Statutory health insurance in the Czech Republic - selected topics

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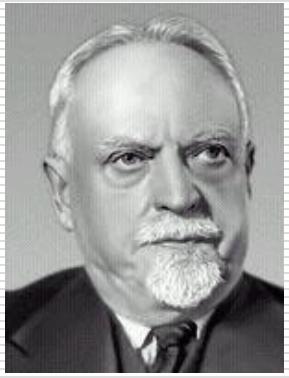
Typology of European health systems

- Beveridge systems = systems of National Health Service
  - UK, Spain, Portugal, Italy, Scandinavia
- Bismarck systems = systems of social health insurance
  - Germany, Netherlands, Switzerland, Austria, Poland, CZ, Slovakia, France, Belgium
- Semashko = centralized healthcare system, centrally planned
  - former Soviet Union and countries of Eastern Block



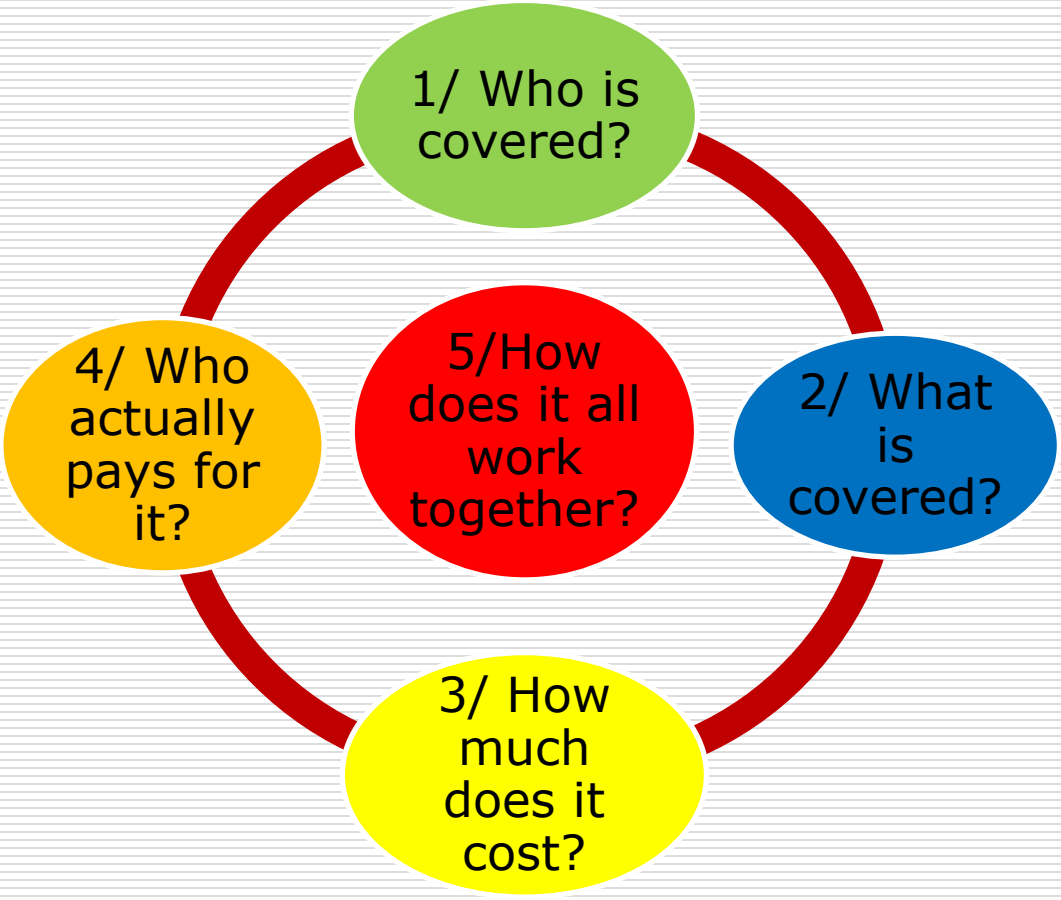
Main characteristics of a typical social health insurance system

- Main source of financing: payroll taxes and contributions made by employers
- Fragmented self-regulated health funds established by employers
- Usually collective negotiation on prices and contracts between health insurance funds and groups of providers
- Private and public providers of health services
- Patient can choose among contracted providers, gatekeeping often missing

Intro: Social health insurance in CZ

- Czech Republic a landlock country, 10.5 mil people
- **According to ability to pay** not according to individual health risk
- **Continuous system, mandatory participation and payment, solidarity as the basic principle**
- Regulated, fixed % from salaries of employees (incl. employers) and self-employed
- **Part** of system revenue also **from general taxes:** State pays on behalf of certain groups of population
- minimum / maximum assessment base

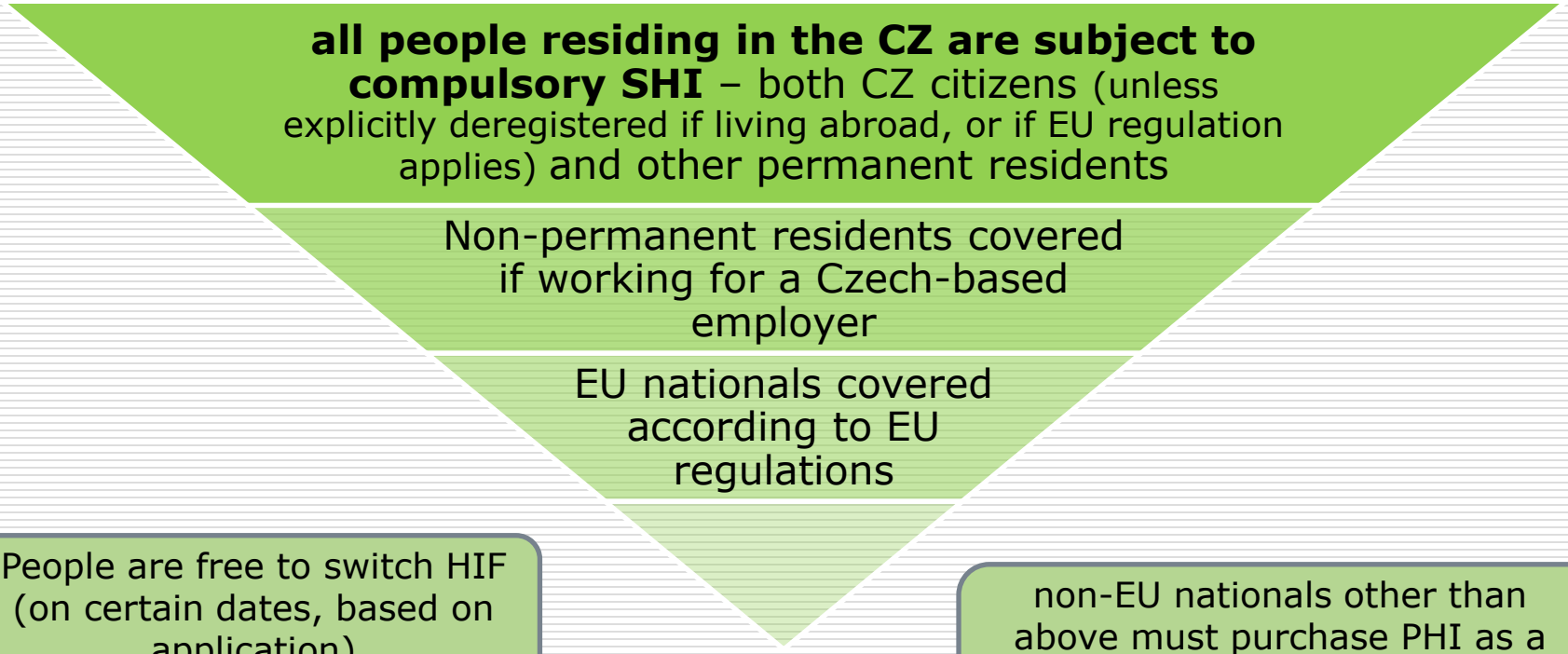
Outline – Czech SHI system



POPULATION COVERAGE

- **Social health insurance**
  - since 1991
  - compulsory membership in one of 7 health insurance funds (public, self-governing bodies, act as payers and purchasers of care)
- **Virtually 100% of population covered by the SHI**
- **Entitlement** to coverage based on **permanent residence** and enshrined in the law

Entitlement to coverage based on **permanent residence** and enshrined in the law



People are free to switch HIF (on certain dates, based on application)

