The Reform of the Czech Health Care System

Olga Výborná

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Abstract

Systém zdravotní péče je jedinou státem tradičně dominovanou sférou, která prošla po politických změnách na konci roku 1989 radikální reformou. Nový systém zdravotní péče je silně orientován směrem k zajišťování zdravotní péče prostřednictvím institucí, které jsou v soukromém vlastnictví. Tento systém usiluje o vyvolání pocitu osobní zodpovědnosti obyvatel za jejich zdravotní stav. Tuto skutečnost lze vysvětlit silnou zainteresovaností provozovatelů zdravotní péče v období přípravy i realizace reformy.

Nový systém trpí typickým neduhem moderních zdravotních systémů -nekontrolovatelným růstem nákladů. K růstu nákladů přispěla reforma zejména vyvoláním dalších administrativních nákladů v průběhu budování systému zdravotních pojišťoven, technickými chybami v systému regulace cen a zavedením čistého systému plateb provozovatelům za vykonané služby v kombinaci s amatérsky sestaveným číselníkem výkonů.

Nicméně nový systém je kompatibilní s tržní orientací celého nového ekonomického systému, nenarušil kvalitu ani přístupnost poskytované zdravotní péče. Lze předpokládat, že se další vývoj zdravotního systému bude ubírat cestou, na kterou nastoupil v uplynulých 3 letech. Bude se soustředit na vylepšení struktury zdravotního pojištění a cenové regulace a o zavedení úprav a doplnění systému plateb za výkony tak, aby byli účastníci systému nuceni snižovat, respektive nezvyšovat náklady.

Abstract

The health care system is the only sphere traditionally dominated by the state that went through radical reform after the political changes at the end of 1989. The new health care system is strongly orientated towards the private provision of health care and is striving to introduce a sense of personal responsibility in individuals for the status of their health. It is possible to conclude that this fact is explicable by the strong support and active co-operation of health care providers in the preparation and realization of health care reform.

The new system suffers from the common problem of all health care systems - the difficulty of controlling increases in costs. The reform of the health care system contributed to cost increases by imposing an additional administrative cost for the creation of a system of health insurance companies, by technical mistakes in the system of price regulation, and by introducing a pure fee-for-service reimbursement system in combination with an amateur fee-for-service Price List.

Nevertheless the new system is compatible with the new market orientation of the whole economy and did not distort the accessibility or quality of health care. In future, the Czech health care system will most likely follow the path on which it has embarked during the last three years. It will concentrate on improvements in the structure of health insurance and price regulation, and on introducing cost-combating modifications of the fee-for-service system.

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Introduction

In this paper several important aspects of health care reform in the Czech Republic after the political changes of November 1989 are discussed.

The health care (HC) reform effort is often criticized for lacking a general concept. Critics state that the absence of a sophisticated, general and detailed conception of reform caused inconsistency in the new system and also some organizational gaps. Some even predict the early collapse of the new system, or at least a rapid deterioration of the national heath status.

There are a number of shortcomings in the contemporary system and some of them are addressed in the sections that follow. Most problems could probably be avoided by following a well-considered plan, step by step. However, it may be ambitious to expect a general plan.

It is interesting to compare the Clinton HC reform plan in the United States with our reform: in the US there are thousands of well-qualified experts with high quality technical data and background. Yet the US plan is still only under discussion. The task set for our reformers was at least as complicated as the task of the American reformers, and there is no doubt that the informative and material conditions of the Czech reformers were far from being comparable with those in the United States.

Advocates of rapid reform stated that the original health care system was incompatible with the new economic situation. From their point of view, rapid reform was unavoidable. There is no way to prove this statement. Nevertheless, it is possible to state that the "trial and error version of reform" did not distort the accessibility and quality of health care.

The new system in the Czech Republic is now at the point where it is possible to start collecting data for an objective evaluation of the system’s performance. Hopefully this paper will be contribute to this evaluation process.

The first section of this paper is devoted to a brief report of the main changes that have occurred up until now, concentrating on the analysis of the forces and reasons that have set the health care system on this path to reform.

The second section describes how the new system works, stressing the most complicated changes. Here the concentration is on health insurance companies’ behavior, especially whether the new system gives some space for competition

in the HC market, and how the changing ownership structure and reimbursement system of HC providers influenced providers behavior. There were hundreds of possibilities for the design of the concrete features of the reformed HC system. The aim of the this section is to analyze the problems of a new system and the avoidance or necessity of these problems.

The third and concluding section concentrates on the analysis of suggestions made by the Minister of Health Care to improve the existing system. These suggestions concern the regulation process in the HC system along with the reimbursement system. The aim of this section is to make some judgements about the future of HC reform.

