CRC 1342 No. 13

Social Policy Country Briefs

Czechia

Ivan Malý

The Health Care System in Czechia

Global Dynamics of Social Policy CRC 1342

Deutsche Forschungsgemeinschaft

Ivan Malý
The Health Care System in Czechia
CRC 1342 Social Policy Country Briefs, 13
Edited by Achim Schmid
Bremen: CRC 1342, 2021

SFB 1342 Globale Entwicklungsdynamiken von Sozialpolitik /
CRC 1342 Global Dynamics of Social Policy

A04: Global developments in health care systems and long-term care as a new social risk

Contact: crc-countrybrief@uni-bremen.de

Postadresse / Postaddress:
Postfach 33 04 40, D - 28334 Bremen

Website:
https://www.socialpolicydynamics.de

[ISSN 2700-4392]

Funded by the Deutsche Forschungsgemeinschaft
(DFG, German Research Foundation)
Projektnummer 374666841 – SFB 1342

Ivan Malý

The Health Care System in Czechia

CRC 1342
No. 13

The Health Care System in Czechia

Ivan Malý*

Content

1. Country Overview . . . 3

1. Selected health indicators . . . 3

2. Legal Introduction of the System . . . 4

3. Characteristics of the system at introduction . . . 4

a. Organisational structure . . . 4

b. Provision . . . 4

c. Financing . . . 5

d. Regulation . . . 5

4. Subsequent historical development of public policy on health care . . . 6

a. Major reform I . . . 6

b. Major reform II . . . 6

5. Description of current health care system . . . 6

a. Organisational structure . . . 6

b. Provision . . . 6

c. Financing . . . 7

d. Regulation of dominant system . . . 7

e. Co-existing systems . . . 8

f. Role of global actors . . . 8

g. List of additional relevant legal acts . . . 8

References . . . 8

* Masaryk University, ivan.maly@econ.muni.cz

1. Country Overview

Source: https://ontheworldmap.com/czech-republic/ (Accessed: July, 2021)

- Sub-Region: Eastern Europe
- Capital: Prague
- Official Language: Czech
- Population size (UN 2021): 10,633,000 (in 2020)
- Share of rural population (UN 2021): 74.0 % (in 2020)
- GDP (World Bank 2021): 250.7 billion US$ (in 2019)
- Income group (World Bank 2021): High income
- Gini Index (World Bank 2021): 25.0 (in 2018)
- Colonial period: N/A
- Independence: 1918 as Czechoslovakia. In 1993 Czechoslovakia split into the independent countries of the Czech Republic and Slovakia.

1. Selected health indicators

Indicator (2019 or latest year available	Country	Global Average
Male life expectancy in years (WHO 2021)	76.3	70.6
Female life expectancy in years (WHO 2021)	81.9	75.0
Under-5 mortality rate per 1,000 live births (WHO 2021)	3.2	37.7
Maternal mortality rate per 100,000 live births (WHO 2021)	3.0	211
HIV prevalence of per 100,000 people, aged 15-49 (WHO 2021; UZIS 2019)	42	700
Tuberculosis incidence per 100,000 people (WHO 2021)	4.9	130

Source: World Health Organisation 2021, and UZIS 2019

2. Legal Introduction of the System

Name and type of legal act	Act no. 221/1924 Coll.[1]; Employees' Sickness, Disability, and Old-age Insurance. Law.
Date the law was passed	October 9, 1924
Date of *de jure* implementation	July 1, 1926
Brief summary of content	The law introduced unified social insurance for employees and established the Central Social Insurance Agency. It administered disability and old-age insurance and supervised sickness funds, which the law newly designated as sickness insurance companies. Free-of-charge basic medical treatment was covered for widely defined groups of employees and their family members.
Socio-political context of introduction	The new insurance in independent Czechoslovakia succeeded the Bismarckian sickness insurance introduced in 1888 in the Austro-Hungarian empire (Act no. 33/1888 RGBI, on Workers' Sickness Insurance). A desire to manifest independence and national sovereignty drove the idea of the new social insurance law in 1920. An expert commission worked out a proposal in two years, and it took another year and a half of political negotiations to reach consensus throughout all political parties in 1924.

