

Optimising Czech Healthcare: Completing the transition



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About this report

Optimising Czech Healthcare: Completing the transition is an Economist Intelligence Unit report, commissioned by Novartis, which looks at the challenges facing the Czech healthcare system as it seeks to complete the evolution of the healthcare system begun following the end of communism in the country.

The findings of this report are based on desk research and in-depth interviews with a range of senior healthcare experts, academics, analysts and insurers. Our thanks are due to the following people for their time and insight (listed alphabetically):

- Kalipso Chalkidou, director of global health policy at the Center for Global Development and professor of practice in global health at Imperial College London, UK
- Tomáš Doležal, director, Institute of Health Economics and Technology Assessment, Prague, Czech Republic
- Pavel Hrobon, partner, Advanced Healthcare Management Institute, Prague, Czech Republic
- Jana Skoupa, president, Czech Chapter of the International Society for Pharmacoeconomics and Outcomes Research, and professor, Medical Data Center, Prague, Czech Republic
- Ladislav Švec, director, Czech Health Insurance Bureau, Czech Republic
- Adam Vojtěch, incoming minister of health, Czech Republic

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Executive summary

In the three decades since the collapse of the Iron Curtain, the Czech Republic has made great strides in modernising its healthcare system. It has made the transition from the fully centralised, command economy system of the communist period to a system modelled more closely on those of its neighbours in the EU, which it joined in 2004.

Life expectancy has risen from just under 72 in 1989, at the fall of the Berlin Wall, to nearly 79 in 2015, still below the average life expectancy in the OECD and EU28, both of which stood at 81 years.¹ The Czech Republic still provides virtually universal medical coverage, and access to modern treatment is comparably good, although funding problems remain.

Yet, the country's healthcare system suffers from several challenges. The overall system of healthcare delivery needs modernisation, with an excess of investment in hospital care rather than in primary care, a looming shortage of general practitioners and an underdeveloped electronic healthcare (e-healthcare) infrastructure driving the need for structural changes. These factors, combined with a lack of sufficient political will for reforming the system, have hobbled policymakers in the past and will present a key test for the country's government.

Many of the problems facing the Czech system are structural in nature. In particular, a lack of modernisation of the system, especially in the provision of mental healthcare services and the introduction of e-health tools, including e-health records, and the absence of legislation to underpin qualitative measurement of the care provided contributes to inefficiency in healthcare delivery.

From a political perspective, there is a lack of clear division of policy-setting roles relating to health insurance spending decisions. Although the statutory health insurance (SHI) is made up of seven independent health insurance funds, the Ministry of Health still dominates spending decisions affecting the insurance funds.

The transition to a fuller functioning, privately operated outpatient sector and the shifting of funding of the hospital sector from the state to health insurance funds has been particularly difficult, given that an effective set of rules governing this change was not put in place at the time of the transition in the 1990s, says Ladislav Švec, director of the Czech Health Insurance Bureau—this is a liaison body for public health insurance and healthcare, the board of which is made up of the general directors of the health insurance funds and representatives of the Ministry of Health and other relevant government agencies.

The transition from a system in which the state dominates the terms of service and payment for services to a system based on the insured's claim against the insurer is a process that continues to

¹ OECD, Life expectancy at birth, <https://data.oecd.org/healthstat/life-expectancy-at-birth>. OECD, Health at a Glance 2017, https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017/life-expectancy-at-birth_health_glance-2017-6-en and The World Bank, Life expectancy at birth, <https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=CZ&view=chart>

evolve, he says. Establishing “a state of independent contractual relations between providers and payers is still the biggest challenge,” he adds.

“The Czech healthcare system is not suited to the challenges of modern healthcare,” adds Pavel Hrobon, a partner at the Advanced Healthcare Management Institute in Prague, which provides degree programmes in the area of healthcare management. “Provision of care is extremely fragmented, the system is not able to provide integrated care for patients with chronic diseases, our hospital structure is outdated in terms of process and there is a growing shortage of doctors and nurses.”