1. Changes in the Health Care System

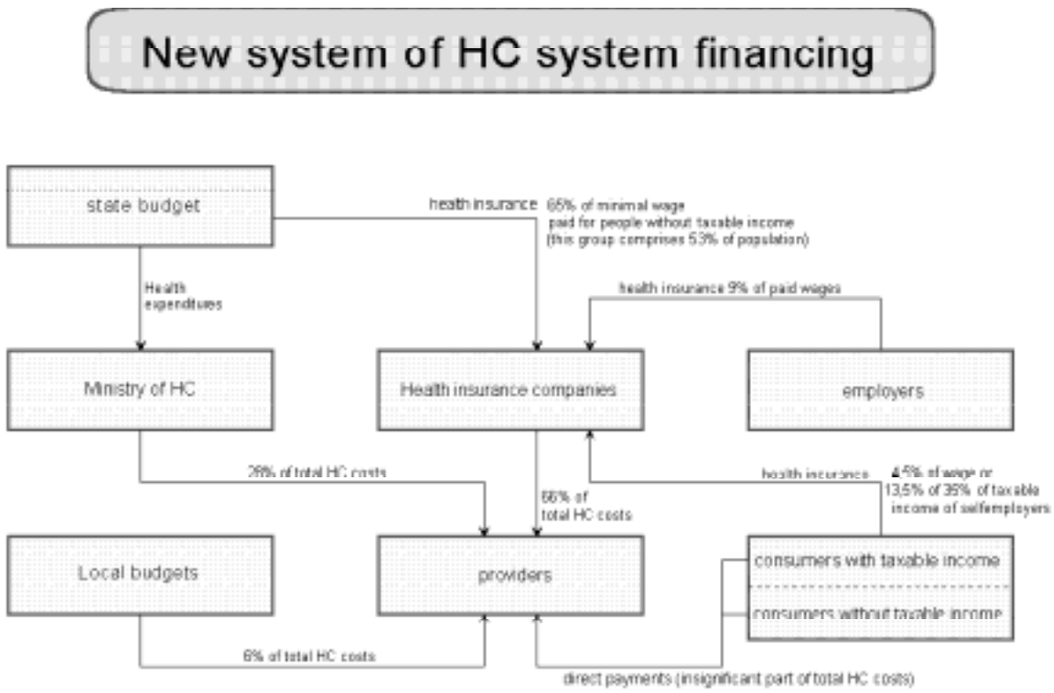
1.1. Description of a new system

Under the previous regime, Czech (and, at that time, also Slovak) HC followed a pure National Health Service model. It was characterized by universal coverage, national general tax financing along with national ownership and control of health care providers.

The new health care system, established through several legal norms (see Table 1) uses the Social Insurance model. This is characterized by compulsory universal coverage, financed by the state, employer, and individual contributions to the General Health Insurance Office or sectional, professional, corporate and other health insurance institutions. It is a fee-for-service system with both public and private providers.

The new system, similar to the previous one, is based on the principle of solidarity. Every citizen has a right to the same level of health care, no matter how much he or she contributes.

The structure of this new system is described in Figure 1. Funds for financing the HC system are raised by collecting health insurance premiums from people with taxable income, payments from employers, and the from state budget. In addition, providers get some financing from the state (through the Ministry of HC) and local budgets and other resources (direct payments from patients, gifts, donations, sponsoring...). Money used in the HC system is distributed through health insurance company offices, the Ministry of HC and local governments. Health insurance offices finance health care services and prescribed drugs. The Ministry of HC is responsible for financing research, medical education, immunization and other programs (special medical care for the elderly, disabled and drug dependent etc.). Local governments support providers of local health care.



1.2 Main changes of the old system

The first substantial change made was in the raising of money for the HC system. The old system used general taxation to raise money for the financing of HC. The new system distinguishes five sources for financing HC:

* health insurance payments
* state government contributions
* local government contributions
* direct payments from patients
* other

Health insurance payments are strictly separated from other tax payments. There are three groups of health insurance payers:

1) persons without taxable income covered by state contributions. This group comprises 53% of the population: children, old age pensioners, persons on maternity leave, officially registered unemployed, persons eligible for social allowances or allowances for the disabled, soldiers in mandatory services, persons under arrest or serving prison sentences
2) persons with taxable income: employees pay 4.5% of their taxable income, self-employed persons pay 13.5% of 35% of their taxable income

3) employers pay 9% of the sum of their employees' taxable income.

Every person is required to register at an insurance institution. The General Health Insurance Office (GHIO) is obliged to register every person who is not registered at some sectional, professional, corporate, or other health insurance office. Rules have been developed for the redistribution of contributions to equalize conditions for all insurance institutions.

The second substantial change was made to the system of payments to health care providers. The old system financed state HC providers by using the government budget. The amount of money providers received depended on the number of their employees, their capacity and the type of HC institution. The new system uses a fee-for-service system. All covered services (and its "prices") provided by HC institutions and covered by health insurance are listed in the Fee-for-service Price List (see Table 1). The number and importance of services that are not covered by health insurance is insignificant. "Prices" are given partially in points and partially in crowns. The system of setting the final price paid by insurance companies to providers is regulated. Patients only pay directly for those services that are not listed in the Price List or for other voluntary choices (for example if they choose a provider who has no contract with any insurance company). Sickness allowance payments are financed by other financial resources and run by the Ministry of Labor and Social Affairs.