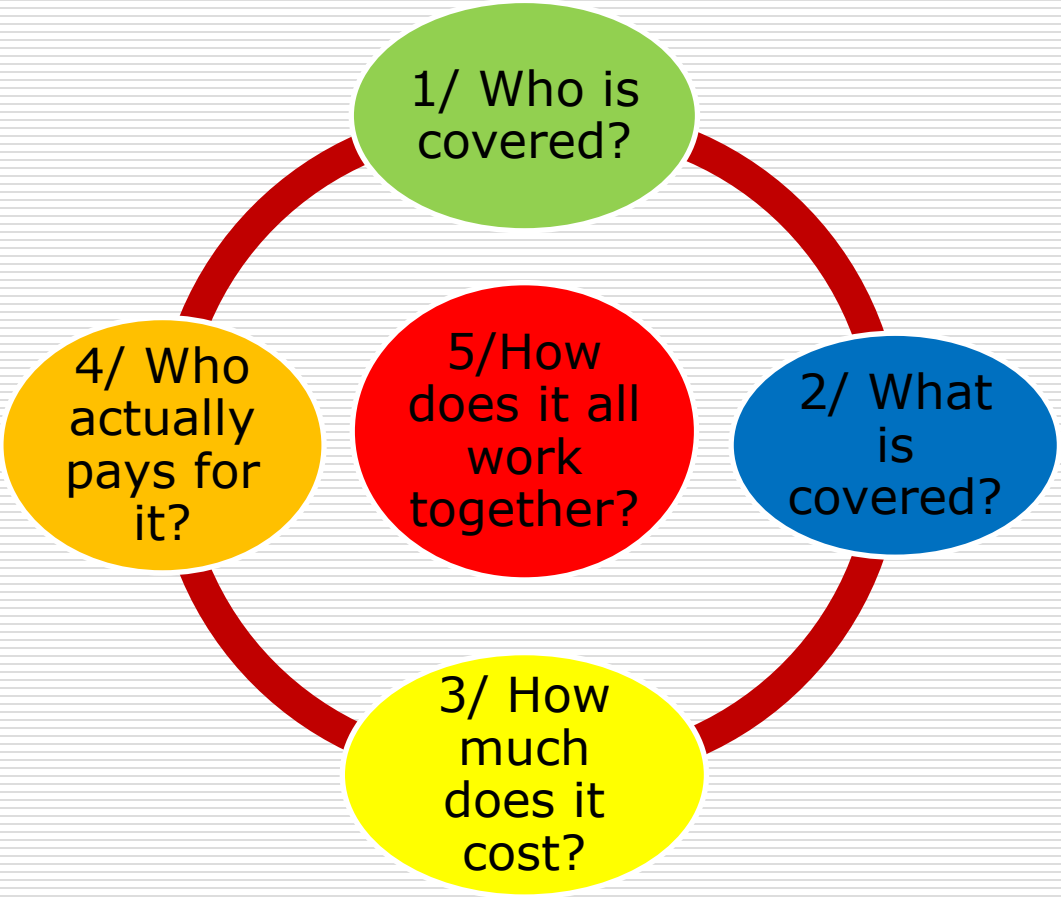
Insurance funds cannot deny admission

non-EU nationals other than above must purchase PHI as a condition to remain in the CZ (health insurance compulsory)

SHI coverage

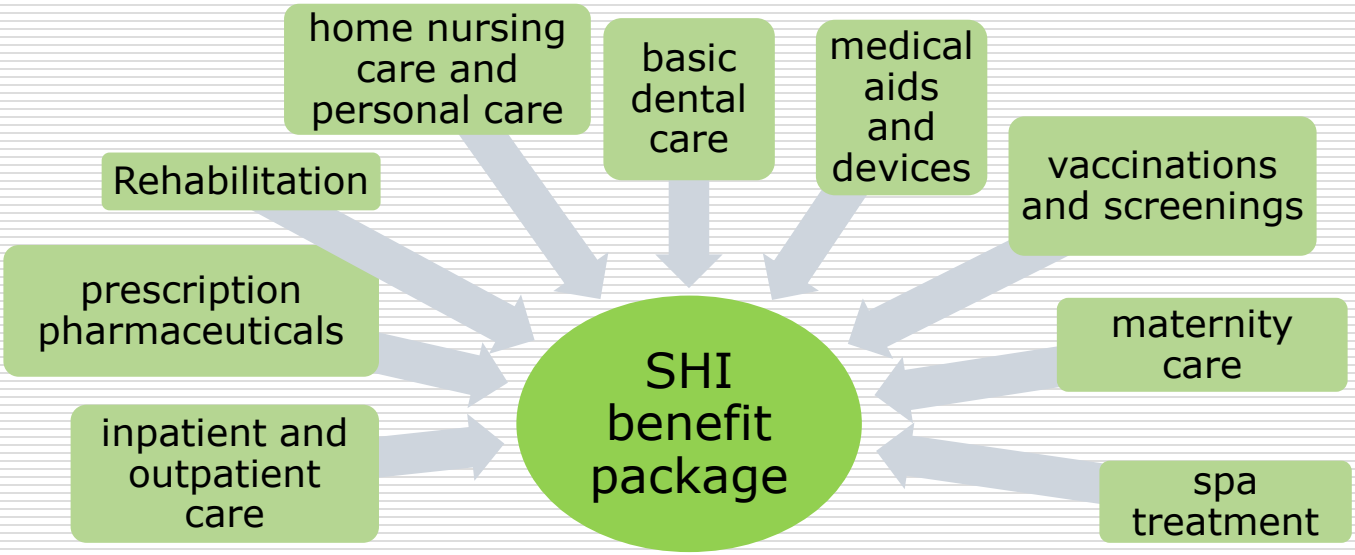
- not conditional upon paying health insurance contributions on time
- ie. debts on contribution do not alter scope or type of services accessible under SHI coverage
- still, there must be a payment made on behalf of every insured person. If not, a person (or employer) is issued a penalty for delayed payment.
- basically, a person falls within at least one of the State insured category (explained further), or must pay a minimal contribution (defined by law).

Outline – Czech SHI system



Benefit package

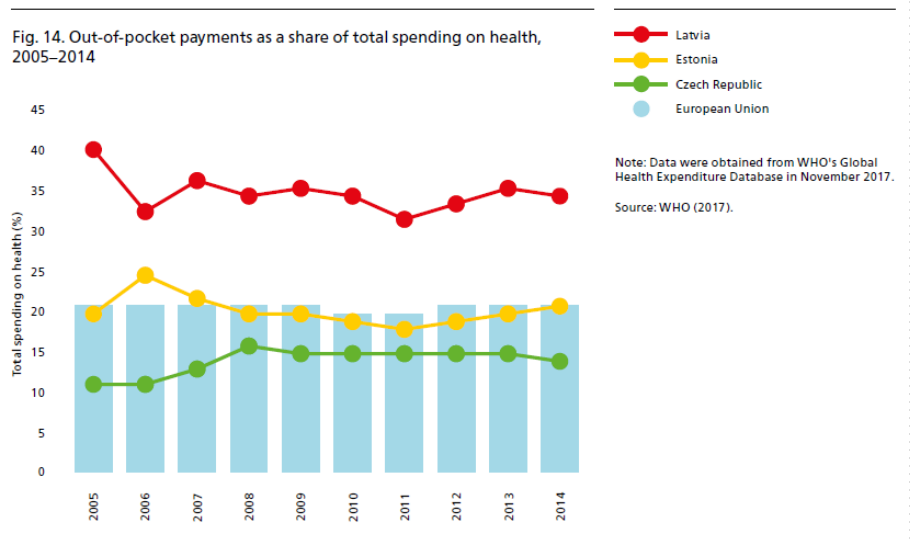
Very broad and generous, covering basicaly all health care services:



Apart from pharmaceuticals and medical aids, partial coverage is not permitted.