Experts have identified three main areas where policymakers need to focus: more comprehensive development of the infrastructure for health technology assessment (HTA); better provision of primary care and integration with other parts of the healthcare system; and more efficient use of financial resources.

Key findings

The transition from a communist to social insurance system is only partially

accomplished: Czech healthcare delivery continues to reflect the mixed system in which it operates, a still overly influential health ministry with the ability to direct policy and payers who have less input over resource allocation. In addition, a lack of data and underlying legislation make it difficult to measure quality metrics within the healthcare delivery system.

Aspects of the system are outdated: the country’s mental healthcare system remains centered around acute rather than community-centered care. Despite an ambitious plan for connecting the health system electronically, few elements of the programme have been implemented.

Staff shortages foreshadow a crisis in primary care: a growing shortage of GPs is likely to make access to primary care even more uneven across the country. Meanwhile, the excessive use of specialists for many forms of care leads to inefficient use of the healthcare care system.

The HTA system needs further development: the Czech HTA system is lagging compared with neighbouring countries with the same agency taking charge of assessment and decision-making for drug reimbursement, and no organisation responsible for assessing the value of medical devices and other interventions. The lack of relevant legislation or university infrastructure in cost-benefit analysis also undercuts the HTA system.

The financial roles of the health ministry and insurance funds need to be more clearly delineated: the lack of a clear division between the state and insurers, and the lack of a private system, puts further financial strains on both and makes it difficult to account for value for money.

Introduction: Brief background of the Czech healthcare system

The Czech Republic, which has a population of 10.57m people,² has been slowly reforming its healthcare system, following its departure from communism and split from Slovakia in 1993.

Under the Soviet sphere of influence, Czech leaders established a Soviet-style centralised and unified healthcare system in 1952, but this was disbanded following the “Velvet Revolution” of 1989, when the country’s new government introduced an SHI system that dramatically liberalised the healthcare system.³

The Czech healthcare system has evolved so that now citizens are required to be a member of one of the country’s seven health insurance funds, which are both payers and purchasers of care.

There is no private insurance sector comparable with those elsewhere in Europe, although it is possible to pay out of pocket for a narrow range of services not provided through basic insurance. Current Czech legislation does not permit private health insurance.

This transition had several significant consequences for individual stakeholders in the Czech system, according to Jana Skoupa, president of the Czech Chapter of the International Society for Pharmacoeconomics and Outcomes Research and professor at the Medical Data Center in Prague.

For physicians and other healthcare providers, the privatisation of outpatient offices (known as GP clinics in other countries), and increased availability of new medical innovations contrasted with a gap in expertise on how to use new treatments appropriately. For hospitals, the structure of healthcare provision from inpatient beds to more outpatient services and day-case surgery picked up speed, but the number of acute facilities still remains exceptionally large in comparison with needs, say experts.

At the same time, with the general public still lacking the perception of health as an asset and having little access to or awareness of preventative healthcare, the government is still seen as the key body with responsibility for individual health, thinks Dr Skoupa.

Meanwhile, Czech health policymakers continue to struggle to set priorities in healthcare as insurance funds fight to keep costs under control. With the balance of policy and decision-making still favouring the state, despite a payment system largely focused on social insurance companies, full modernisation of the system has been more difficult.

² World Bank, Country profile of the Czech Republic. http://databank.worldbank.org/data/views/reports/reportwidget.aspx?Report_Name=CountryProfile&Id=b450fd57&tbar=y&dd=y&inf=n&zm=n&country=CZE

³ Kinkorova J and Topolcan O, “Overview of the healthcare system in the Czech Republic”, *The EPMA Journal*, 2012, Vol. 3, Issue 4, pages 1-8

Table 1: Key health metrics for the Czech Republic

Indicator	Czech value	OECD value
Mortality (all causes) rate per 100,000 population ²	1,308.2	1,020.9 (EU28)
Infant mortality per 1,000 live births ¹	2.0	3.6
Estimated life expectancy	78.7	80.6
Hospital beds per 1,000 population ¹	6.5	4.7
Doctors per 1,000 population	3.7	3.4
Out-of-pocket expenses (%) ¹	15	20
Mortality due to cancer per 100,000 people ¹	220.5	203.7
Mortality due to ischaemic heart disease per 100,000 people ¹	237	112
Mortality due to respiratory diseases per 100,000 people ²	82	82.5 (EU28)
Suicide rate per 100,000 people ¹	12.3	12.1

Source: OECD, Health at a Glance 2017.