3. Characteristics of the system at introduction

a. Organisational structure

- Centralisation of the health care system: The new republic inherited a fragmented system in 1918, with hundreds of institutions offering social security and sickness insurance. The various schemes were organised according to professional, regional, or other criteria (Bryndová et al. 2009). There were as many as 2,073 sickness funds in the first days of the new state. Over the following decades, sickness insurance companies gradually merged. By 1946, there were only 105 funds (Pechová 2017). The period 1919-1938 was associated with efforts to reform the area of hospital care in Czechoslovakia and increase the centralisation of the health care system. However, plans and proposals for the reforms of inpatient medical care, designed in the 1920s, were still not implemented by the beginning of World War II (Murtingerová 2020).
- Eligibility: Under the sickness insurance law of 1924, widely defined private sector employees were eligible for health care. The insurance included benefits for family members. Public employees (including rail workers and post office workers) and civil servants were covered by a similar law passed the following year (Act no. 221/1925 Coll. on Sickness insurance of public employees). The latter scheme provided more generous health care benefits at lower levels of insurance premiums (Heřman 2020).
- Coverage (principal health insurance): In the second half of the 1920s, compulsory sickness insurance in Czechoslovakia covered up to 3.5 million employees plus their family members. In total, more than 7 million inhabitants were insured, which was approximately 50% of the population (Heřman 2020).

b. Provision

- Number/density of physicians and midwives: In the Czech health care system since it was established in 1924, family practitioners working on contract in private practice provided most health care services. There were also physicians working as employees for large companies and more than one thousand physicians employed by public authorities. The latter mainly provided care for poor people. Physicians were also employed by hospitals (Gladkij 2003). Figures for practising physicians and midwives are given in the following table (referring to the regions representing the current Czech Republic: Bohemia, Moravia, and Silesia).

1 Collection of laws.

Practising Physicians (1930)					
Bohemia			Moravia & Silesia		
number	per 100,000 population	per 100 km^2	number	per 100,000 population	per 100 km^2
5,082	71.5	9.8	2,011	56.4	7.5

Certified midwives (1930)					
Bohemia			Moravia & Silesia		
number	per 100,000 women	per 100 km^2	number	per 100,000 population	per 100 km^2
3,699	101	7.1	1,059	111	7.7

Source: Stibor 2012

» Number of inpatient facilities (public/private): There was a relatively dense network of inpatient facilities in former Czechoslovakia[2]; however, there were significant disparities between regions – Bohemia reported twice as many facilities as Moravia and Silesia. (Stibor 2012). There were 159 public hospitals in the whole of Czechoslovakia in 1930 (Mášová 2005)

Inpatient facilities and number of beds (Czech regions only, 1929-1937)				
Type of facility	1929		1937	
	No. of facilities	Beds	No. of facilities	Beds
Hospice	71	7,424	96	9,707
TBC	21	3,578	26	4,394
Mental care	11	11,737	32	15,457
Private	148	8,376	165	10,941
Public general hospital	130	26,956	134	35,348
total	381	58,071	453	75,847

Source: Stibor, 2012

c. Financing

» Both employees and employers contributed to the sickness insurance premium. The rate was 4.3% of the median daily wage in 1926, and it gradually increased to 6% in 1946 as the system suffered to cope with rising costs of treatment and sickness benefit payouts.

d. Regulation

» Actors responsible for regulation: The Ministry of Social Affairs served as the main guarantor of the social security system. The Central Social Insurance Agency supervised sickness insurance companies, and it could approve increased contribution rates due to rising costs.

» Insured persons and their family members were entitled to free outpatient and hospital treatment in the third (lowest) class of hospitals under basic insurance. Civil servants were entitled to Class II. Class I was at an extra cost (Vurm 2007). In case of illness, the insured person received sickness benefits to the amount of about 60% of the average wage for 20 weeks (later 25 weeks) (EURO 2018).

