does not "own the practice." He indicated that, as a result, Czech physicians have relatively little economic motivation and that emigration of Czech-trained clinicians is a significant issue.

### **THE SPA-VACATION MENTALITY**

Few traditions are as deeply held to Czech citizens as the restorative value of spa therapy. Thirty-three spas operate in the country, with most located in the northern regions. Although 50% of the visitors to the Czech

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spas are foreigners, a once-yearly visit to the spa is covered for Czech citizens under the universal health care benefit, with referral by a specialist.

Eighty percent of the country's spas are privately owned, the remainder run by the regional or federal governments. Interestingly, spa facilities represent one area of the Czech health system

where private ownership and management dominates.

Therapies common to the spa centers include dietary, exercise, and other health and lifestyle counseling. Medical treatment is not generally available. However, the spas offer therapies in differing types of springs (e.g., radon gas and other minerals), carbon dioxide baths, acupuncture, electrotherapy and rehabilitation services, and hydrotherapy. The field of balneology, or treatment by immersion in baths, is booming in the Czech Republic, in large part because of the values of its citizens.

Although the thought of bathing in radon-gas infused springs may not be attractive to the U.S. consumer, Europeans have utilized spa therapy for decades. One spa facility, Lázně Jachymov in the town of Jachymov, offers accommodations in the "Radium Palace" and "Curie Hotel," which provide both extensive hotel and spa services.

According to Eduard Bláha, MD, Managing Director of Lázně Jachymov, "The dose of radiation received during a 21-day spa stay is like living 60 to 70 years in a home with radon gas exposure." Radon bath immersion session last for 20 minutes, in 36° C water. By the fifth or sixth day, said Dr. Bláha, the effects of therapy can be seen, as patients become fatigued. One to three months later, therapeutic effects, such as reduction of joint inflammation, are noted. The beneficial effects of spa therapy are reported to last for up to eight months.

Lázně Jachymov's clients are often those with disorders of the joints and connective tissue (e.g., rheumatoid arthritis, Bechterew's disease, and psoriatic spondylitis). The scientific evidence for the benefits of radon spa therapy is mixed; however, it is highly valued by the society.

## **A FORAY INTO CONSUMER-DIRECTED HEALTH CARE?**

A real question remains as to whether the accumulated debt of the Czech health care system comprises a crisis. This has become the fence separating the political parties. Is the crisis not truly one of access or is it only financial? Does this debt represent a crisis at all, when compared with other subsidized national systems? Pavel Hroboň, MD, Chairman of Health Reform CZ, agreed that "an accumulated debt of 10% is not too unusual for European countries."

However, more may be at stake tied to this debt: As a new member of the EU, the Czech Republic intends to adopt the euro in 2010. To do so, it must first attempt to reduce its publicly financed debt to below 3% of GDP (which must be maintained for at least 2 yr). Therefore, pressure is on the government to improve the country's macrofinances and reduce its debt, and to do so, it needs to address the financial pressures from the health care system.

Ludwig Dittrich, PhD, Chairman of the Arlington Group in Prague, and an occasional advisor for the Czech government, commented that the basic problem is that the society "must redefine first health care as a commodity, a long-term investment, or both. Then you can define performance attributes according to the objectives of the health care system."

Dr. Hroboň pointed out that the available data on quality and cost show wide variation across the country (costs are based on claims costs, not on what is paid, which is fixed), indicating that providers are likely maximizing their diagnosis-related group claims. "From the patient's perspective, variations in outcomes exist based on where one is treated," he said, "and this information is not available to the public." Furthermore, different hospitals have large variations in waiting times for procedures, "which is also not publicized," according to Dr. Hroboň. "Currently, it is more about obtaining better client services rather than access to better institutions."

Dr. Bek stated that "15 years of experience with the public health insurance system has given us reasonable scope to examine how the system works. We need to redefine the scope of services paid from public health insurance, promoting a basic scope of services with minimum and maximum deductibles, and disclose valid quality information to help consumers make the right decisions." The fact that Americans do not yet have all of the quality information needed to validate that a consumer-directed health care approach achieves its goals is only one of the problems facing Czech

health reformers. Even so, the health reform proponents are considering consumer-directed health care with health savings accounts, similar to what is beginning to grow in the United States.