¹ OECD, Health at a Glance 2017 https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017/main-causes-of-mortality_health_glance-2017-8-en

² OECD, Health at a Glance: Europe 2016, <https://www.oecd-ilibrary.org/docserver/9789264265592-en.pdf?expires=1528131844&id=id&accname=guest&checksum=449BD918183C67EF59DFF3162B185081>

Note: Data can also be found via <http://dx.doi.org/10.1787/888933428552> and <http://dx.doi.org/10.1787/888933428644>

“It is not by chance that there is widespread opinion in the public domain that health insurance benefits are provided by the state and not by the health insurance company to which the insured person is a member,” says Mr Švec.

The Czech Ministry of Health is responsible for making health policy, overseeing the health system and preparing relevant health legislation. Meanwhile, the State Institute for Drug Control (SUKL) has a dual function: it regulates the marketing approval and also undertakes their HTA before determining whether or not the drugs will be reimbursed and at what level.⁴ This system is in contrast with other European countries where these functions are often done by two separate organisations. For instance, in the UK, the Medicines and Healthcare Products Regulatory Agency is the regulator while the National Institute for Health and Care Excellence (NICE) is the HTA body.

The Czech Republic does reasonably well on providing nearly universal care to its citizens, with around 50% of the population covered by the state-owned General Insurance Fund, and the remaining 50% insured by six professional funds, which initially covered different professional sectors, such as the military and the banking industry, but now are open to insure anyone in the country.⁵ In comparison, neighbouring Slovakia had one state-owned health insurer covering around 65% of the population in 2016, with the remainder of the population belonging to two privately owned health insurers.⁶

⁴ Alexa J, Recka L, Votápková J et al, “Czech Republic Health System Review”, *Health Systems in Transition*, 2015, Vol. 17, No. 1

⁵ Health Insurance Bureau, Health insurance system in CZ, <https://www.kancelarzp.cz/en/links-info-en/health-insurance-system-in-cz>

⁶ Smatana M, Pažitný P, Kandilaki D et al, “Slovakia Health System Review”, *Health Systems in Transition*, 2016, Vol. 18, No.6

Although the Czech Republic's professional funds are nominally private organisations, they are predominantly differentiated by the services they don't reimburse such as non-mandatory vaccinations and contributions for gym memberships.

Kalipso Chalkidou, director of global health policy at the Center for Global Development and professor of practice in global health at Imperial College London, says: "Systems where there are weak regulatory capacities for working with the private sector, where things have been traditionally done by the state, are tricky because you need to have relationships."

There are few quality measures available to assess the performance of the Czech healthcare system.

Mr Švec points out that there is better availability of highly specialised care in the Czech Republic per capita than in other developed countries, and that Czech public health insurance covers many services not included in basic coverage elsewhere, including spa treatments and some dental care, something that Dr Skoupa also acknowledges.

The number of physicians in the Czech Republic is around 3.7 per 1,000 population, which is slightly above the OECD average of 3.4. Yet, as this paper will outline, staffing is significantly higher in the secondary and tertiary sectors than in primary care, where demand is increasing.

Access to state-of-the-art drugs is generally better in the Czech Republic than elsewhere in the Central and Eastern European (CEE) region,⁷ although the high cost of new drugs has put pressure on government finances, especially in the years after the 2008-09 global financial crisis. These pressures have led to both delays in putting drugs on the reimbursement list and some restrictions on reimbursement of approved drugs, even for eligible patients, according to Tomáš Doležal, director of the Institute of Health Economics and Technology Assessment in Prague.

Yet, although the Czech health system delivers high-level acute and specialised care, experts see a number of targets for improvement.