2 In the part representing the current Czech Republic (Bohemia, Moravia, Silesia)

4. Subsequent historical development of public policy on health care

a. Major reform I

Name and type of legal act	Act no. 103/1951 Coll. on Unified Preventive and Medical Care. Law.
Date the law was passed	December 19, 1951
Date of *de jure* implementation	January 1, 1952
Brief summary of content	In 1952 a soviet-style centralised system of unified health care (the so-called Semashko model) was introduced. The new system was based on a state monopoly of the provision, funding, and administration of health care. It effectively solved the post-war problems of the early 1950s. However, in the 1960s, it reached a turning point. As centralised and rigid as it was in many aspects, it proved unable to respond flexibly to new health problems arising from lifestyle changes and environmental factors.
Socio-political context of introduction	After World War II, Czechoslovakia fell into the sphere of influence of the Soviet Union, which had a substantial impact on the political, social and economic system and negative effects in terms of political freedom and economic development.

b. Major reform II

Name and type of legal act	Act no. 550/1991 Coll. on general health insurance. Law.
Date the law was passed	December 30, 1991
Date of *de jure* implementation	January 1, 1993
Brief summary of content	Health care was transformed into a system based on compulsory public health insurance, with competition among payers, a plurality of providers, and a very widely defined benefit package.
Socio-political context of introduction	The Velvet Revolution in November 1989 initiated the transformation of the political regime into a democracy, as well as the transformation of the economic system into a market economy. There was also a need to implement a fundamental health care reform, ensuring transparency, economisation, democratisation, humanisation, and a higher standard of health care.

5. Description of current health care system

a. Organisational structure

» Centralisation of health care system: The Czech statutory health insurance system is decentralised despite strong state regulation. There is a plurality and autonomy of health care providers: the state (central government), public (regional and municipal authorities), and private facilities are treated in the same way. Decisions regarding the price and the volume of care are mostly conducted through negotiation between representatives of providers and payers. The system is funded from multiple sources (see: c. Financing).

» Regional allocation of responsibilities for health care: Regional and municipal authorities license and supervise providers (Alexa et al. 2015). Further, regional governments serve as the founders of the majority of acute care hospitals, and they operate emergency medical services (EMS).

» Eligibility/entitlement: Permanent residents and employees of employers based in the territory of the Czech Republic are entitled to health care.

» Coverage: The compulsory health insurance provides for universal coverage, i.e., 100% of the resident population.

b. Provision

» The health care facilities network seems to be quite dense and stable, despite certain local shortcomings. The network of inpatient care providers consisted of 189 hospitals, 126 specialised medical facilities (in-

cluding convalescence homes and hospices), and 88 spa facilities in 2020 (Sirovátka et al., 2020). Hospital bed capacity was 6.6 per 1 000 population in 2018 (compared to EU 5.0) (OECD 2020). Inpatient facilities of the central state accounted for 36.1% of all inpatient beds, while regional facilities represented 38.5% and municipal facilities 7.6% of all beds. Finally, private institutions owned 17.8% of beds in inpatient facilities (UZIS, 2019).

» Number/density of physicians and nurses: Czechia reports a density of practising doctors similar to the EU average (4.0 doctors per 1,000 population compared to 3.8) and a slightly lower nurse density (8.1 nurses per 1,000 population compared to 8.2). The number of doctors has increased over the past decade (OECD 2020). However, the shortage of certain specialists, (e.g. dentists and paediatricians) and a general staff shortage in rural areas are apparent (Sirovátka et al. 2020). Of physicians, 20.1% worked in state institutions of the central state, and 23.4% in the health facilities of the regional or municipal authorities; 56.5% of physicians worked in private facilities established by a natural person, the church, or other private legal entity (UZIS, 2019).

c. Financing

» Total expenditure, i.e., expenditure from the public health insurance system, the state budget, territorial budgets, private expenditure, and other marginal sources reached the value of approx. CZK 477,7 billion/€18.7 billion in 2019 (ČSÚ 2021). In comparison with the previous year, this represents an increase of 10%. The decisive part of health services funding (83%) comes from public sources. As a share of GDP, expenditures reached 8.3%).