The third substantial change was the establishment of a legal framework for private HC providers (especially the Act on Health Care in Non-Governmental Health Care Facilities). Private HC institutions have developed through the ongoing privatization process, by building new facilities and through leasing existing capacities from state institutions for private practices. The reimbursement system is the same for both public and private providers.

1.3 Character of a new system

From this brief report, it is apparent that the system of HC has been through a dramatic process of change, and has two main targets:

1) to enable the provision of private HC
2) to enable the introduction of personal responsibility of patients for their health status

At the same time, HC is the only part of the traditionally state-dominated social sphere - education, social insurance, and health care - that has been through such profound economic reorganization. Why only health care?

This is not an easy question to answer but the hypothesis presented below seems quite plausible.

There are two extreme views concerning the state's role in the social sphere. The first "conservative" view can be represented by statements such as:

" We should deny the philosophical premise of the welfare state, that education, medical care, and the like ought to be available to all as a matter of right". "[The right to services and benefits]...is merely the right to seize income and wealth from other individuals through the body politic. The right of one is the duty of another, the benefit of one is the loss of another." [2] p.2.

The second "socialistic" or "welfare state" view is represented by a simple statement:

"The state is responsible for individual welfare from the cradle to the grave". [1],p.278.

Having had more than 40 years of negative experience with the"socialistic" approach, we should not be surprised that the fathers of our economic reform inclined towards the "conservative" extreme. The tendency to suppress the government's role in the social sphere was clear from the very first proclamations of the new government after the 1990 elections. However, their dream was not realistic without support from the object of the reform: reformers needed the same support as they got from the rapidly emerging private firms which had started to operate in industry. Advocates for the limited role of the state in the social sphere could hardly expect to receive a call for a new system of financing peoples needs from retired and disabled people or people on maternity leave. It would also be naive to expect visible support from academics who were educated under Marxist ideology and strongly influenced (in the better case) by a western European"welfare state" approach to education, to plead for privatization or the introduction of school fees in the system of education.

The situation among doctors was different. One of the striking facts about doctors under the previous regime is that they were willing to work extremely hard for extremely low wages (the average doctor's wage was just slightly above 50% of the average wage [3 p.58].

Why were doctors willing to work so hard, even for extraordinarily low wages? Under "really-existing" socialism, a person's social and welfare situation was not indicated by his income or wealth, but by his ability to offer services in exchange for scarce goods and other services. Under this peculiar barter system, the position of doctors in the exchange process was one of the best in the social structure.

Note:
Several more subtle reasons can be suggested for this situation, but they are based only on familiarity with the medical environment. As far as is known, no serious sociological research has been undertaken to verify these statements:

* relatively low ideological pollution of the medical environment
* the maintenance of the traditional heritage of medical professions from one generation to another
* any mistake or act of negligence in this profession might have meant death or disability, which was too great a burden for the normal conscience.

Once the basic package of legal norms for economic reform was adopted in May 1990, it was apparent that this old system "barter incentive" would be lost.

The liberalization of the prices of goods by almost 80 % eliminated shortages and the growth of the private sector brought liberalization in the income structure. These changes made bartering between patients and doctors even more absurd and offensive, and much too complicated. At the same time, doctors were aware of the tragic situation regarding the technical level of hospital equipment that was threatening to bring a collapse of the HC system.

This hypothesis is supported by the fact that there was a "medical lobby" on whose support government reform could be built. The fact that all "post revolutionary" HC ministers were doctors and the Czech Medical Association participated greatly in the preparation of new legal norms also supports this hypothesis.

2. Performance of the new HC system

As already mentioned, the most important fact regarding the performance of the new HC system is that it did lead to a collapse in health care. This means that it did not complicate or deteriorate access to health care for individuals, and it did not increase the share of HC expenditures in individuals budgets.
Payments of health care insurance did not result in an additional income deduction. The sum of personal income tax, health care and social insurance payments represents a similar burden to that of the general tax payment under the previous regime. Patients now have unlimited choice of providers and all services that were provided by the previous HC system for free are now listed in the Fee-for-service Price List.

On the other hand, because it is similar to systems in standard market economies', it suffers from the same common problem as these systems: rising HC expenditures that are difficult to control.

Among all agents of the HC system (patients, providers, health insurance companies, state government, and local government), the behavior of two was remarkably influenced by the latest changes: health insurance companies and providers. Analysis of their behavior should help us to understand why the costs of HC are rising, whether it is just a developmental disease of the new system, or the result of mistakes in the reform's design or an inevitable feature of any market-based system of HC.