E-healthcare remains underdeveloped, as we will see later in this paper, and the mental health system is in need of modernisation. And mortality rates from ischaemic heart disease and cancer are higher in the Czech Republic compared with the average in OECD countries (see Table 1).

The country also has an emphasis on acute care—more than half of its population visited an emergency department in 2011-13 because primary care was not available, nearly twice the EU26 average (see Chart 1).

⁷ Detiček A, Locatelli I, Kos M. "Patient Access to Medicines for Rare Diseases in European Countries", *Value in Health*, 2018, Vol. 21, Issue 5, pages 553-560, <https://www.sciencedirect.com/science/article/pii/S109830151830189X>

Chapter 1: Articulating the need for health technology assessment

HTA bodies aim to evaluate the potential impact of new treatments, including the extent to which they are truly innovative and represent value for money. In Europe, one of the most well-known HTA bodies set up was the UK's NICE, which was established in 1999.

The Czech Republic was rather late to the HTA concept. It was in 2008, driven in part by the EU's Transparency Directive, that the Ministry of Health gave SUKL responsibility for carrying out HTAs, which included pharmaceuticals, but it was not given the mandate to assess medical devices, other health treatments and care pathways. This is a factor that those interviewed identify as a key drawback in addressing the value and impact of new technologies in the healthcare system.

In addition, the agency has limited capabilities for doing its own comprehensive analysis of the effectiveness of new drugs, according to Dr Doležal.

"SUKL are not doing their own assessment or own analysis, but they are doing a critical appraisal of the evidence submitted by pharmaceutical companies," he says.

But, since 2013, SUKL has assessed the cost effectiveness of pharmaceuticals based on their budget impact and contribution to additional quality-adjusted life years (QALYs). The threshold for QALYs were initially set according to a "floating" rate, based on the country's GDP from the previous year. In 2017 it was fixed at around €47,000 per each additional QALY gained, with drugs below this threshold accepted for reimbursement.

"Other technology, devices or preventive measures are not under SUKL's scrutiny at all," Dr Doležal adds. "We are a little bit of an outlier in Europe, as we are one of the last countries where HTA is not applied to non-pharmaceutical products."

Of the approximately 30-40 new molecules assessed each year by SUKL, 90% are approved based on managed entry agreements (MEAs), he adds, and virtually all of these agreements are financially based rather than focusing on health outcomes. As a result, those interviewed say, there is little transparency on what criteria is then used to set final prices.

In most cases involving highly innovative and expensive drugs, MEAs consists of a simple discount by the company to SUKL, combined with a price cap for five years, according to Dr Skoupa.⁸

Ultimately, there is an issue around how to finance products that aren't considered cost-effective by SUKL, she adds.

⁸ Kawalec P, Tesar T, Vostalova L et al., "Pharmaceutical Regulation in Central and Eastern European Countries: A Current Review", *Front Pharmacol*, 2017; Vol. 8: Article 892, <https://www.frontiersin.org/articles/10.3389/fphar.2017.00892/full> DOI: 10.3389/fphar.2017.00892

At the end of the day, Dr Doležal and others add, the basic access to new medicines is less of a problem than the amount of time needed to approve innovative drugs for reimbursement by SUKL. The reimbursement process can take up to two years from the date of a product's approval by the European Medicines Agency, he says.

"In many cases, the drugs are [limited] by SUKL for smaller populations or selected populations in comparison with the eligible population [seen in the licensed indications of a product]," Dr Doležal adds, noting that this often appears to be based on economic rather than evidence-based rationale.

Incoming health minister Adam Vojtěch acknowledges that the government is under pressure to reduce the time necessary for determining reimbursement amounts, and that the ministry is interested in finding ways of sharing costs.

"The introduction of the risk-sharing principle is being seriously considered, which would divide the costs between the healthcare system and the pharmaceutical company that supplies the preparation to the market," he says. "The principle is that if the preparation is effective, it will be paid by the insurance company and if it is not effective, the costs will be borne by the pharmaceutical company that brought it."

The level of development of the HTA system in the Czech Republic lags behind that of other countries in the CEE region, Dr Chalkidou says, noting that neighbouring countries have done more to develop HTA, with "relatively mature systems that feed into pricing decisions."