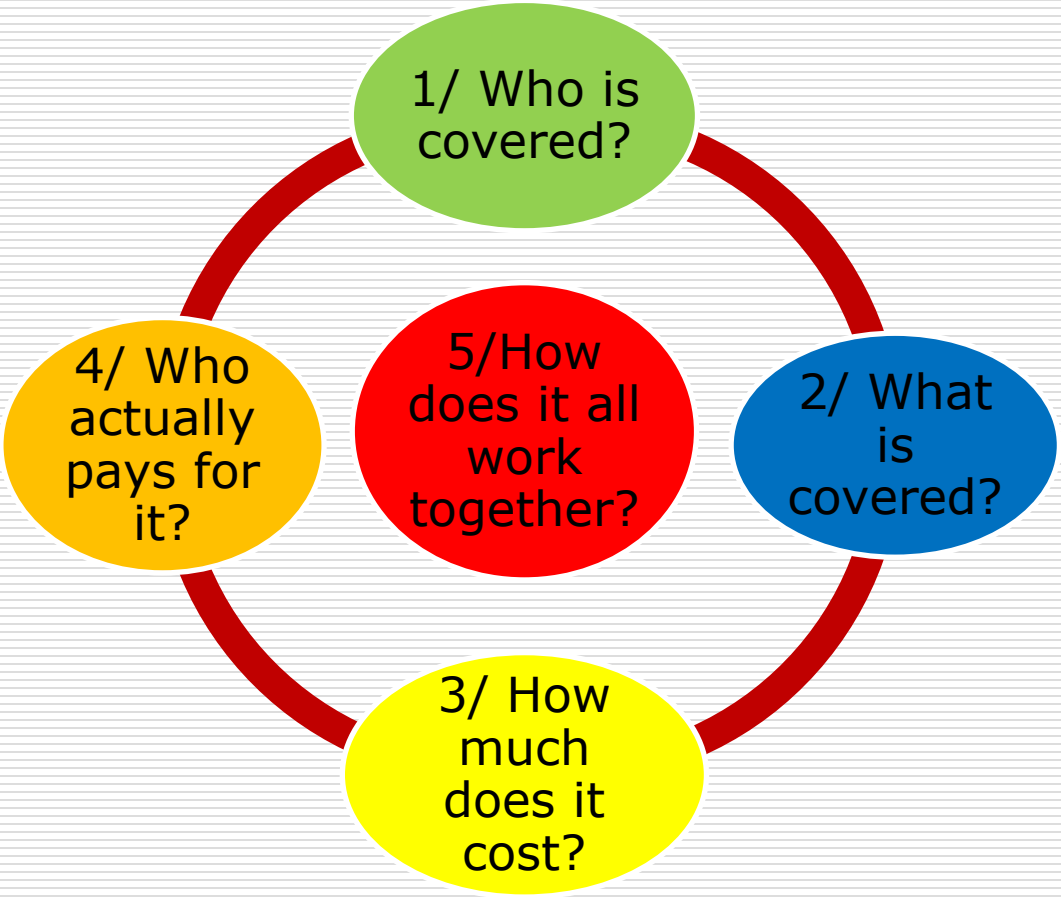
What is left for **cost-sharing**

1) Over-the-counter pharmaceuticals and some dental procedures
2) copayments on medical aids and prescription pharmaceuticals
3) user fees (currently only for using ambulatory services outside of standard office hours)
4) plastic surgery, VIP services in hospital (one-bed room), voluntary abortion,…