If residents of the Czech Republic had to pay for their spa visits or physician office visits, would their utilization be reduced (as would medical costs)? This is the gist of the controversy occurring today in Czech health policy circles. In fact, the elections in June favored the opposition's central-right political (the Civic Democratic) party, which means that the country may go forward with this party's reform plan, using a healthy dose of American-style consumerism. This would also enable private health care providers to operate on a level playing field in this nation. Although the Civic Democratic party won the elections, it did so with a small majority, and will have to form a coalition government. It is unclear under the new Administration if they will have the ability to implement major reforms, but any significant changes would still have to be approved by Parliament.

"Will we move toward an old, centralized health care system?" asked Dr. Hroboň. "Everyone else is backing away from this model." Without reform, he foresees a two-class system, with those who can pay for care receiving better access and higher quality. Furthermore, this secondary avenue will be unregulated. Dr. Hroboň prefers a vision of regulated competition, with complementary insurance purchased optionally by those who prefer more comprehensive benefits.

Tomáš Macháček, MD, believes that by splitting the current health care benefit into a basic catastrophic package of services and a complementary, comprehensive benefit into which the public can buy, a strong element of consumerism can be added to the market. This would also stimulate the growth of private health care providers who can provide efficient services. Copayments and coinsurance would be utilized. "We would use public financing to pay for the basic benefit and to sponsor citizens according to their health risk, allowing them to buy supplemental health insurance," said Dr. Macháček. The plan would incorporate high-deductible insurance plans and health savings accounts, funded with both private and public money. "We would need to redefine the role of the government into that of a regulator in this market-oriented plan."

Will the population accept further rapid change in the health system, which will be squarely against the social principles on which it was based? What will be the average citizen's reaction to an added layer of ad-

ministration in the health system to regulate competition and monitor quality and efficiency? Dr. Hroboň acknowledged that such a consumer-based system would have to be introduced gradually. "The first step is to reduce inefficiencies, demonstrating that people can get more care for their money. [Second,] in terms of what the people experience with the insurance system, we must keep it close to what they are used to."

Dr. Dittrich agreed, and said, "We are still a social insurance-based country. We need to experiment a little bit, empowering the consumer, testing the consumer's ability to choose."

Yet, this is a country that is accustomed to rapid changes. "In three years time, we'll have a clear indicator of success—whether the efficiency of the system improves," said Dr. Hroboň.

### AN ACUTE CARE PRESENT

Despite the high outpatient visit utilization described earlier, the health system is very much focused on acute care visits. This is where quality initiatives are focused. Hospital facilities are a key focus of the present administration's cost-cutting efforts. The Academy for International Health Studies trade/study delegation saw first-hand how a tertiary care hospital in Prague is able to make due with these reduced payments. The Motol University Hospital's structure itself was aging and in need of maintenance, but it serves 0.5 million people and is a referral facility for complex cases. Dr. Bojar, led a tour of his neurology department, and explained that this medical center is being subjected to patient dumping, caused by the federal cutbacks by the Ministry of Health. "The last six to eight months have caused greater and greater financial problems," he said.

The hospital demonstrated technologically advanced instrumentation, including a magnetic resonance imaging scanner, a gamma knife, and five positron emission technology scanners. In an excellent example of making do with little money, the staff transformed a former rest room into a DNA laboratory.

Furthermore, this tertiary-care facility is heavily involved in research, with more than 100 pediatric studies underway. Research accounts for more than \$1 million in expenditures each year at the hospital.

The annual budget for the medical center is Kč 3.5 billion (about \$152 million). Payments from the government average \$25 to \$30 per day for standard medical-surgical rooms, and \$130 per day for intensive care unit utilization.

Dr. Bojar stated that professors in the medical center (which is part of the medical school) earn only \$10



**Freestanding, community-based LTC facilities are few in the Czech Republic, and virtually nonexistent in the rural areas.**

an hour. However, their American counterparts may not be paid for teaching in a U.S. medical school, and instead teach for the privilege of having a private practice at the medical center.

Physicians in the hospital are given utilization monitoring reports on a biweekly basis, in which they are graded on a plus-minus sys-

tem relative to their colleagues.