A key problem is that Czech politicians have been thus far unwilling to introduce the necessary legislation to underpin a more detailed, transparent HTA system, which is partially a relic of the communist era, when there was little culture around putting data into the public domain, she adds.

In addition, it also takes time to set up the infrastructure in Czech universities to build up the skills and capabilities needed to carry out HTA assessments.

"If you don't have demand for HTA in the Czech Republic, it is not embedded in universities," Dr Doležal says.

As of June 2018, there has been cautious optimism that the likely incoming government could be amenable to extending HTA to high-cost devices, but the political parties have been unsuccessful in forming a government so far.

Developing parameters to measure the quality of health outcomes will also be key. "It would increase transparency and knowledge about what you are paying for, and create many positive benefits and synergies if you started to evaluate cost and benefit through all parts of the health system," Dr Doležal adds.

Chapter 2: Uneven care provision

Despite significant changes in parts of the healthcare system in recent years, the Czech system is still heavily focused on acute care, with little modernisation of the general practice system or preventive care.

A key factor affecting the weakness of the primary care system is the increasing shortage of healthcare providers, especially in general practice. Data from 2011 and 2013 suggested that nearly 52% of patients who visited a Czech emergency department did so because primary care was not available, compared with an average of around 27% in the EU26.⁹

Mr Hrobon notes that there is a very strong cohort of physicians currently aged between 50 and 60, but one-third of physicians are likely to retire in the next ten years. As a consequence, policymakers will need to find new models of care for outpatient services, including those better able to provide comprehensive prevention services such as screening, health promotion and self-management of chronic conditions. The lack of a system of quality management is hampering such efforts, he notes.

This is something the government appears to be taking on board.

“We want to move on from volume-based care towards value-based healthcare,” said Mr Vojtěch, the incoming Czech health minister. “It is also necessary to develop new payment mechanisms that will take into account integrated care for chronically ill patients.”

Although the Czech Republic has roughly the same number of physicians per 1m population as other countries across the OECD, provision of outpatient care is uneven, with staffing shortages especially in rural areas. There is very little co-ordination of care or exchange of medical information, Mr Hrobon notes.

In addition, Dr Skoupa notes, the system is less efficient than it should be because many prescriptions and medical interventions are restricted to specialist care providers. Czech patients have among the highest frequency of annual contact with physicians and six times the number of specialists compared with the OECD average.

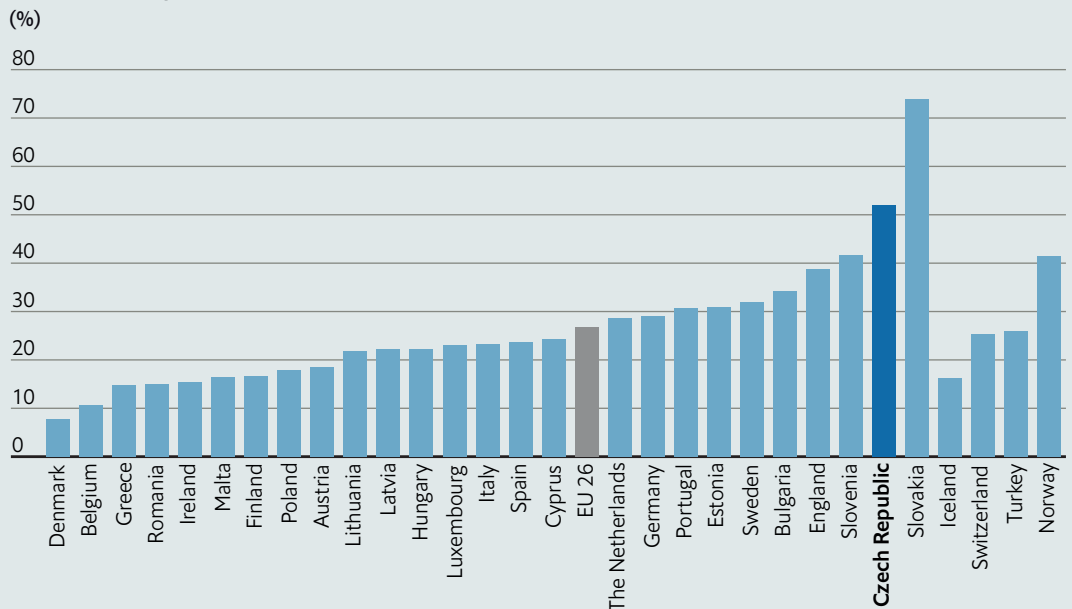
The Czech Republic also lags behind many of its European neighbours in the development of a community mental healthcare system.