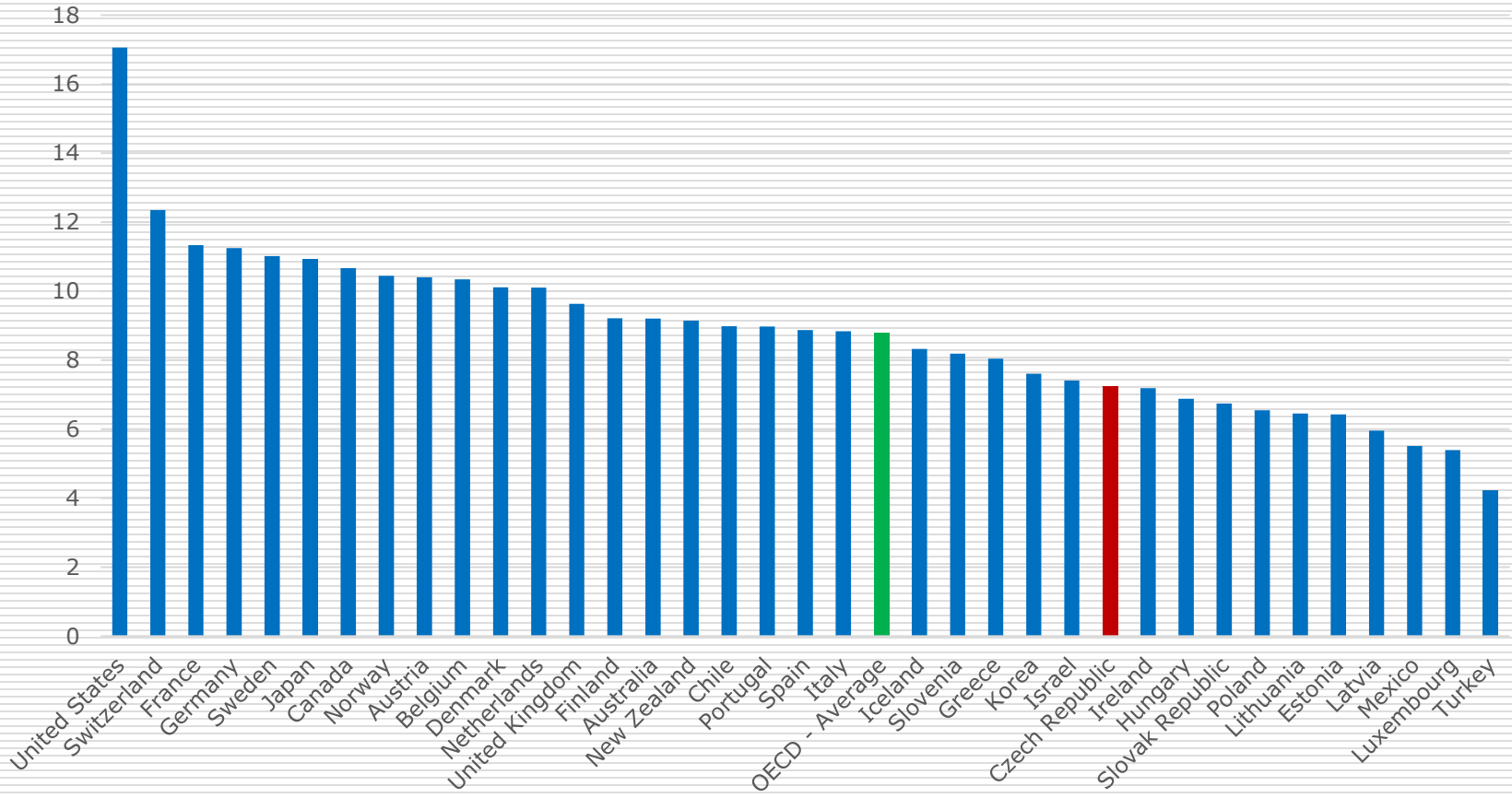


Yet, there are caps, or stop-loss limits, on defined copayments

Outline – Czech SHI system

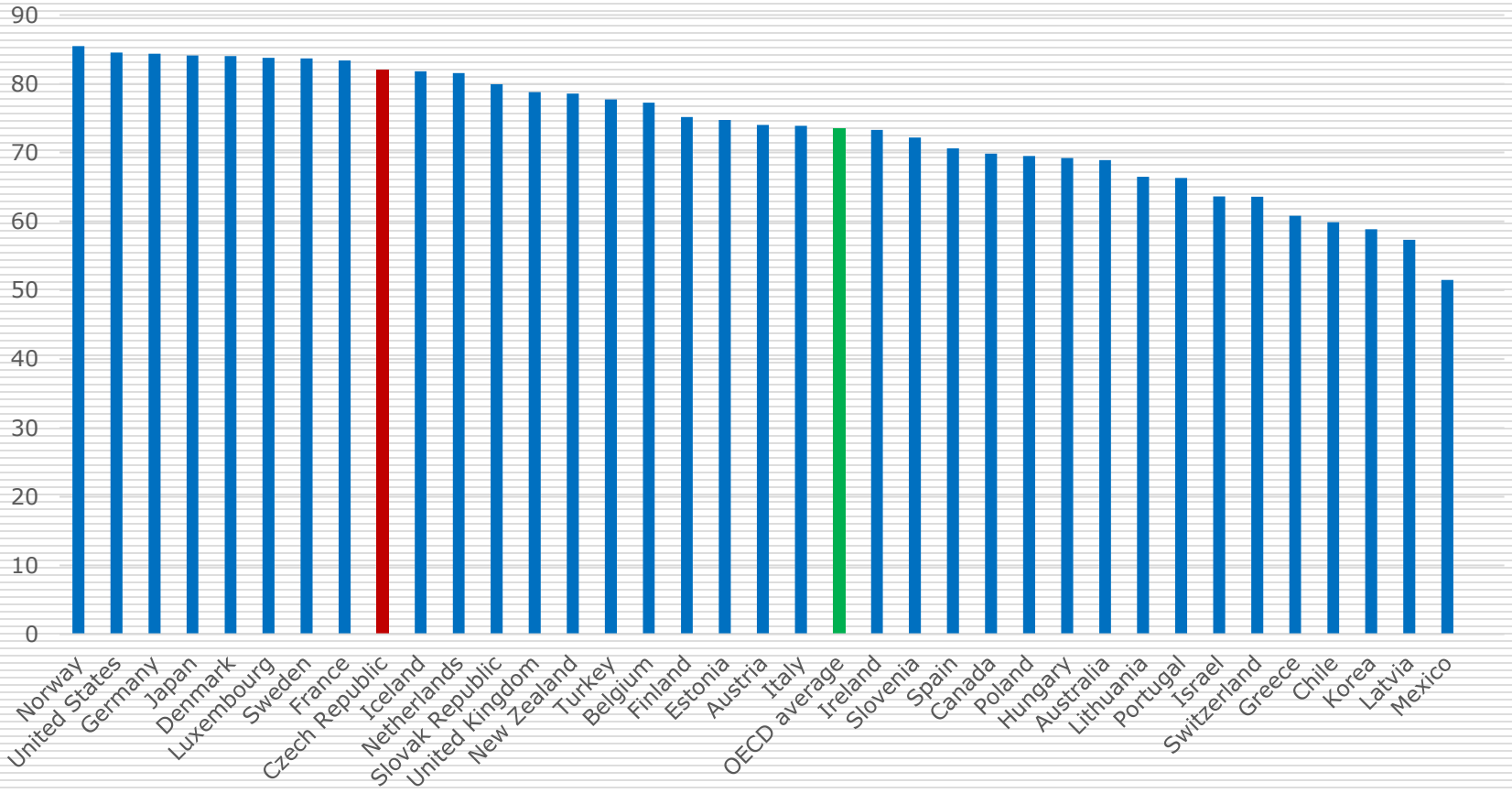


Total healthcare expenditures as % of GDP



Source: OECD Health Statistics 2019 (data refer to 2017).

CZ: dominant public financing – 82% of THE



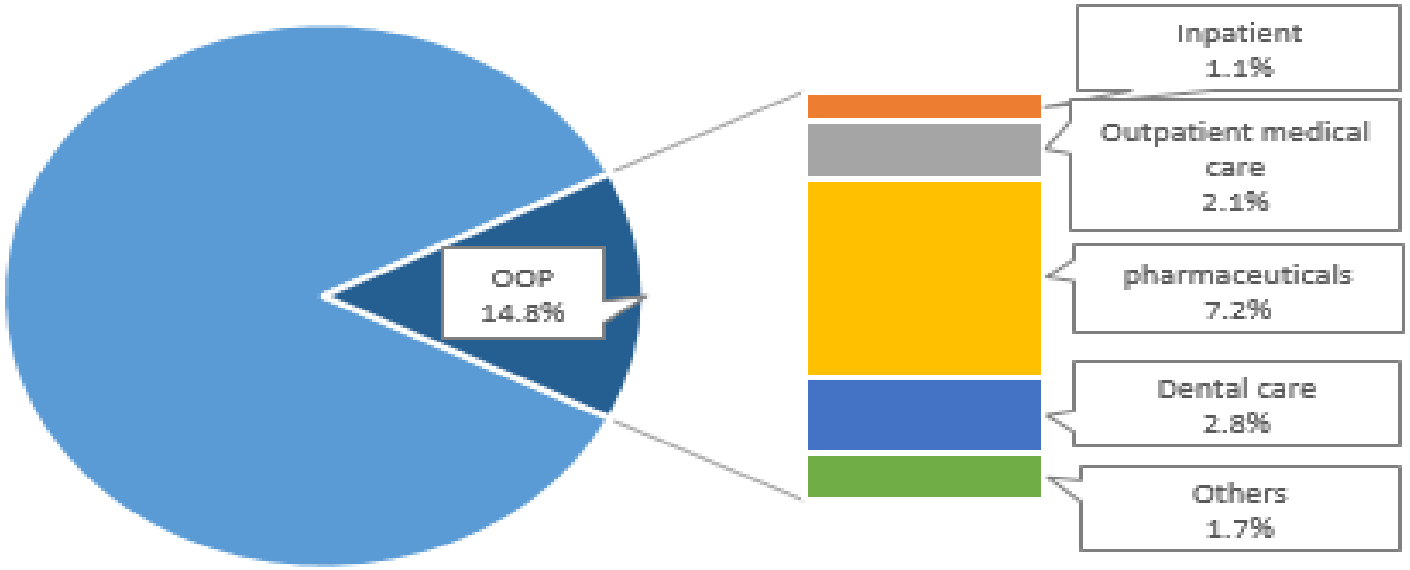
Source: OECD Health Statistics 2019 (data refer to 2017).

OOP spending - mainly payments for pharmaceuticals

Czechia

Overall share of health spending

Distribution of OOP spending by type of activities



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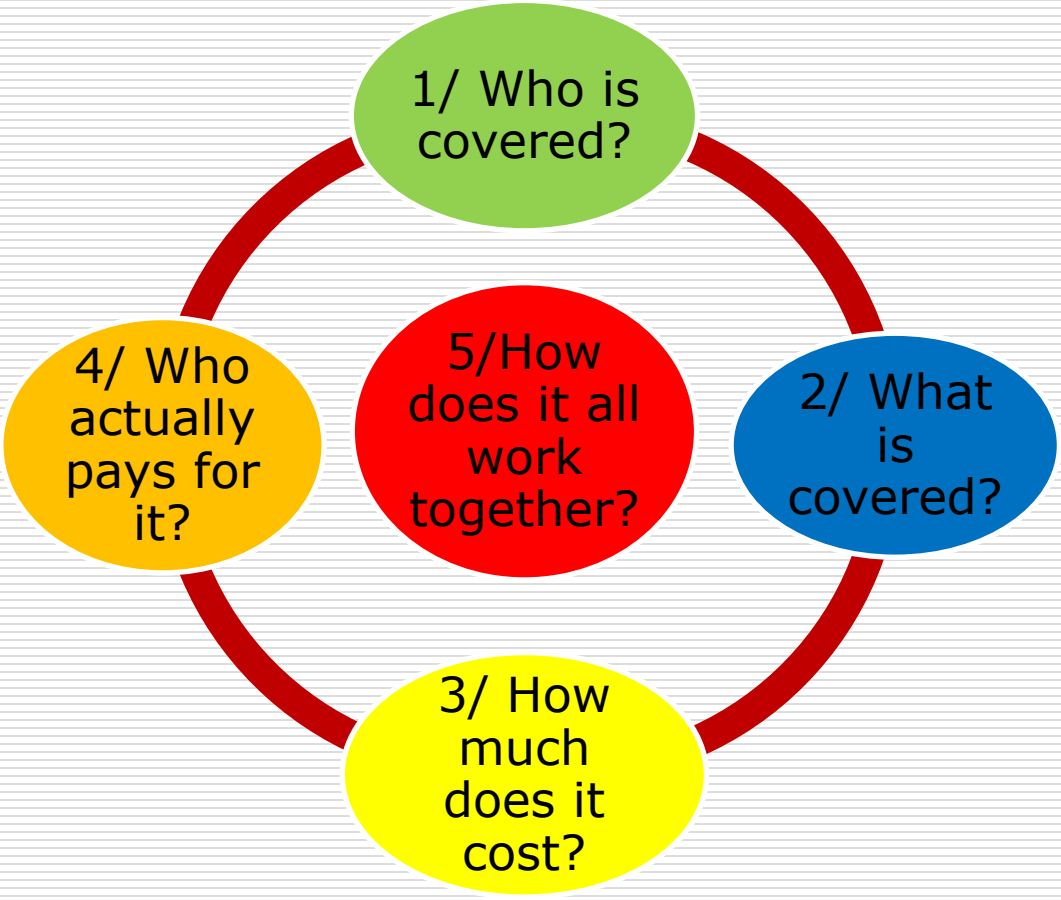
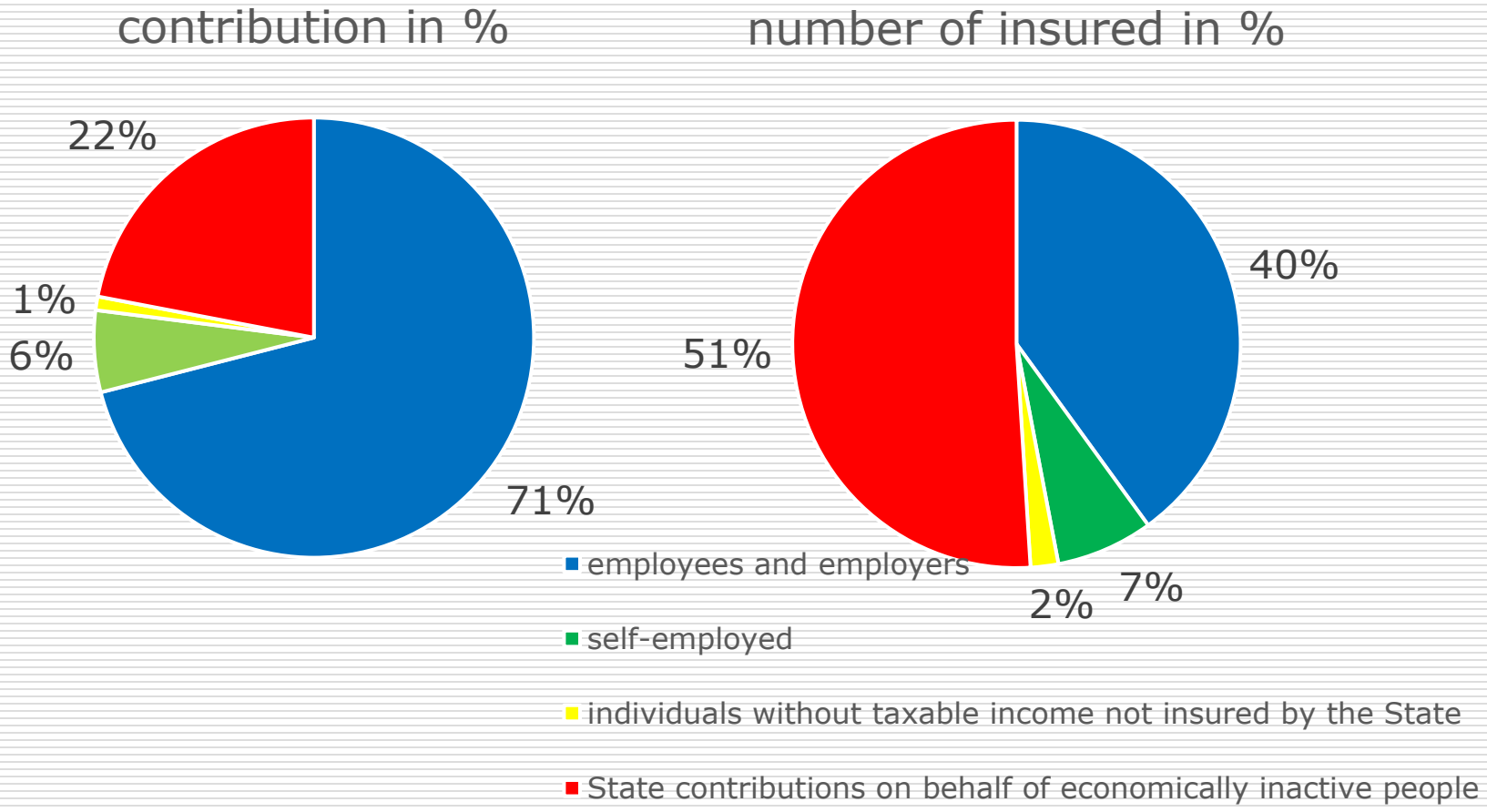