Czechia: Health care expenditures, in thousands CZK (2018,2019)

Source of funding	2018	2019 (preliminary)	Share of total expenditure
1 Public sources total	361,852	395,757	82.84 %
1.1 Public budgets	77,939	85,993	18.00 %
1.1.1 Central government budget	69,503	76,758	16.01 %
1.1.2 Regional and municipal budget	8,436	9,235	1.93 %
1.2 Public insurance companies	283,913	309,764	64.84 %
2 Private sources	14,924	18,235	3.82 %
2.1 Private insurance	564	684	0.14 %
2.2 NGOs	13,163	16,300	3.41 %
2.3 Enterprises – occupational preventive care	1,197	1,251	0.26 %
3 Households	57,344	63,732	13.34 %
Health care expenditures total	434,120	477,724	100.00 %

Source: ČSÚ 2021

d. Regulation of dominant system

» Actors responsible for regulation: The Ministry of Health (MOH) formulates, regulates, supervises, monitors and evaluates policies. The MOH issues a "reimbursement decree" annually, in which it can accept a result of a negotiation process between providers and payers or regulate payments on its own. Together with the Ministry of Finance, the MOH assesses health insurance companies' (HICs) health insurance plans. Health insurance plans consist of expected revenues and expenditures, expected composition of clients, operating cost plan, details of the scope of the services covered by the HICs, description of measures ensuring the availability of services offered by the HICs, and list of contracted providers of health services. The Chamber of Deputies provides the final approval of health insurance plans.

- Regulation of providers: An authorization for health services provision is required (Act. 372/2011 Coll. §16). The regional office for the region in which a health facility or practice is located conducts the authorization procedure.
- The public service package is universal and quite comprehensive. It is defined in Act 47/1998 Coll. on Public Health Insurance (§13). Inclusion of services is in the jurisdiction of Parliament. All types of care are covered, including hospital care, outpatient services and medicines. A list of services, pharmaceuticals, and material that are not covered is presented in Annex 1 of the aforementioned law (§15).

e. Co-existing systems

- There is no co-existing system in the Czech Republic. A marginal number of physicians, midwives, therapists, or private facilities provide their services outside the insurance scheme for direct payments. This may be the case mostly in large cities (Prague) and for specific clients (foreign expats, etc.).

f. Role of global actors

- With the notable exception of the EU, global actors do not play any significant role in providing and financing health care in the CR. The EU's structural funds represent an important source for funding investment and development activities. The third multiannual programme of EU health action (the *3rd Action Programme*) presented an opportunity to finance projects focusing on public health, and for the period 2014-2020, €449.4 million were provided in this way. The programme focused on the protection of citizens' health, promoting a healthy lifestyle, improving access to health care, and building effective health systems. Since the year 2020, a new European investment instrument, *ReactEU* has supported the recovery from the Covid19 crisis and preparation for ecological, digital and resilient recovery. The total allocation for the Czech Republic was 21.7 billion CZK in 2020, and investment projects for the construction, reconstruction, modernisation of selected workplaces and acquisition of instrumentation including beds and fans were supported.

g. List of additional relevant legal acts

- Act no. 48/1997 Coll. on Public health insurance: definition of the whole current system; it replaced the Act 550/1991 Coll.
- Act no. 372/2011 Coll. on Health services: entitlement for health services provision, requirements, typology of services.
- Act No. 95/2004 Coll. on the conditions for obtaining and recognizing professional competence and specialised competence to exercise the medical profession of physician, dentist, and pharmacist.
- Act no. 258/2000 Coll. on Public Health
- Decree no. 428/2020 Coll. "Reimbursement decree" 2021: setting up value of health services, reimbursement methods, and regulatory restrictions.

References

Alexa, Jan, Lukáš Rečka, Jana Votápková, Ewout Van Ginneken, Anne Spranger, and Friedrich Wittenbecher. 2015. "Czech Republic: Health System Review." *Health Systems in Transition* 17 (1): 1-165.