A 2016 study of the country’s mental health system since 1989 found that mental healthcare had not seen any fundamental systemic change since the 1990s, due in part to the continuing lack of financial resources and the lack of a national policy for mental healthcare.¹⁰ Public health insurance rules around expenses provide an incentive for private outpatient psychiatrists to

⁹ OECD, *Health at a Glance : Europe 2016*, https://ec.europa.eu/health/sites/health/files/state/docs/health_glance_2016_rep_en.pdf

¹⁰ Dobiasova K, Tušková E, Hanušová P et al, “The Development of Mental Health Policies in the Czech Republic and Slovak Republic since 1989”, *Central European Journal of Public Policy*, 2016, Vol. 10, pages 35-46.

Chart 1

Proportion of patients who visited an emergency department because primary care was not available, 2011-13

Source: Health at a Glance: Europe 2016 - OECD 2016 (available as Excel).

“see a high number of patients without taking the time to provide a proper therapy,” the study found. And a 2015 article in *European Psychiatry* found that levels of stigmatisation of those with mental illnesses were higher in the Czech Republic compared with England.¹¹

A World Health Organisation report found that Czech government expenditure on mental health in 2013, the latest year for which data are available, was around 3% of overall health spending, compared with an average of 6% for the European region as a whole.¹²

¹¹ Winkler P, Csémy L, Janoušková M et al, “Reported and intended behaviour towards those with mental health problems in the Czech Republic and England”, *European Psychiatry*, 2015, Vol. 30, Issue 6

¹² Quoted in Dobiasova K, Tušková E, Hanušová P et al, “The Development of Mental Health Policies in the Czech Republic and Slovak Republic since 1989”, *Central European Journal of Public Policy*, 2016, Vol. 10, page 37.

“[Provision of mental healthcare] is a proxy for health system strengthening, like mothers giving birth,” says Dr Chalkidou. “It’s a significant predictor of systems that function or not.”

Historically, the Czech system was based on large inpatient institutions. While discussions on how to introduce more community-based care have been taking place for the past two decades, the high investment needed for such a reform and the lack of communication between the healthcare system and social care system have put major changes on hold, Dr Skoupa notes.

Because community care is more costly to introduce, reform of the institutionalised mental healthcare system has been slow. Still, in the case of mental healthcare, as in the case of other areas considered to be core responsibilities of the state, Czech patients are resistant to taking up the cost burden themselves, Dr Skoupa notes.

“People are willing to pay to have plastic surgery or for dental care, but they are not expecting or willing to pay for mental health or to treat hypertension,” she adds.

The government is developing a plan to modernise mental health and a pilot project of five centres is currently under way, with the aim of eventually placing at least one centre in each district of the country, says Mr Vojtěch.

“The aim of these mental health centres will be to look after patients who are currently in the general community, and to preventively detect cases that would otherwise lead towards hospitalisation,” he adds.

A key area in which modernisation of the healthcare system has lagged behind that of other European countries is in the area of e-health provision. The Czech government has had ambitious plans for improving its e-health offering since 2008. A white paper by the Ministry of Health into e-health projects in 2016 laid out a series of targets, including e-health documentation, electronic prescriptions, electronic identification and payment systems for insurers and health service providers, as well as the consolidation of ministry data and clinical protocols as part of HTA.

Much of this programme remains on the drawing board,¹³ and the Czech e-health capacity remains extremely low, especially in comparison with that of its CEE neighbours such as Estonia, Dr Skoupa says.