SHI revenues by contributors VS number of contributors by revenue categories (2019)



State payment on behalf of economically inactive people

- in place **since inception** of SHI in 1990's
- financed through **general taxation**
- **eligible** groups of people **defined by law**
- Always **per capita payment**, its calculation has evolved over time. Often, its adjustments used for various policy purposes (not only health).
- A moderate **counter-cyclical tool** due to its per capita nature

Eligible groups of „State insurees“


children


students


pensioners

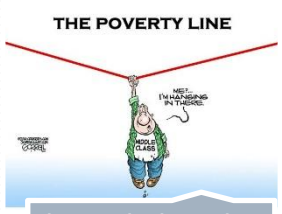

unemployed


prisoners


asylum seekers


maternity leave


parental leave

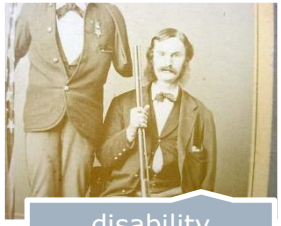


living below the poverty line


moderate to serious dependency + caregivers

armed service (not soldiers)

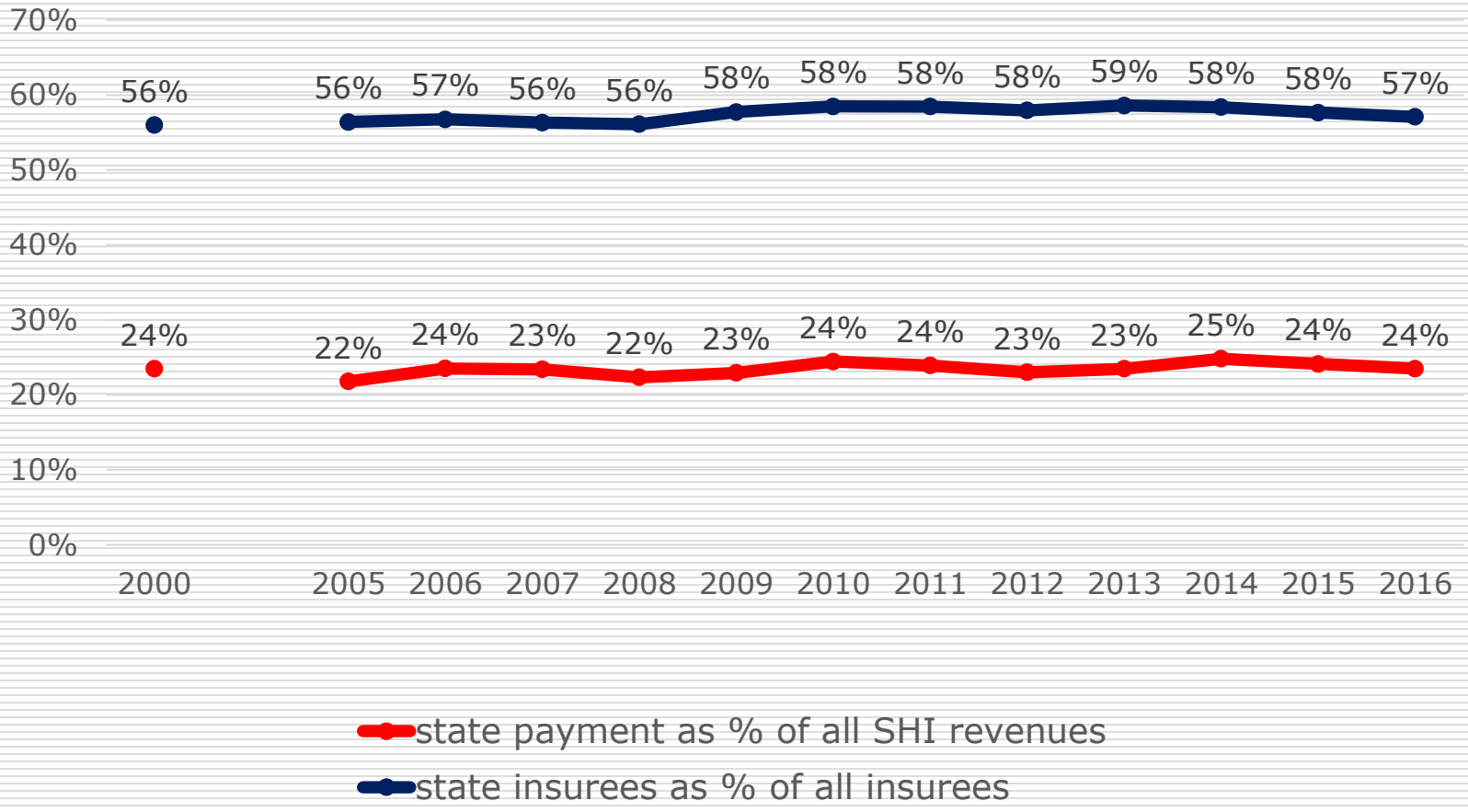

without taxable income if ill over long period


disability pensioners


Parental care, 1=7yrs, 2=15yrs


long-term volunteers

State payment as % of total SHI revenue
State insurees as % of total number of insured



State payment calculation

At the beginning, it wasn't thought of as adequat premium contribution of the so-called State insurees as compared to other contributors. Instead, a **flexible mechanism to subsidize the SHI system**.

The contribution per person is set by law, but can be adjusted by governmental decrees.