2.1 Health insurance companies' behavior

The new system of financing HC brought a group of completely new actors onto the HC stage - health insurance companies (the legal framework for establishing these institutions was provided by the General Health Care Insurance Act and the General Health Insurance Office Act that had been in operation since the beginning of January 1992 and also the Sectional, Professional, Corporate and other Health Insurance Offices Act that had been in operation since 1993 - see Table 1).

The standard role of insurance is to spread the risk of unanticipated high costs among a great number of people. This makes the unexpected payments less threatening to the financial stability of households.

The reform of the HO system followed a very common approach to health insurance: the payment of health insurance is compulsory and the state pays the insurance for those who are unable to pay.

There are usually two explanations for this approach:

1) the health status of the individual has some external relevence e.g. influences the well being of other members of society (infectious diseases),
2) the justice argument - peoples' health status should not depend on their economic situation or that the wealthier part of the population is made responsible for the well being of the less wealthy part.

In the case of our republic there was one more reason. The previous regime assured equal "free" access to HC for everybody, regardless of her/his contributions to state financial resources. To assure "social peace" during economic reform it was assumed necessary to continue this tradition.

Even in the case where the state accepts responsibility for the populations' health status, there is a strong argument against the pure public provision of health care. Individuals' health status is significantly influenced by their behavior (the traditional components influencing health status are: health care 14%, lifestyle 60%, environmental factors 25% , and genetic predisposition 15% [3,p.8]). This is why most HC systems build incentives to provoke individual responsibility for health status. The first necessary, but not sufficient, condition for building these incentives is to separate payments for health care from other compulsory payments. Individuals need to know how much they spend on HC. Following this strategy, a new tax system introduced in January 1993 lowered personal income tax to make room for the collection of health insurance and sickness insurance as separate income deductions.

Previously, the Ministry of HC managed the section of the state budget that was used for financing HC. When this money was not a part of the state budget, it was assumed practical to establish an institution that would deal with the money collected for financing HC. This was one of the most important activities proposed for the General Health Insurance Office (GHIO), a corporation established in January 1992, with the state as a dominant shareholder.

Having just one health insurance office on the health insurance market, it was necessary to justify its monopoly position. The only way was to show that there is a natural monopoly situation on this market. Without any data concerning cost functions it was easier to use experiences from other relevant countries. In such

countries, free access to the health insurance market predominates. In January 1993 this fact helped a group of parliament members to push the Sectional, Professional, Corporate and other Health Insurance Offices Act through Parliament. The question of whether this competition between health insurance companies is "sound" is now the subject of analysis.

Today there are 19 health insurance companies (HIC) operating in the Czech HC market. Some data about their performance can be seen in Table 2. The GHIO insures 83.73% of all the insured (next is Hornicka HIC with 3.01%), 88.47 % of the insured with insurance paid by state, and 92.76% of the insured over the age of 60. The total percentage of insured with insurance paid by the state is 53.83 %, the total percentage of insured over the age of 60 is 17.26% [3 p.54 and 5 pp.8-19].

The HIC's main revenue comes from health insurance payments paid by people insured. In order to maximize their revenue they, should maximize the number of insured. The amount of insurance payment depends on the income of the insured (the average monthly contribution of people with taxable income was 700 Kc, the state contribution per person was 229 Kc. [Nemec, J., Redistribution Among Health Insurance Offices, Prakticky lekar, 73, 1993, No. 10, p.450]). To maximize insurance payments the HIC should attract the insured with high income.

The main costs of HIC are payments made to providers for health services provided for the HIC's insured. To minimize costs, HIC should attract the insured with the lowest probability of health problems. The other possibility is to lower payments for services, but as providers are in indirect contact with patients they could therefore discourage patients from using HIC's services that have an extremely low level of payment.

Following the above mentioned logic, the new HIC concentrated their attention on attracting young people, preferably with high incomes. (The total number of insured that left the GHIO in January 1994 was 193,584, of this number only 9% were betwen the ages of 55-94, with the total percentage of people over the age of 60 being 17% [5 pp.8-19].). Some HIC did not hesitate to invest money in order to favorably affect the structure of their insured population. Some paid employers of personal offices from enterprises with high average wages for recruiting their employees or teachers at school for recruiting children, or else sponsored those hospitals that transferred their employers to this HIC, organized advertising campaigns etc. This behavior is strongly criticized mainly by GHIO representatives. The argument is that the money spent on such activities is a

waste of the money that has been collected for HC. Another strategy that the HIC used to attract the insured was to offer coverage on those services and drugs that are not listed in Fee-for-services and the Drugs and Other Remedies Price List. In this case the criticism expressed by the GHIO is based on justice arguments. The argument is that this is a redistribution of collected money in favor of those with higher income (people with low incomes are mostly registered at the GHIO, who cannot afford to offer these extra services and drugs). Also, to avoid a boycott from providers (the new HIC means more administrative work for the provider), the new HIC usually offer higher point value in crowns (Kc) for one point (see Table 2). In their advertising campaigns, the HIC's use information regarding higher payments to providers because patients believe that with higher payments you receive better services.