Bryndová, Lucie, Kateřina Pavloková, Tomáš Roubal, Martina Rokosová, and Matthew Gaskins. 2009. "Czech Republic: Health system review." *Health Systems in Transition* 11 (1): 1-122.

ČSÚ. 2021. *Výsledky zdravotnických účtů ČR – 2010-2019* (Results of the health accounts of the Czech Republic). Praha: Český statistický úřad.

Euro. 2018. "Nemocenské pojištění první republiky patřilo k nejlepším v Evropě. Lidé si vybírali z více než 300 pojišťoven". Euro.cz 28.10.2018.

Gladkij, Ivan a kol. 2003. *Management ve zdravotnictví*. Brno: Computer Press.

Heřman, Václav. 2020. *Právní úprava péče o zdraví v českých zemích od roku 1918 do roku 1989.* (The Legislation of Providing Health Care of Residents in the Czech Lands from 1918 to 1989). Plzni: Západočeská univerzita v Plzni.

Kinkorová, Judita, and Ondřej Topolčan. 2012. "An Overview of the Healthcare System in the Czech Republic with Respect to Predictive, Preventive and Personalized Medicine." In *Healthcare Overview*, edited by Vincenzo Costigliola, 95-110. Dordrecht: Springer.

Kinkorová, Judita, and Ondřej Topolčan. 2012. "Overview of Healthcare System in the Czech Republic." *The EPMA Journal* 3 (1): 4-4. https://doi.org/10.1007/s13167-012-0139-9.

Malý, Ivan, Marek Pavlík, and Zuzana Darmopilova. 2013. "Health Reforms in the Czech Republic." In *Health Reforms in Central and Eastern Europe. Options, Obstacles, Limited Outcomes*, edited by James Warner Björkman and Juraj Nemec, 69-94. Den Haag: Eleven Publishing.

Mášová, Hana. 2005. *Nemocniční otázka v meziválečném Československu: moderní pojetí role nemocnice, jak se ormovalo a postupně realizovalo v období první republiky.* Praha: Karolinum.

Murtingerová, Kateřina. 2020. *Pražské nemocnice v letech 1948-1968.* (Prague hospitals during 1948-1968). Praha: Univerzita Karlova

Nemec, Juraj, Marek Pavlík, Ivan Malý, and Zuzana Kotherová. 2015 "Health policy in the Czech Republic: General character and selected interesting aspects." *Central European Journal of Public Policy* 9 (1): 102-113.

OECD. 2020. *Health at a Glance: Europe 2020: State of Health in the EU Cycle.* Paris: OECD.

Pechová, Zuzana. 2019. *Zdravotní péče-historický vývoj financování na našem území.* (Health care – historical development of financing in our territory). Plzni: Západočeská univerzita v Plzni.

Sirovátka, Tomáš, Robert Jahoda, Ivan Malý. 2020. *ESPN Country Profile: Czech Republic 2019-2020.* Brussels: European Commission.

Stibor, Martin. 2012. *Být někdy nemocen je zdravé. Zjistíme, že zdraví je k nezaplacení. Komparace výdaje na zdravotní péči v letech 1918-1938 a 1993-2003.* PhD thesis. Praha: Vysoká škola ekonomická v Praze.

United Nations. 2021. "World Population Prospects 2019." Accessed May 15, 2021. https://population.un.org/wpp/DataQuery/

ÚZIS, ČR 2019. *Zdravotnická ročenka České republiky 2018.* Praha: ÚZIS ČR.

Vurm, Vladimír. 2007. *Vybrané kapitoly z veřejného a sociálního zdravotnictví: pro studující ZSF JCU.* Praha: Triton

World Bank. 2021. "National Accounts Data, and OECD National Accounts data files." Accessed May 15, 2021. https://data.worldbank.org/

World Health Organisation. 2021. "WHO Global health observatory database." Accessed May 15, 2021. https://www.who.int/data/gho