State per capita monthly payment in 2018: **EUR 38**

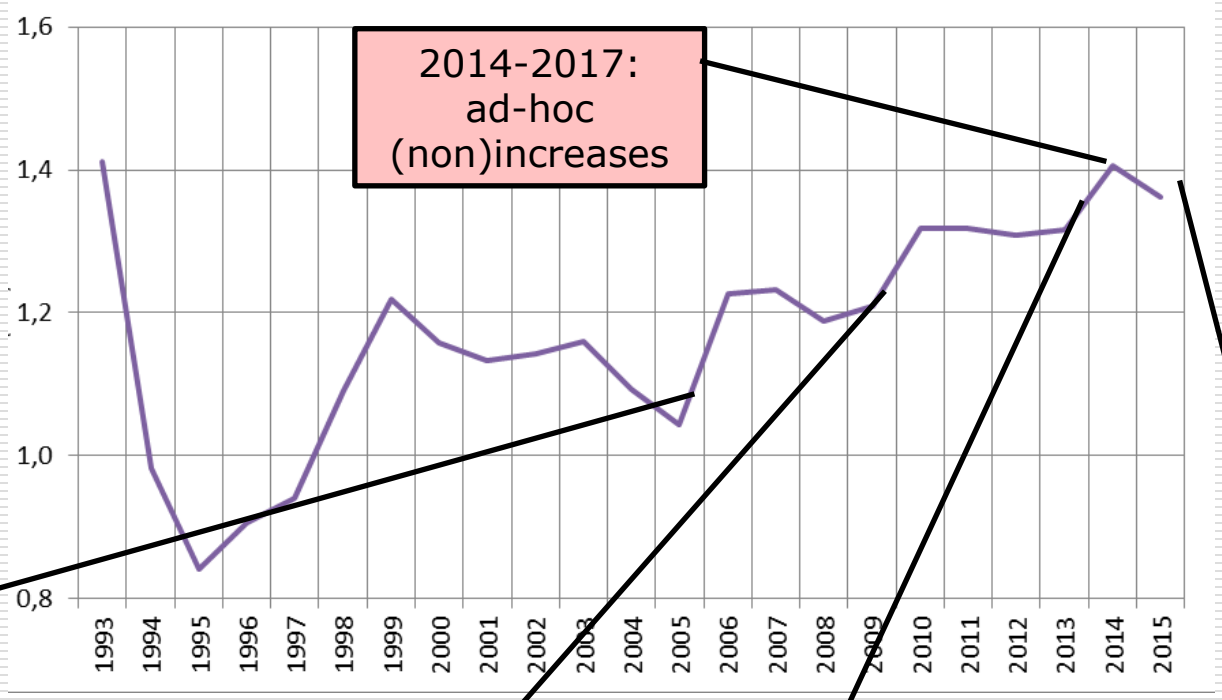
≠

Average contribution (employer+employee) per **employed person: EUR 160** in 1stQ 2018

Objective of the tool regularly discussed and questioned.

Many think the automatic valorisation of state contribution per person should be stated directly in the law and not left to current political will. Talks on this issue make regular part of political discussion in the Chamber of Deputies.

State budget contributions into SHI system as % of GDP



2014-2017: ad-hoc (non)increases

2018: governmental proposal: automatic valorisation based on social contribution average base from 2020 on

2006: payment linked to average wage

stagnated during economic crisis

2014: link to economic performance abolished

2018-2020: political agreement on annual increase of EUR 137.3 mil

COST SHARING and **FINANCIAL PROTECTION** in the Czech Republic

„The role of political populism in healthcare cost-sharing“

- User fees
- Pharmaceutical copayments
- Copayment caps (stop-loss limits)

User fees – a short-lasting epizode (2008-2014)

Before 2008 and since 2015, inpatient and ambulatory care services free of charge at the point of use. 2016: 15 outpatient contacts per cap (the highest in WHO Euro)

2008 Aim: to contain costs by reducing inappropriate demand

Safety net : exemptions and stop-loss limits (copayment caps)

Exemptions : preventive services, people living below the poverty line, neonates, chronically ill children, pregnant women, tissue and organ donators, patients with infectious diseases

2009: children up to 18years of age exempted from user fees for doctor visit

Amount: EUR 1.20 per doctor visit; EUR 2.40 per hospital day; EUR 3.60 per use of ambulatory services outside of standard office hours; EUR 1.20 per prescription pharmaceutical (later changed to per prescription)

2011: user fee per hospital day increased to EUR 4

Constitutional Court ruling in 2013: abolished the user fees for hospital stays *(„EURO 4 per day could be too much for some vulnerable groups*")

Since January 2015 – user fees per doctor consultation and pharmaceutical prescription abolished (**political populism**)

2018: the only user fee per use of ambulatory services outside of standard office hours (90 CZK)

Changes in user fees, 2008–2015

Type of service	User fee 2008	User fee 2013	Changes envisaged for 2015
GP visits	CZK 30 (€1.20)	CZK 30 (€1.20)	abolished
Ambulatory specialist visits	CZK 30 (€1.20)	CZK 30 (€1.20)	abolished
Out-of-office-hours ambulatory care visits	CZK 90 (€3.60)	CZK 90 (€3.60)	CZK 90 (€3.60)
Hospital stays (per day)	CZK 60 (€2.40)	CZK 100 (€ 4.00)	abolished
Pharmaceuticals (per item)	CZK 30 (€1.20)	abolished	abolished
Pharmaceuticals (per prescription)	Not introduced	CZK 30 (€1.20)	abolished

Pharmaceutical copayments

For prescription pharmaceuticals, maximum prices based on international benchmarking

Reimbursement system based on **reference pricing** (reference group = group of therapeutical substitutes, ATC)

- Basic reimbursement level for a reference group = least expensive pharmaceutical in that group AND/OR substances for which at least one pharmaceutical should always be fully covered (list as appendix to the law)

What counts into the copayment cap:

- Copayment (in full or in part or zero) on a prescription pharmaceutical whose **actual price exceeds the reference price** in a particular pharmaceutical group
- **In part**: up to the copayment of the least expensive drug with the same therapeutical substance and the same way of administration
- **Zero**: if that least expensive drug is fully reimbursed

2008: 57% of prescribed and collected pharmaceuticals without any copayment (apart from the user fee)

Generic substitution allowed since 2008

Copayment caps (out-of-pocket stop-loss limits)

New: limit for disabled people

Introduced in 2008 in line with user fees introduction

A **user-friendly system** for patients, all administration done by the HIFs, **no patients' claims necessary**.

HIFs check whether limits have been reached **on quaterly basis**. All additional user fees (before their abolishement) and eligible drug copayments that the patient paid are automatically reimbursed to him/her (**account transfer or postal order**)

2008: **annual limit EUR 200**, counts with user fees (not for hospital stays and for ambulatory services outside of standard office hours) and eligible copayments on prescription drugs (in 2008, this limit reached only by **0.2% of all insured people**)

2009: limit lowered to **EUR 100 for persons under 18 and above 65 years** (2013: limit reached by **2.2% of population**)

2018: limit for **people under 18 and over 65 lowered to EUR 40**, for those **above 70 lowered to EUR 20**, **all others EUR 200**

=> 1st half of 2018: **30times more people reached the limit**, HiFs already 10times more money reimbursed than 1st half of 2017 (EUR 7.4mil already, estimated EUR 17.5mil for the whole 2018)

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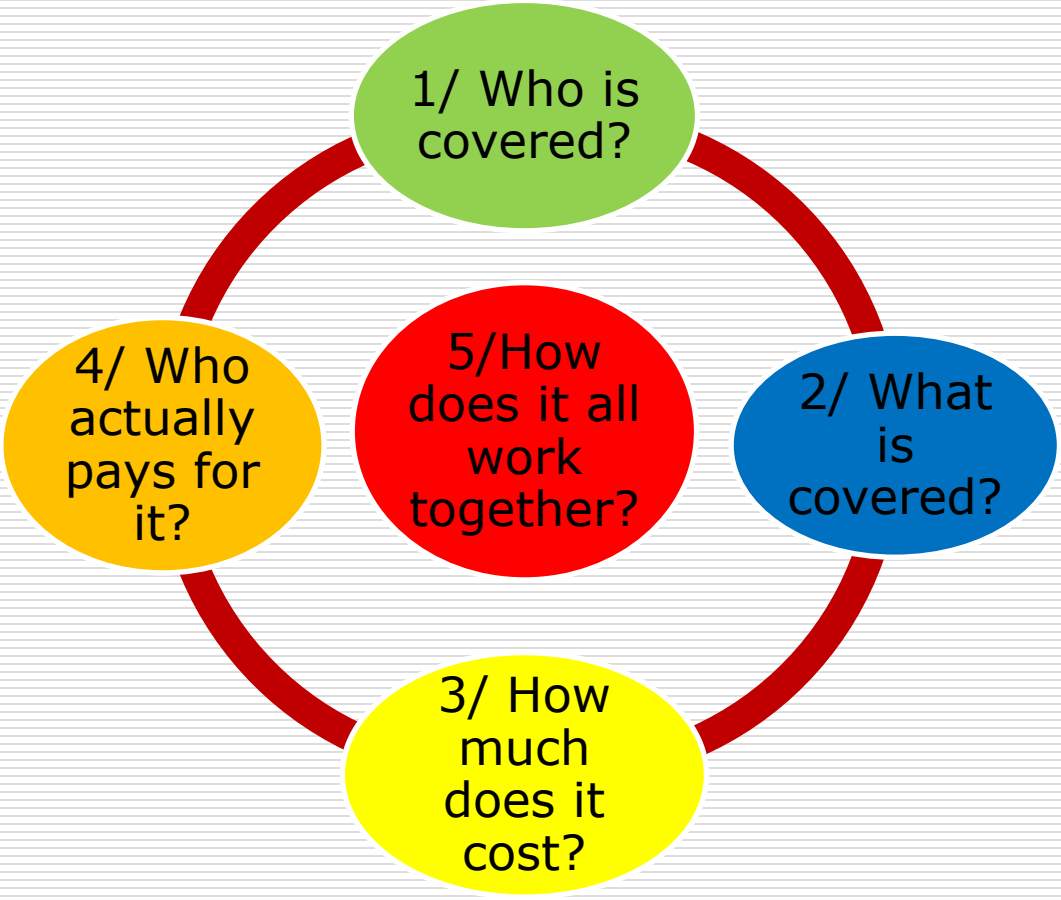


How can it all work together?