To make conditions for all HIC's comparable, the system of redistribution of collected health insurance was introduced. All HIC's have to send 60% (previously 50%) of collected health insurance from taxable incomes and all the money they receive from the state to a separate GHIO account. The sum of these funds is used in the calculation of a "normalized health contribution". This is the average contribution where people over the age 60 were counted three times. However, health care costs for people over 60 years of age are four times higher than average, [Nemec, J., Redistribution Among Health Insurance Offices, Prakticky lekar, 73, 1993, No. 10, p.450]. Every HIC gets back the normalized health contribution times its number of insured where the insured over the age 60 are again counted three times (see Note).

Note:

P_i- 60% of the sum of health insurance collected from insured with taxable income plus all state contributions for insured of i-th HIC

N_i- number of insured of i-th HIC

$N_i o$- number of insured over the age of 60 of i-th HIC

$S = \$P_i/(\$N_i + 2\$N_i o)$

S_i- the amount of money i-th HIC gets back

$S_i = SxN_i + Sx2N_i o$

2.2 Providers' behavior

The previous system was characterized by a small number of highly centralized state owned providers of HC. The first step of HC reform was the decentralization of state owned institutions. The next step was the creation of legal conditions for the introduction of private HC institutions (Health Care in Non-Governmental Health Care Facilities Act) in April 1992.

The result, or first step, was the increase in the number of HC institutions from 142 at the end of 1990 to more than 900 institutions at the beginning of 1992 [Ekonom 21/93 p.36]. The number of non-governmental institutions at the end 1992 was 1563 [Zpravodaj VZP, 1/94, p.8], and the private providers' share of GHIO payments was 1.7% [5, p.41].

Simultaneously, privatization of state owned institutions began. The aim of the process of privatization is to totally or partially privatize 83% of all (1055) state owned institutions, 18% should be transferred to local governments, 16% should be a mixture of private and local government ownership and 66% should be owned exclusively by private owners [4 p.47].

The most complicated and controversial result of HC reform is the system of HC providers' reimbursement. The system adopted by the reform is a fee-for-service reimbursement system. Every service covered by health insurance is listed in the Fee-for-service Price List. The price of a service can comprise two parts:

1) price expressed in number of points (should include 70-85% of all HC costs according to complexity and frequency of service),

2) price expressed in Kc (Czech currency): this is based on the direct or optional cost of the service.

The ratio of the two parts of this price varies widely. The share of points on price varies from 35% to 65% [5 p. 28].

The price of one point paid by the GHIO is regulated by the Ministry of Health Care. The GHIO and professional medical associations have some advisory power in the price setting process. The problem with the two-part pricing structure is that it mixes regulated and deregulated elements. The second or the non-point part of the price is not regulated at all. Of course, this then causes these elements of payment for services to increase faster than the point payments. During 1993 the number of points paid by the GHIO increased by

13%, the amount paid for direct costs by 26% and the amount paid for optional costs by 55% [5 p. 34].

The data for awarding points to services was generated by professional medical associations. It is very likely that an attempt to base the number of points on the complexity, labor, material and capital consumption of services completely failed. The reason for this failure is not any malicious intent on the part of the authors. The problem is the absolute lack of relevant information and experience combined with a very low level of accounting skills. This process should have at least been supervised by accounting professionals. The consequence of this highly imperfect point system is that providers' costs are not related to the number of points they receive for a procedure. However, it is extremely difficult to test this hypothesis because of the lack of data regarding providers' costs. Providers are not obliged to supply any state institution with the relevant data.

The GHIO made some estimates of providers costs and calculated that the number of points deferent, medical specializations need to reach a net profit of 12,000 Kc per month. They also reported the number of points these providers actually reported in the first half of 1993. Both figures vary considerably. Surgeons needed about 105,000 points to reach a net profit 12,000 Kc. The number of points they actually reported in the first half of 1993 was 120,000. The number of points pediatricians needed to reach a net profit of 12,000 Kc was about 82,000: the number of points they actually reported in the first half of 1993 was approximately 78,000 [6].

The result of this situation is that HC providers have to find an adequate system by which to adjust the number of points they report in order to raise enough financial resources to stay in business. For state institutions, this means being able to cover their costs, because the possibility of paying out extra high salaries to state employees is limited by wage regulations. For private providers, it means not only being able to cover costs, but also to earn a profit high enough to maintain incentive for their investors. It was almost totally impossibile to monitor what services were really provided and whether the service provided was necessary to enable the existence of such a reporting system.

To summarize why the reform contributed to increasing HC costs (a 14% increase in total HC costs during 1991-1992, 44% during 1992-1993 [4,p.3]) we can conclude that:

* establishing HIC brought extra administrative costs,

* the absence of regulation for one part of the services price lead to a sharp increase in direct and optional costs,

* a pure fee for the service reimbursement system in combination with an amateur Fee-for-service Price List resulted in the inflation of "well awarded services.