“They have set out a lot of documents, but it usually ends with shelving them,” she adds, noting that there was significant opposition among pharmacists to the idea of e-prescriptions.

Although there is little movement toward national standardisation of e-health, the electronisation of healthcare and the development of telemedicine has been a more bottom-up process, with some pilots taking place at the local scale, says Mr Švec.

The new government hopes to expand the use of telemedicine, including teleradiology, Mr Vojtěch says, noting that telemedicine could be especially useful in the care of chronically ill patients.

¹³ The Ministry of Health, “National eHealth Strategy of the Czech Republic: 2016-2020”, https://www.dataplan.info/img_upload/7bdb1584e3b8a53d337518d988763f8d/national_ehealth_strategy__v0.2_en.pdf

Chapter 3: Towards a more efficient system of financing care

Although Czech healthcare expenditure has generally kept pace with demand, rising from the equivalent of 5.7% of GDP in 2000 to 7.3% in 2016, it still has one of the lowest rates in the EU (see Table 3).¹⁴ And the way in which funding is directed remains a key issue for some observers.

Problems following the financial crisis in 2008–09 led to solvency problems for the country's health insurance funds, although these were sufficiently resolved by 2012. At the time of the financial crisis, health insurers had accumulated some Kc40bn (US\$1.85bn) in their reserve accounts, yet much of this was spent during the recession that followed 2008.

Hospital-based physicians and other healthcare providers have been successful in recent years in striking for higher salaries amid a brain drain of healthcare specialists and some nurses abroad, Dr Skoupa and others note. Yet increasing staff costs and more expensive medicines have put additional pressure on insurance funds. When the government agreed to increase salaries for health workers, it directed the insurance funds to pay the higher wages, without increasing health spending. As a result, insurance companies, despite being more stable financially than in years past, have virtually no cash reserves.

"These increased costs are mainly compensated for by reductions of coverage of pharmaceuticals," Dr Skoupa says. "This was done successfully for a number of years; however, now there are not many sources for such savings."

The pressures on the health insurance funds are exacerbated by the lack of a significant private healthcare sector, with commercial healthcare activities largely covering a narrow range of unreimbursed services. Consequently, the Czech Republic has one of the highest rates of public expenditure on healthcare in the EU. However, out-of-pocket expenses are around 15%, which is still significantly lower than other CEE countries, according to Dr Skoupa.

Tentative efforts to increase contributions from patients have also been unpopular, Mr Švec says, noting that the introduction of a system of "regulatory fees" for a doctor's visit or hospital stay in 2008 were politically unpopular, and significant adjustments were made thereafter.¹⁵

"People think that by paying taxes, which are not very high, that they should have the newest drugs and interventions," Dr Skoupa says.

The lack of any comprehensive system of quality measurements means that insurance funds are left to distribute money to hospitals and physicians on the basis of pure accounting numbers rather than on quality or performance indicators, those interviewed say.

¹⁴ Latest OECD figures from 2016.

¹⁵ See also: van Ginneken E, Ottichova A and Gaskins M. "User Fees in the Czech Republic: the continuing story of a divisive tool," *Eurohealth*, 2010, Vol. 16, No. 3, pages 1-4

Table 3: Health expenditure as a percentage of GDP in OECD countries (2000-16)