Dr. Bojar explained, "It takes certain survival skills here, but you make it work through research grants and other financing." The delegates observed that patients are "camping out in beds, because there is no other place to send them—there is no postacute setting."

## **A LONG-TERM CARE FUTURE?**

The Trade/Study delegation visited a long-term care (LTC) facility in Prague, the Sue Ryder Home. This non-profit organization, headquartered in Great Britain, established their only Czech LTC facility in Prague in 1998. Eighty-five percent of its residents live there for at least three months. Today, the Sue Ryder Home has just 57 residents (avg age, 86 yr), most with limitations in activities of daily living (42% with deficiencies in all activities of daily living) but with only early stages of dementia. The Home is trying to raise money to build a wing dedicated to individuals with more advanced dementia, and no set timetable has been placed on its construction. Furthermore, the LTC facility is undertaking a pilot project involving personal assistance and nursing care in the community.

Freestanding, community-based LTC facilities are few in the Czech Republic, and virtually nonexistent in the rural areas. However, the government requires each hospital to set aside some proportion of their beds for LTC patients. Regions with many hospitals (e.g., cities) should therefore have more LTC beds available than regions with fewer acute care facilities (e.g., the rural countryside).

The federal government has little interest in fully funding a freestanding facility such as the Sue Ryder Home. Instead, the organization has found innovative ways to help fund its facility. It has a fully operational restaurant on its premises, it operates a second-hand

clothing shop, and it has opened its doors to the community with a library, community center, and open garden areas. Joana Plechatá, PhD, Director of the facility, said, "Our business activities generate 45% of the money that we need to operate (approximately \$1.4 million). The Prague municipality pays another 22%. We receive some subsidies from veterans' organizations and private donations, but we will need to make up another 10% of the budget in 2007 as the Sue Ryder Foundation reduces its contribution per its operating plan. We're trying to convince the Ministry of Defense to support us, as the veterans will increasingly need facilities like these."

One of the greatest challenges LTC facilities face is that they are categorized as "social," not "medical," facilities by the federal government, limiting possible contributions. Dr. Plechatá tries to use that designation to the benefit of the facility; they use a heavy dose of volunteerism of the community—more than 55 regular volunteers help run the facility, in addition to its 90 full-time employees. In 2007, she pointed out, the facility will need a part-time medical director. Today, they simply drive residents in need of medical care to the physician's office.

Yet, facilities like the Sue Ryder Home are clearly needed, now and in the future. The waiting list for admission to the Sue Ryder Home is long, as clients vie for a limited number of beds. With the present demographics of the Czech Republic, the Ministry of Health must reexamine in the near future whether this type of social facility will play a critical role in the medical care of an aging population.

## **SUMMARY**

The Czech government is facing difficult challenges in its health care system today; however, some may be only perceived challenges. The health policy makers and governments are distressed over the mounting health care deficit, which is currently at 10% of total health care expenditure, even though the percentage of GDP associated with health expenditures is relatively low. The government's reaction to that deficit may have contributed to the providers' plight—slashed budgets, payment delays, and a state of unease. Furthermore, the populace does not seem to be mandating great change in the health system, and if such change was introduced, it would need to consider the majority of people who are accustomed to the centralized, socialized system. Considering that the system has undergone a number of adjustments in its short life, changes in public

sentiment toward the system can be expected to lag behind the problems.

### **CONCLUSION**

As is the case with most countries, including the United States, Czech leaders are reluctant to address directly the need for improved LTC planning in the face of an aging population. However, this is only one facet of the health care challenge.

Bruce Pollack, President of the AIHS, agrees that a move toward market-based health care could help. "The most immediate quick fixes might come in the form of sharing more of the financial burden with the consumer/patient (to bring the Czech Republic more

in line with other EU countries), which is likely to have an immediate effect on outpatient utilization, which is at 12 visits per year. Tightening the formulary (excluding over-the-counter items such as aspirin) could have the dual benefit of minimally reducing pharmaceutical costs while eliminating the physicians' appointments scheduled to obtain the script." These initiatives may very well be attempted in the aftermath of June elections.

Components of the market approach favored by proponents of reform may indeed set the system on the path to greater revenues and lower debt. Yet, for a country that has seen great changes over the past 15 years, is this too much change—or too little?