The first problem could be a young disease in the new system that might be cured by improvements in the HIC structure and by fine tuning of the redistribution system.

The second problem is a technical mistake. A necessity to regulate prices in HC provision is based on the argument concerning imperfect information. Because the patient is completely dependent on the doctor's judgment concerning what kind of service is needed and how much it will cost, it is argued that at least the price of these services should be regulated.

Note:
My personal view concerning this argument can be simply expressed as follows:

a safe function of my care is also a vital necessity and I am completely dependent on serviceman judgment regarding what and how much service my care needs.

If there is a price regulation it should be clear and efficient. This is definitely not the case of contemporary price construction.

The third problem is partially a developmental disease, i.e. the lack of information and qualified experts to calculate the point structure. However, the major problem is that the system lacks the constraints used by several other countries with similar systems. Some type of fee-for-service system is used in many other countries but it is usually combined with some kind of cost combating systems such as patients co-payment, lump sum payments for health plans or other forms of capitation. The lack of such costs constraining the structure of the Czech system is a very serious problem.

This analysis brings us to the concluding part of this paper, to the judgment concerning the future of the HC system.

3. The future of health system reform

Changes in the HC sector have been strikingly rapid and remarkable. All these changes have been closely scrutinized by media and have enjoyed great publicity. The fact that the Minister of HC was the first minister of contemporary government who was recalled, despite being a member of the most powerful party of coalition, supports the above statements.

Note:
The second and only other recalled minister was from the Ministry of Culture, a member of the third powerful party in a coalition of four.

In order to make judgments concerning the future of the Czech HC system as practical as possible, there will be comment made on the Draft of Reform of General Health Insurance System delivered to parliament Committee for Health Care by the Ministry of Health Care (14.3.94) [4].

This draft makes two suggestions:

* to change the structure of the HIC and to change some features of the HIC-provider relationship,
* to change the reimbursement system.

3.1 Changes in health insurance companies' structure

The position of the GHIO is rather ambiguous. Simultaneously, it plays both the role of health insurance provider and of regulator. The GHIO controls more than 80% of health insurance payments, has access to the best available data, and is legally responsible for the insurance of all those who are not insured elsewhere or were insured by a failed HIC. The structure of the GHIO enables it to significantly influence regulatory decisions.

Another rather awkward situation is caused by the separation of health insurance and sickness insurance (sickness insurance and sickness payments are controlled by the Ministry of Labor and Social Affairs). The problems are caused by a complicated administrative structure and the possibility of perverse incentives. Doctors are responsible for the decision concerning the length of time a person should receive sickness benefit. If there is the opportunity to make a cure

cheaper or to make the patient happier by prolonging the time a they spend on sickness benefit, both doctors and the HIC have are inclined to opt for the latter.

The Minister's suggestion is to establish a new independent regulatory institution (controlled by parliament) that would organize the redistribution of insurance payments, register and evaluate performance of all HIC's, summarize and publish all information about HIC's and providers directed at the patients. The existence of such an institution should also help to unify the collection of health and sickness insurance and the control of sickness benefits.

One objection to this plan is that this role is (or should be) played by the GHIO and the Ministry of HC, and that the new institution would only make the system even more complicated and costly.

According to regulatory theory, a regulator should be independent of the providers of the regulated activities and have an independent source of finance (usually the government). This is the reason why this is high priority item for change.

Another proposed change concerning the HIC's role is to loosen conditions under which a HIC provides insurance. There should be introduced the possibility for a HIC to:

* collect extra insurance for extra services,
* limit the free choice of providers,
* institutionally combine provider and HIC.

All these changes would definitely help to suppress costs but these changes are also a dangerous threat to "social peace". The necessary first steps should be:

* improvements in price regulation,
* definition of basic services that should be delivered by every insurance plan for basic compulsory payments.