Country	2000	2005	2010	2016
Australia	7.6	8.0	8.5	9.6
Austria	9.2	9.6	10.1	10.4
Belgium	7.9	9.0	9.9	10.4
Canada	8.3	9.1	10.6	10.6
Chile	7.0	6.6	6.8	8.5
Czech Republic	5.7	6.4	6.9	7.3
Denmark	8.1	9.1	10.4	10.4
Estonia	5.2	5.0	6.3	6.7
Finland	6.8	8.0	8.9	9.3
France	9.5	10.2	10.7	11.0
Germany	9.8	10.3	11.0	11.3
Greece	7.2	9.0	9.6	8.3
Hungary	6.8	8.0	7.6	7.6
Iceland	9.0	9.2	8.8	8.6
Ireland	5.9	7.6	10.5	7.8
Israel	6.8	7.1	7.0	7.4
Italy	7.6	8.4	9.0	8.9
Japan	7.2	7.8	9.2	10.9
South Korea	4.0	5.1	6.5	7.7
Latvia	5.4	5.9	6.1	5.7
Luxembourg	5.9	7.2	7.0	6.3
Mexico	4.9	5.9	6.0	5.8
The Netherlands	7.1	9.3	10.4	10.5
New Zealand	7.5	8.3	9.7	9.2
Norway	7.7	8.3	8.9	10.5
Poland	5.3	5.8	6.4	6.4
Portugal	8.4	9.4	9.8	8.9
Slovakia	5.3	6.6	7.8	6.9
Slovenia	7.8	8.0	8.6	8.6
Spain	6.8	7.7	9.0	9.0
Sweden	7.4	8.3	8.5	11.0
Switzerland	9.3	10.3	10.7	12.4
Turkey	4.6	4.9	5.1	4.3
UK	6.0	7.2	8.5	9.7
US	12.5	14.5	16.4	17.2

Source: OECD
<http://stats.oecd.org/index.aspx?DatasetCode=SHA>

The mismatching balance of power between the government and insurance funds must also be confronted to enable the Czech system to work better, Mr Hrobon and others say, with the division of roles and competencies still unclear.

“In terms of financing, there is a more competitive health insurance system, but the [health] ministry still has strong powers and roles that don’t fit well with a statutory [insurance] system,” he says, noting that national and regional government bodies are directly responsible for managing the majority of hospital beds and have disproportionate say in negotiations with insurers and providers.¹⁶ “The country has returned to the social role of insurance but hasn’t curbed the role of the health ministry accordingly.”

Czech incoming government proclamation proposals on healthcare

In a proclamation, cited by a local Czech newspaper (iDNES.cz)¹⁷ in May 2018, the incoming Czech government proposes that it will provide a “high-quality, modern and financially stable public service for citizens”.

In the proposals the following priorities are included:

- Preparation of a law incorporating the regulation of medical devices and a more flexible system of pricing and reimbursement of medicines to make it easier to bring “life-saving medicines with proven benefits” to patients. Introduction of a more transparent health technology assessment system with a greater emphasis on cost-effectiveness.
- Preparation of a new approach to the functioning of health insurance companies, including the possibility of reducing their number and increasing the availability of care, especially outside working hours.
- Modification of the existing law governing e-prescriptions, and extension of the electronisation of healthcare and data sharing between health providers.
- Introduction of quality control measurements, including financial incentives for providers and greater transparency for patients.
- Expansion of the skills of GPs and the strengthening of primary care.

¹⁶ <http://www.who.int/health-laws/countries/cze-en.pdf>

¹⁷ https://zpravy.idnes.cz/dokument-prohlaseni-vlada-ano-cssd-dtl-/domaci.aspx?c=A180511_070724_domaci_bur

Conclusion

The Czech healthcare system has real promise for modernisation, with some areas needing specific attention, according to experts. These include strengthening HTA processes, which include the expansion of technologies assessed, the upgrading of mental healthcare service provision, the uptake of e-health measures and more efficient financing.

The make-up of the next government remains unclear at the time of writing, but those interviewed articulated a few key priorities for the incoming health minister, most of which focus on system innovation involving laws and regulations of the health system. A recent proclamation by the government published on a news site lays out a series of ambitious plans for continuing the development of e-health and improving the HTA apparatus (see Boxout). Regulations also need to be brought up to date, a process that is likely to go hand in hand with giving more responsibility to health insurers.

Ministers could bring in more qualitative measures, starting with basic metrics of process-based outcomes—such as the volume of procedures, fulfillment of recommendations in clinical guidelines—before moving to results-based or patient-focused outcomes. Although the first could be accomplished within a year or two, the second is likely to take upwards of five years, Mr Hrobon says.

The implementation of both structural and cultural changes to the Czech health system will not be a quick one. However, a process of modernisation and streamlining of health delivery will allow the Czech Republic to continue to offer improved outcomes to its citizens comparable to those of its European neighbours.

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