1. Mandatory participation
2. No admission denial allowed
3. Very generous basic benefit package by law
4. Premiums based on ability to pay
5. Existence of risk adjustment + redistribution of revenues

Risk adjustment, redistribution

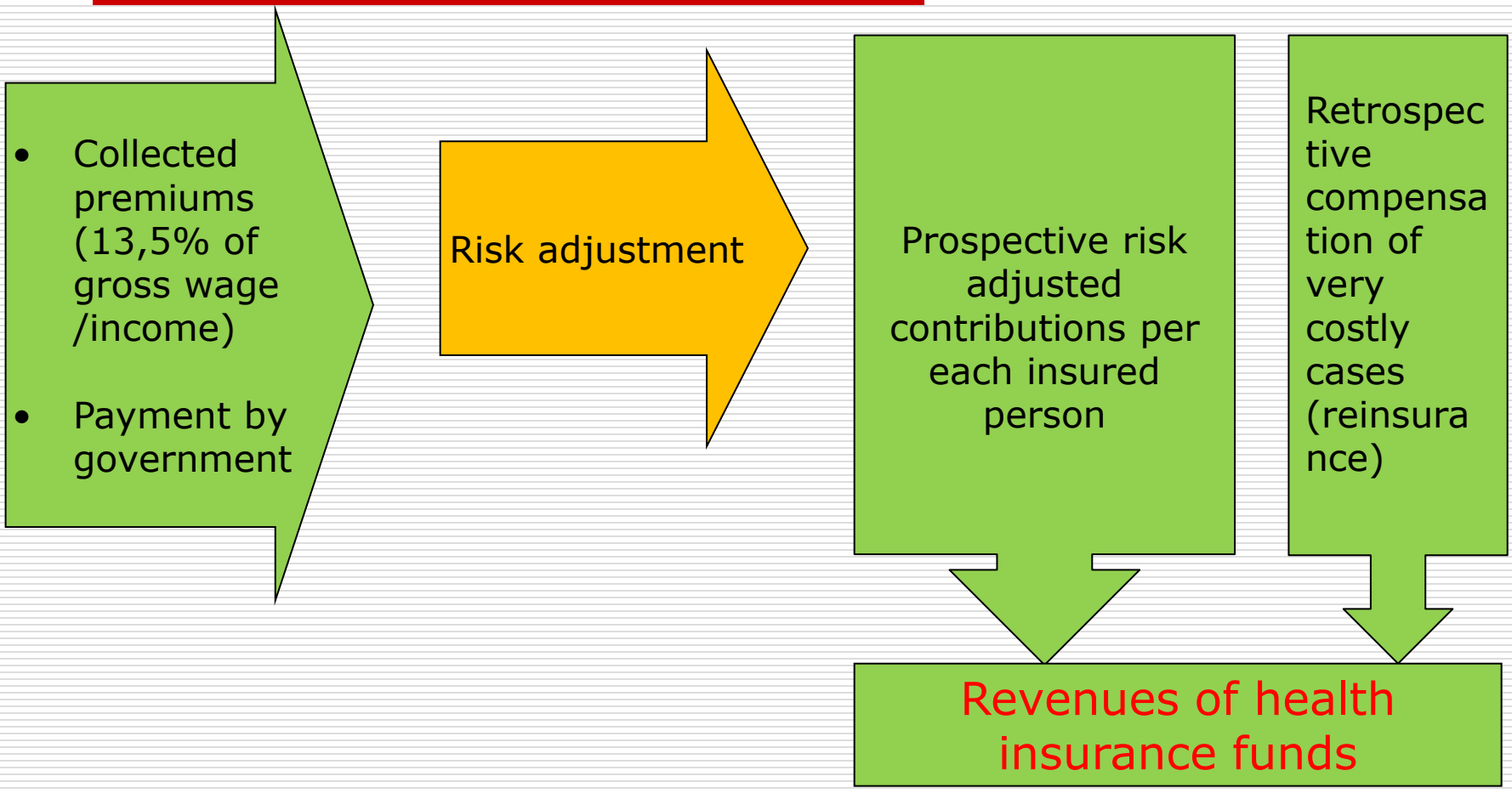
- All SHI revenues are subject to redistribution

- To level differences in health risks of insured population + to compansate for very expensive cases (reinsurance)

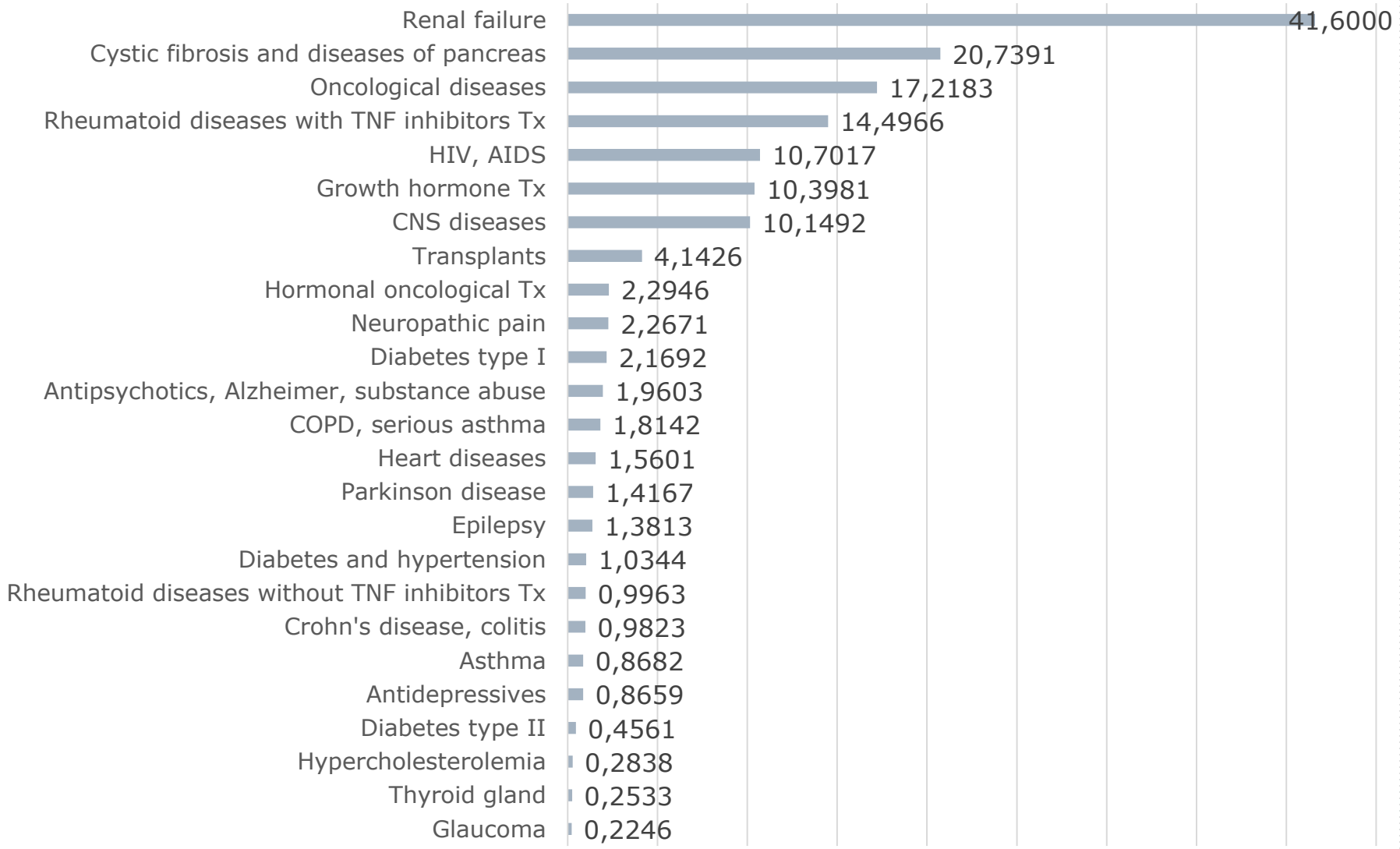
=> To minimize adverse selection

- 38 age-sex interacted risk cathegories + 25 (noninteracted) pharmaceutical-based cost groups (PCGs)
- Redistribution scheme is zero-sum. Though health insurers do not purchase the reinsurance, they pay an implicit premium for it.
- High ability of the redistribution model to cover substantial share of differences in individual health care costs.