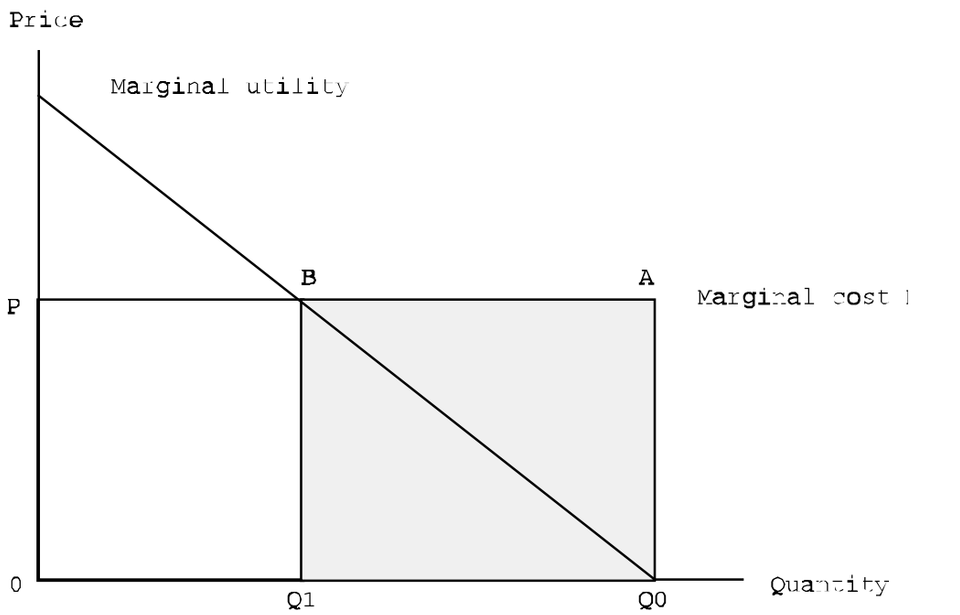
3.2 Changes in the reimbursement system

There are two groups of suggestions on how to change the reimbursement system and to combat costs: the first concerns patient behavior and the second providers' behavior.

If the amount of services patients receive from providers is unrelated to the amount of contributions they pay for health care, they behave in the same way as if the HC were free. Standard theory uses welfare loss analysis to show why this behavior is inefficient for society. In other words the system encourages patients to "waste" medical services.

When consumers can obtain "free" medical care they will use medical services up to the point where the last service has very low or even had zero value. However, the marginal cost of the last consumed service is not zero and thus, the extra services consumed as a result of free medical care have less value than their cost to society. The difference between cost and value is welfare loss (see Figure 2).

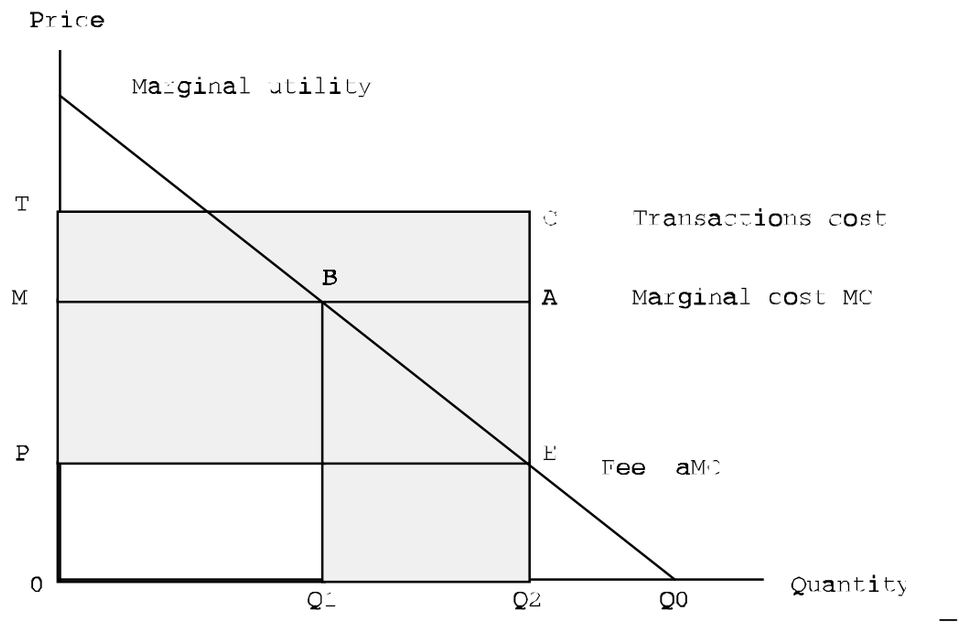
Figure 2



With zero price the consumer demands Q_0. If the price were P = MC, the consumption of health services would be Q_1. The extra services are worth Q_0BQ_1 to the consumer. This is less than their cost of P* (Q_0 - Q_1), resulting in a welfare loss of BAQ_0 or waste of.

When a system of patient co-payment is introduced, there are some additional costs from running the fee system - transaction costs (CT). Let the fee equal the *a* times marginal cost (*a*MC). If CT is too high, *a* small amount of the welfare loss could be even bigger than without a fee. To show why, the description of a figure can be used.

Figure 3



With zero price the consumer demands Q_0 and the welfare loss is equal BQ_1Q_0. With price $P = a$MC, the consumer demands Q_2. Saved loss is Q_2Q_0E but extra costs are MTCA. Hence, lowering overconsumption of services by introducing co-payment does not save enough consumer welfare to offset the transaction costs.

The HC system still operates in quite a clumsy and cumbersome manner. It suffers especially from the unavailability of data. The transaction cost as a result of running the fee system would probably be extremely high, especially when it would be necessary to distinguish between people eligible for exemption from this payment due to low income. This is why any decision about the form of a possible co-payment by patients should be postponed until more information about the elasticity of consumer demand and estimates of the transactions cost can be made available.

Concerning providers' behavior, the suggestions below concentrate on modifications of the fee-for-service system.

One group of these suggestions calls for improvement of the Fee-for-service price list. Finding an acceptable method of calculating health service prices is partially a technical problem, where accounting and regulation theory can be

used. However, institutionally there is a conflict between providers represented by medical associations that have information costs and the GHIO still has a monopoly on consumption information. A change in HIC structure mentioned in the previous subsection may help to improve this situation.

The second group of suggestions deals with the addition of different forms of capitation payments to the fee-for-service system. This should be helpful, especially in solving the problem of different overhead costs in HC institutions and in helping to controls costs. It would be useful to separate payments for "living expenses" in hospitals (bed and food) from payments for HC services. Here the transaction cost would be low and the threat to social peace minor.

Conclusions

The purpose of this paper was definitely not to identify and address all problems connected with the new HC system. Also, it was not the purpose to decide what is wrong and what is right in this system. The aim of this paper was to classify some of the problems and to give health policy authors extra information to help them in their difficult task.

References:

[1] Gough, I., Welfare State. In: Social Economics, edited by J.Eatwell, M. Milgate, P. Newman.

[2] Sennholz, H.F., Politicized Medicine, The Foundation for Economic Education, Ins. Irvington-on-Hudson, New York, p.2.

[3] Analysis of the Contemporary Situation of Transformation of Czech Health Care - material for Czech Parliament, Czech Ministry for Health Care SM/38536/1994

[4] Draft of Reform of the General Health Insurance System, Ministry of Health Care, 14.3.94

[5] Analysis of the Contemporary Problems of Health Insurance System,General Health Insurance Office, March 1994, prepared for Czech parliament

[6] Data calculated by General Health Insurance Office, not published. Provided for research purposes to the author of this paper by the director of the GHIO Ing. Nemec

Table 1

List of Legal Norms Important for the Establishment of the New HC System

General Health Care Insurance Act
(No. 550/91),
in operation since 1.1.92, some paragraphs since 1.1.93
amended by laws No. 592/92, 10/93, and 15/93
General Health Insurance Office Act
(No. 551/91),
in operation since 1.1.92, some paragraphs since 1.1.93
amended by law No. 592/92
Health Care Act
(No. 86/92), in operation since 15.4.92
Health Care in Non-Governmental Health Care Facilities Act
(No. 160/92), in operation since 15.4.92
Government Decision - Health Care Code
(No. 216/92),
in operation since 22.5.92, amendment since 29.1.93
amended by government decisions 50/93, 117/93
Sectional, Professional, Corporate and other Health
Insurance Offices Act
(No.280/92)
in operation since 1.1.93, some paragraphs since 1.7.93
Notice of the Ministry of Health Care - Fee-for-service Price List
(No. 258/92), in operation since 1.6.92
Notice of the Ministry of Health Care - Drugs and Other Remedies
Price List
(No. 426/92), in operation since 15.9.92
amended by the announcement of the Ministry of Health Care and other ministry offices
(No. 427/92), in operation since 31.8.92
Notice of the Ministry of Health Care - Directly Paid Health Care
(No. 467/92), in operation since 15.10.92
Laws - Basic Norms for Preparing Privatization Projects
(No.92/91 Federal) and (No. 171/91)
Government Decision - Categories of Health Care Facilities for
the Purpose of Privatization
(No. 137/93)
amended by law No. 210/93
Government Decision - Further Strategy in Privatization
(No. 568/93)

Table 2

Data about Health Insurance Companies

	Number of insured N	Number insured paid by state % of N	Number of insured over 60 years % of N	Kc per point
1. GHIO	8875319	56.87	19.12	0.52
2. Vojenska	208956	39.03	6.78	0.65
3. Hornicka	319720	43.80	9.48	0.60
4. Zeleznicni	133522	19.35	6.36	0.70
5. Garant	73629	30.78	4.83	0.60
6. Hutnicka	217038	48.26	12.79	0.57
7. Moravska	64276	35.57	3.86	0.60
8. Bankovni	92126	29.06	1.33	0.70
9. Atlas	65942	25.20	6.94	0.60
10. Skoda MB	36303	56.95	13.14	0.60
11. Skodovaku	30251	23.31	6.40	0.60
12. Vnitra	181785	39.25	12.11	0.65
13. Stavebni	50406	16.14	2.78	0.62
14. Revirni	103590	56.38	3.56	0.66
15. REZAPO	37886	26.57	5.07	0.65
16. Mor.slezka	34024	28.09	2.70	0.60
17. Salvus	34743	35.70	5.74	0.60
18. Metal	39953	47.29	2.59	0.60
19. Crystal	199	39.19	3.51	0.60

Total number of insured (sum of N) - 10,599,304
Total number of insured paid by state - 5,705,759
Total number of insured older than 60 years - 1,829,861

Source: [10 p.54 and 12 pp.8.19].