Financial flows in the CZ social health insurance system



PCGs indexes



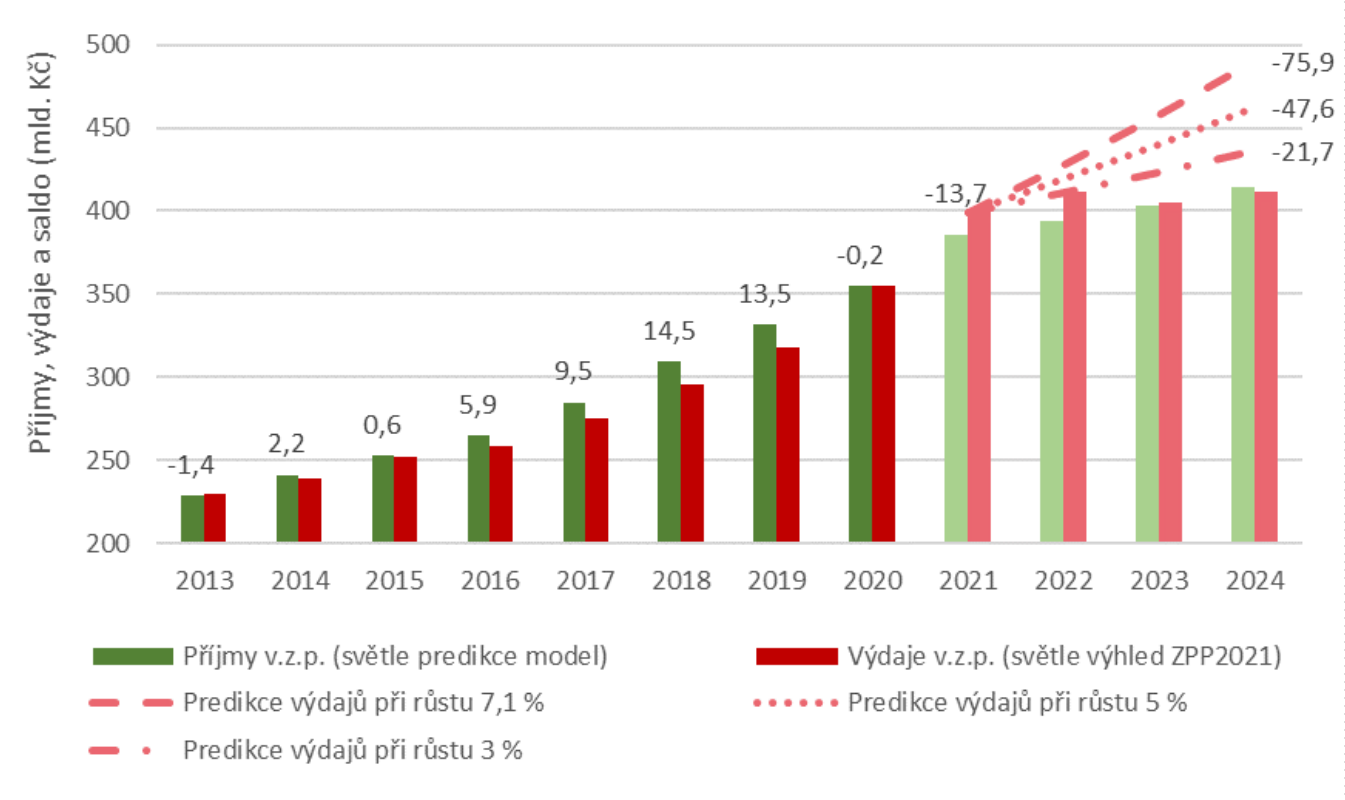
Source: Law no. 592/1992 Coll. , amended by 145/2017 Col., valid since 1. 1. 2018

Thank you for your attention.
Let's discuss..

For discussion

- What is left for coinsurance / private insurance ?
- Where, in what domain, can health insurance funds actually compete?
- What would you suggest to change in system‘s setting to make it more efficient?
- How vulnerable do you think is such system to external (economic) conditions?
- And to other external factors such as population transition?

Financial Sustainability

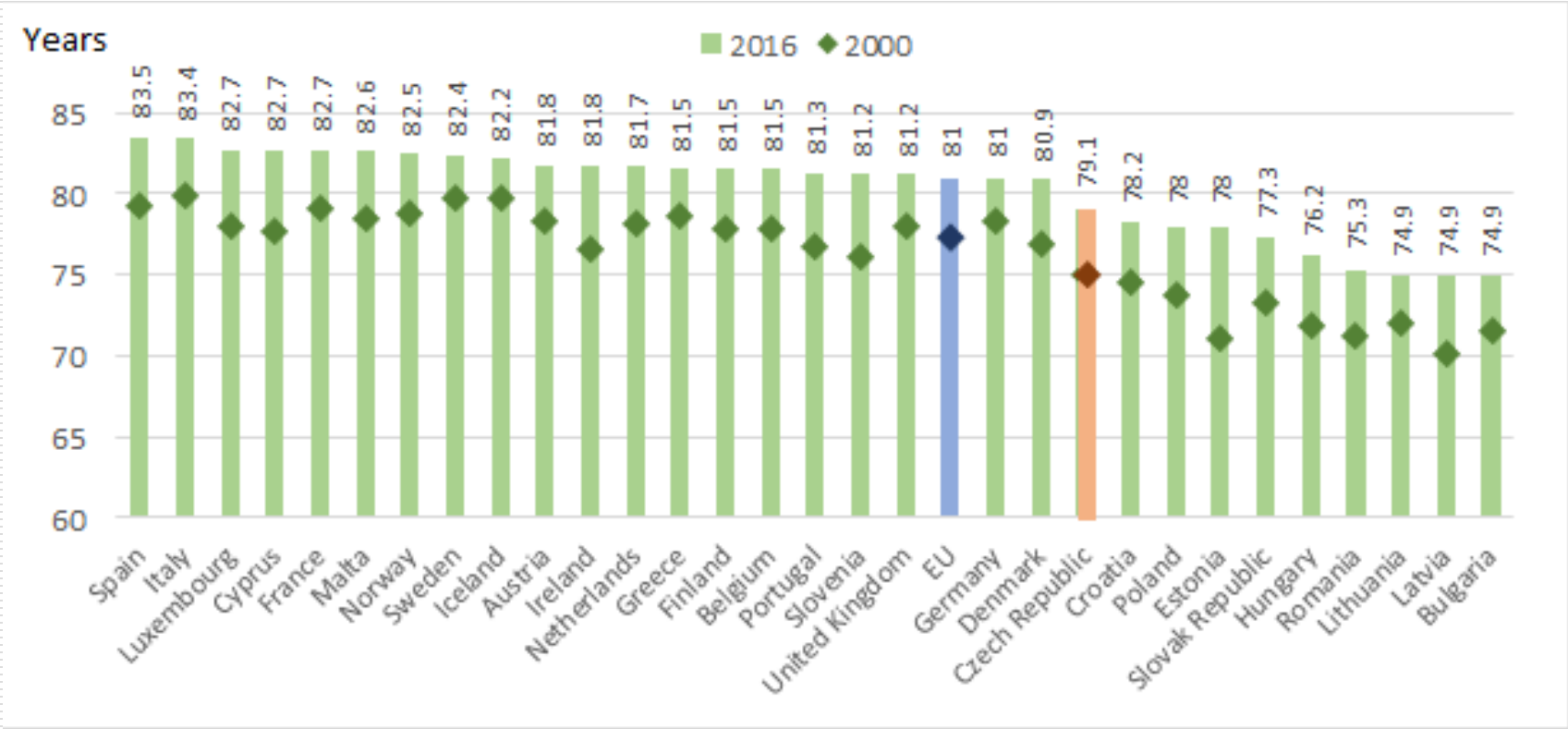


Source: Bryndová, Šlegerová (2021), IDEA paper

Population Ageing financial Sustainability gap for Health systems (PASH) Simulator

- https://eurohealthobservatory.who.int/themes/observatory-programmes/health-and-economy/population-ageing-financial-sustainability-gap-for-health-systems-simulator

Life expectancy (2016)



Source: Eurostat Database.